THE STEPHEN GROUP

APPENDICIES

NEBRASKA TREATMENT FAMILY CARE AND FOSTER CARE RATE ANALYSIS

JUNE 2021

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Rate Methodologies and Components

	California	Ohio	Wisconsin	Michigan	Indiana	New York	Kentucky	Illinois	North Carolina
Rate	Standardized Rates	Provider Specific	Provider Specific Calculated but limited to a maximum daily rate CPAs low $50s – mid $60s	Provider Specific Existing provider program change or augmentation may be approved for an interim rate when the change or augmentation is contractually agreed to by DHS	Provider specific	Standard Rate	Standard rate	Standard Rate	Standard Rate
Cost Report	Annually, but not used to base rates. Rates were established in 1985 and have had COLAs applied. Reviewed for reasonability of cost and "unusual industry-wide" cost but in practice not used to re-base rates.	Annually – used to calculate maximum reimbursement rates per provider	Annually	Annually	Annually, used annually to establish rates based on service (cost) data and prior year utilization.	Annually	Annually – Haven't been used lately. Blended rates (multiple funding sources)	Annually	Annually
Audit Requirement	Single Audit	Cost Report audited to Single Audit Standards by	Audited Financial Statement	Audited Financial Statement	Audited Financial Statement. Report subject to DCS desk review and	Audited Financial Statement	Audited financial statements	Single Audit, Certified Independent Audit, or Certified	Audited financial statements

	California	Ohio	Wisconsin	Michigan	Indiana	New York	Kentucky	Illinois	North Carolina
		independent auditor prior to submission			subsequent site review.			Financial Report	
Staffing Caps	Original methodology used ranges to calculate applicable staffing costs using a "point system" method. Required extensive documentation of staff, education, experience.	Not Capped	Staffing ratios applied to direct service and supervisory staff in the methodology.	No	Staffing cap based on number of case management staff, supervisors, and recruitment / licensing staff	Staffing ratios utilized in the residential care model. Separate caps are applied to social services and direct care staff.	No	No	
Fringe Caps	Averages Used 20.4% in mid-80s	Not Capped			Changes annually. Based on a reasonable deviation from the median as determined by DCS.		No	25% by State Code, but allows for exception through appeal	27.5% (based on USDOL data)
Admin Caps	Averages used in mid-80s	Not Capped			Changes annually. Based on a reasonable deviation from the median as determined by DCS.	An administrative "parameter" of either 17% or 21% is calculated and compared to actual cost. The lesser of the two is applied	No	20% by State Code but allows for exception through appeal.	25% - Definition is aligned with traditional expenditures for administration
COLA	"Discretionary COLA" Was the subject of the	Yes based on CPI - > 6% in 2011	CPI applied		Changes annually. Based on a		No	Not Apparent (NA)	Yes – Wages 3.6%, other costs

	California	Ohio	Wisconsin	Michigan	Indiana	New York	Kentucky	Illinois	North Carolina
	California Association Lawsuit. Applied annually				reasonable deviation from the median as determined by DCS.				
Profit	N/A	No applied profit beyond reported costs	Allowed		Allowed. For Profit Providers only. Changes annually.	No applied profit beyond reported costs	No applied profit beyond reported costs	Limited to 9% and classified as administrative cost	No applied profit beyond reported costs

AGREEMENT NUMBER: **20-21-10400401**
AMENDMENT NUMBER:

Between

WEST MICHIGAN PARTNERSHIP FOR CHILDREN
213 Sheldon Ave, Suite 2 A
Grand Rapids, MI 49503

And

SERVICE PROVIDER	Bethany Christian Services of Michigan
SERVICE PROVIDER ADDRESS	901 Eastern Ave, NE, Grand Rapids, MI 49503
SERVICE PROVIDER EMAIL	rwillis@bethany.org

CONTRACT ADMINISTRATOR	Pamela Martinez
EMAIL	pmartinez@wmpc.care

AGREEMENT SUMMARY			
SERVICE DESCRIPTION	Child Welfare Continuum of Care		
GEOGRAPHIC AREA	Statewide		
INITIAL EFFECTIVE DATE	11/01/2020	CURRENT EXPIRATION DATE	09/30/2021
CURRENT AGREEMENT VALUE			
AGREEMENT TYPE	Unit Rate/Per Diem		

The undersigned have the lawful authority to bind the Service Provider and West Michigan Partnership for Children to the terms set forth in this Agreement.

FOR THE SERVICE PROVIDER:
BETHANY CHRISTIAN SERVICES OF MICHGIAN

Signature of Director or Authorized Designee

Print Name

Date

FOR WEST MICHIGAN PARTNERSHIP FOR CHILDREN:

Signature of Director or Authorized Designee

Kristyn Peck
Print Name

Date

PART I

1. Period of Agreement

This Agreement will commence on the date of the Service Provider's signature or November 1, 2020 whichever is later and continue through September 30, 2021. No service will be provided and no costs to WMPC will be incurred under this Agreement prior to November 1, 2020, or the effective date of the Agreement, whichever is later. Through this Agreement, the date of the Service Provider's signature or November 1, 2020, whichever is later, shall be referred to as the Begin Date. This Agreement is in full force and effect for the period specified.

2. Agreement Renewal

This Agreement may be renewed for one term not to exceed the original term of the Agreement. Such renewal shall be made by mutual agreement and shall be contingent upon satisfactory performance evaluations as determined by WMPC and shall be subject to the availability of funds. Any renewal shall be in writing and shall be subject to the same terms and conditions as set forth in the initial Agreement, Attachments, and subsequent Amendments.

3. Purpose

The purpose of the program is to deliver a continuum of culturally-responsive and trauma-informed comprehensive foster care, independent living, guardianship, and adoption services in accordance with the Michigan Department of Health and Human Services ("MDHHS") Foster Care, Adoption, and Guardianship Manuals to eligible children and families under the care and supervision of Kent County MDHHS as provided for in the Grant Agreement between MDHHS and WMPC.

4. Agreement Amount

Any payments or other types of funding that WMPC is obligated to provide under the Agreement is only required if the grant funds under the Grant Agreement are available to provide that payment or funding. If grant funds under the Grant Agreement are not available for payment or funding, WMPC is not obligated to provide that payment or funding. Service Provider acknowledges that payments received from WMPC are a subaward of the grant funds under the Grant Agreement and are subject to 2 CFR 200.331 (a).

5. Conflicting Terms

Service Provider shall comply with all applicable terms and conditions of the Grant Agreement. In the event of a conflict between the Grant Agreement and the provisions of this Agreement, the provisions of the Grant Agreement shall prevail. A conflict between the Grant Agreement and this Agreement, however, shall not be deemed to exist where the Agreement:

A. Contains additional non-conflicting provisions not set forth in the Grant Agreement;
B. Restates provisions of the Grant Agreement to afford the Service Provider the same or substantially the same rights and privileges as WMPC and MDHHS; or
C. Requires the Service Provider to perform duties and/or services in less time than that afforded WMPC in the Grant Agreement.

6. Relationship of the Parties

A. Service Provider is a subrecipient of WMPC. Nothing herein shall create or shall be construed as creating a partnership, joint venture, agency, or any other relationship between WMPC and Service Provider. Neither Service Provider nor any of Service Provider's employees or representatives will be deemed or construed to be an employee of WMPC for any reason including, but not limited to, the Federal Unemployment Tax Act, any workers' compensation laws, or income tax withholding laws. Service Provider shall have sole responsibility for the payment of all federal, state, and local taxes applicable to Service Provider's services and services provided by Service Provider's employees, agents,

independent contractors, volunteers, and students.

B. WMPC shall act as the sole liaison between Service Provider and MDHHS involved with any Client in matters related to the operation of the Kent County Consortium model and/or WMPC's System of Care or any Client being served by the Service Provider through this Agreement with WMPC.

C. This Agreement does not affect the Service Provider's accountability to MDHHS for the subcontracted activity.

D. WMPC may submit a copy of the executed copy of this Agreement if requested by MDHHS.

7. Statement of Work

The Service Provider agrees to undertake, perform, and complete the services described in Attachment A, which is part of this Agreement through reference.

8. Financial Requirements

Any billing or request for reimbursement for costs under this Agreement shall be supported under this Agreement and include adequate source documentation on costs and services. The financial requirements shall be followed as described in Attachments B and C, which are part of this Agreement through reference.

9. Reporting Requirements

The progress reporting methods shall be followed as described in Attachment D, which is part of this Agreement through reference.

10. General Provisions

The Service Provider agrees to comply with the General Provisions outlined in Part II and Attachments E, F, G, H, and I which are part of this Agreement through reference.

11. Special Conditions

A. This Agreement is valid upon approval and execution by WMPC and signature by Service Provider.

B. WMPC will not assume any responsibility or liability for costs incurred by the Service Provider prior to the signing of this Agreement.

12. Special Certification

The individual or officer signing this Agreement certifies by his or her signature that he or she is authorized to sign this Agreement on behalf of the responsible Service Provider.

PART II
GENERAL PROVISIONS

1. Responsibilities – Service Provider

The Service Provider in accordance with the general purposes and objectives of this Agreement shall:

A. Publication Rights

i. Service Provider must obtain prior written authorization from WMPC before publishing any material that specifically references WMPC or that WMPC developed, in whole or in part, or copyrighted.

ii. Service Provider shall not make any media releases related to this Agreement or work performed under it without prior written authorization from WMPC.

B. Intellectual Property Rights

i. WMPC has full ownership, possession, and control over all intellectual property, inventions, and written or electronically created materials, including manuals, presentations, films, or other copyrightable materials, arising from or relating to any business WMPC conducts, regardless of whether or not it arises from or relates to work performed by Service Provider under this Agreement.

C. Fees and Other Sources of Funding

i. Service Provider guarantees that any claims made to WMPC under this Agreement shall not be financed by any source other than WMPC under the terms of this Agreement. If funding is received through any other source, the Service Provider agrees to deduct from the amount billed to WMPC the greater of either the funding amount received, or the actual costs of the services provided.

ii. Service Provider may not accept reimbursement from a client unless the Agreement specifically authorizes such reimbursement in the "Service Provider Responsibility" Section. In such case, a detailed fee scale and criteria for charging the fee must be included. If the Service Provider accepts reimbursement from a client in accordance with the terms of the Agreement, the Service Provider shall deduct these fees from billings to WMPC.

iii. Other third-party funding sources, e.g., insurance companies, may be billed for contracted client services. Third party reimbursement shall be considered payment in full unless the third-party fund source requires a co-pay, in which case WMPC may be billed for the amount of the co-pay. No supplemental billing is allowed.

D. Recoupment of Funding

Service Provider shall comply with WMPC's recoupment of funding policy.

E. Program Operation

Service Provider shall provide the necessary administrative, professional, and technical staff for operation of the activities described in this Agreement, and obtain and maintain all necessary licenses, permits, or other authorizations necessary for the performance of this Agreement.

F. Reporting

Service Provider shall comply with any reporting requirements contained in the Grant Agreement or imposed by MDHHS.

G. Record Maintenance/Retention

Service Provider shall maintain adequate program and fiscal records and files, including source documentation, to support program activities and all expenditures made under the

terms of this Agreement, as required. Service Provider shall assure that all terms of the Agreement are appropriately adhered to and that records and detailed documentation for the grant project or grant program identified in this Agreement are maintained for a period of not less than three years from the date of termination, the date of the submission of the final expenditure report or until litigation and audit findings have been resolved. This Section applies to Service Provider, any parent, affiliate, or subsidiary organization of Service Provider, and any subcontractor that performs Agreement activities in connection with this Agreement. Upon demand, at no additional cost to WMPC, Service Provider shall facilitate the duplication and transfer of any records or documents during the required retention period.

H. Authorized Access

i. Service Provider shall permit within 10 calendar days of receiving notification, and at reasonable times, access by authorized representatives of WMPC, MDHHS, Federal Grantor Agency, Inspectors General, Comptroller General of the United States and State Auditor General, or any of their duly authorized representatives, to records, papers, files, documentation and personnel related to the Agreement, to the extent authorized by applicable state or federal law, rule or regulation.

ii. The rights of access in this section are not limited to the required retention period but last as long as the records are retained.

iii. Service Provider must cooperate and provide reasonable assistance to authorized representatives of WMPC, MDHHS, and others when those individuals have access to Service Provider's records.

I. Notification of Modifications

Service Provider shall provide timely notification to WMPC, in writing, of any action by its governing board or any other funding source that would require or result in significant modification in the provision of services, funding, or compliance with operational procedures.

J. Software Compliance

Service Provider shall ensure software compliance and compatibility with MDHHS's data systems for services provided under this Agreement including, but not limited to: stored data, databases, and interfaces for the production of work products and reports. All required data under this Agreement shall be provided in an accurate and timely manner without interruption, failure, or errors due to the inaccuracy of the Service Provider's business operations for processing data/time data. All information systems, electronic or hard copy, that contain state or federal data must be protected from unauthorized access.

K. Human Subjects

Service Provider shall comply with Protection of Human Subjects Act, 45 CFR, Part 46. The Service Provider agrees that prior to the initiation of the research, the Service Provider will submit Institutional Review Board (IRB) application material for all research involving human subjects, which is conducted in programs sponsored by the MDHHS, WMPC, or in programs which receive funding from or through the state of Michigan, to the MDHHS's IRB for review and approval, or the IRB application and approval materials for acceptance of the review of another IRB. All such research must be approved by a federally assured IRB, but the MDHHS's IRB can only accept the review and approval of another institution's IRB under a formally-approved IRB Authorization Agreement. The manner of the review will be agreed upon between the MDHHS's IRB Signatory Official and the Service Provider's IRB Signatory Official. Service Provider must provide a copy of any application to MDHHS or other state agency under this provision pertaining to programs funded in whole or in

part by WMPC.

L. Mandatory Disclosures

i. Service Provider shall provide notice to WMPC in writing within 14 days of receiving notice of any litigation, investigation, arbitration, or other proceeding (collectively, "Proceeding") involving Service Provider, a subcontractor, or an officer or director of Service Provider or subcontract, or that arises during the terms of this Agreement including:

a. All violations of federal and state criminal law involving fraud, bribery, or gratuity violations potentially affecting the Agreement;

b. A criminal Proceeding;

c. A parole or probation Proceeding;

d. A Proceeding under the Sarbanes-Oxley Act;

e. A civil Proceeding involving:

1. A claim that might reasonably be expected to adversely affect Service Provider's viability or financial stability; or

2. A governmental or public entity's claim or written allegation of fraud; or

f. A Proceeding involving any license that Service Provider is required to possess in order to perform under this Agreement

ii. Notify the WMPC, at least 90 calendar days before the effective date, of a change in Service Provider's ownership or executive management.

M. Conflict of Interest and Code of Conduct Standards

Service Provider is subject to the provisions of 1968 PA 317, as amended, 1973 PA 196, as amended, and Title 2 Code of Federal Regulations, Section 200.318 (c) (1) and (2). Accordingly, Service Provider and any subcontractor of Service Provider that performs activities in connection with this Agreement must uphold high ethical standards and is prohibited from:

i. Holding or acquiring an interest that would conflict with this Agreement;

ii. Doing anything that creates an appearance of impropriety with respect to the award or performance of this Agreement;

iii. Attempting to influence or appearing to influence any state employee by the directly or indirectly offering of anything of value; or

iv. Paying or agreeing to pay any person, other than employees and consultants working for Service Provider, any consideration contingent upon the award of this Agreement.

Service Provider must immediately notify WMPC of any violation or potential violation of these standards.

N. Federal Funding Accountability and Transparency Act (FFATA)

i. Service Provider shall complete a FFATA Executive Compensation report if:

a. Service Provider's federal revenue was 80% or more of Service Provider's annual gross revenue;

b. Service Provider's gross revenue from federal awards was $25,000,000 or more; and

c. The public does not have access to the information about executive officers compensation through periodic reports filed under Section 13(a) or 15(d) of the Securities Exchange Act of 1934 or Section 6104 of the Internal Revenue Code of 1986.

O. Insurance Requirements

i. Service Provider must maintain a minimum of the insurances or governmental self-insurances listed below and is responsible for all deductibles. All required insurance or self-insurance must:
   a. Protect the State of Michigan and WMPC from claims that may arise out of, are alleged to arise out of, or result from the Service Provider's performance;
   b. Be primary and non-contributing to any comparable liability insurance (including self-insurance) carried by WMPC or the State; and
   c. Be provided by a company with an A.M. Best rating of "A" or better and a financial size of VII or better.

ii. Service Provider must maintain the following insurance types:
   a. Commercial General Liability Insurance.
   b. Workers' Compensation Insurance: Coverage according to applicable laws governing work activities. Waiver of subrogation, except where waiver is prohibited by law.
   c. Employers Liability Insurance.
   d. All policies must be endorsed to add "the State of Michigan, WMPC, their departments, divisions, agencies, offices, commissions, officers, employees, and agents" as additional insureds.

iii. Service Provider agrees that any employee, agent, independent contractor, volunteer, or student who transports clients and/or their family members will have a current, valid driver's license appropriate for the vehicles driven and work performed. Service Provider shall have automobile insurance for all vehicles the Service Provider owns or leases. If an employee, agent, independent contractor, volunteer, or student is using his or her own private vehicle or a third-party's vehicle to transport clients and/or their family members, he or she must have personal automobile liability insurance. All applicable automobile insurance policies for Service Provider shall have a liability limit of not less than One Million_ and 00/100 Dollars ($1,000,000.00) per claim and Two Million and 00/100 Dollars ($2,000,000.00) in the annual aggregate.

iv. These insurance requirements are not intended to and are not to be construed in any manner as waiving, restricting, or limiting the liability of the Service Provider from any obligations under this Agreement.

v. Service Provider must promptly notify WMPC of any knowledge regarding an occurrence which may result in a claim against WMPC or Service Provider. The parties must cooperate with each other regarding such claim.

P. Emergency Preparedness Plan

i. If the tasks to be performed pursuant to this contract include the physical care and/or supervision of clients, the Service Provider shall, within thirty (30) days of the execution of this contract, submit to the WMPC Chief Financial Officer or designee a current fiscal year emergency preparedness plan which shall include provisions for pre-disaster records protection, alternative accommodations for clients in substitute care, supplies, and a recovery plan that will allow the Service Provider to continue functioning in compliance with the executed contract in the event of an actual emergency. For the purpose of disaster planning, the term supervision includes the responsibility of WMPC, or its contracted providers to ensure the safety, permanency, and well-being of a child who is under the

jurisdiction of a dependency court. Children may remain in their homes, be placed in a non-licensed relative/non-relative home, or be placed in a licensed foster care setting.

ii. WMPC shall respond in writing within thirty (30) days of receipt of the plan if WMPC rejects the plan and/or to request modifications of the plan. Otherwise the plan shall be considered accepted by WMPC. In the event of an emergency, WMPC may exercise oversight authority over the Service Provider to assure implementation of agreed emergency relief provisions.

iii. Service Provider shall submit an updated emergency preparedness plan no later than 12 months following the acceptance of an original plan or acceptance of an updated plan. WMPC agrees to respond in writing within 30 days of receipt of the updated plan, rejecting or requesting modification to the plan; otherwise the plan shall be considered accepted by WMPC.

2. Statutory Requirements

The following assurances are hereby given to WMPC:

A. Compliance with Applicable Laws

Service Provider will comply with applicable federal and state laws, guidelines, rules, and regulations in carrying out the terms of the Agreement. Service Provider will also comply with all applicable general administrative requirements, such as Title 2 Code of Federal Regulations (CFR) covering cost principles, grant/agreement principles, and audits, in carrying out the terms of this Agreement. Service Provider will comply with all applicable requirements in the original grant awarded to MDHHS if the Service Provider is a subgrantee. If Service Provider is providing services under this Agreement outside the State of Michigan and its services under this Agreement are otherwise subject to licensure or regulation under the laws of a jurisdiction other than Michigan, Service Provider shall nonetheless comply with Michigan law when and to the extent there is no conflict applicable between Michigan law and the law of the other state regulating or licensing the services. If WMPC determines that Service Provider has not complied with applicable federal or state laws, guidelines, rules, and regulations in carrying out the terms of this Agreement, WMPC may then terminate this Agreement.

B. Anti-Lobbying Act

Service Provider will comply with the Anti-Lobbying Act, 31 USC 1352 as revised by the Lobbying Disclosure Act of 1995, 2 USC 1601 et seq, and Section 503 of the Departments of Labor, Health and Human Services, and Education, and Related Agencies section of the FY 1997 Omnibus Consolidated Appropriations Act (Public Law 104-208).

C. Non-Discrimination

i. Service Provider agrees not to discriminate against any employee or applicant for employment or service delivery and access, with respect to their hire, tenure, terms, conditions, or privileges of employment, programs, and services provided or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, gender identity or expression, sexual orientation, political beliefs, physical or mental disability unrelated to the individual's ability to perform the duties of the particular job or position or to receive services. The Service Provider must comply with the Elliot-Larsen Civil Rights Act, 1976 PA 453, as amended, MCL 37.2101 et seq., and the Persons with Disabilities Civil Rights Act, 1976 PA 220, as amended, MCL 37.1101 et seq., and any breach thereof may be regarded as a material breach of this Agreement.

ii. Service Provider will comply with all federal statutes relating to nondiscrimination. These include but are not limited to:

a. Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color, or national origin;

b. Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex;

c. Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of disabilities;

d. The Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age;

e. The Drug Abuse Office and Treatment Act of 1972 (P.L. 92- 255), as amended, relating to nondiscrimination on the basis of drug abuse;

f. The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616) as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism;

g. §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee 3), as amended, relating to confidentiality of alcohol and drug abuse patient records;

h. Any other nondiscrimination provisions in the specific statute(s) under which application for federal assistance is being made; and

i. The requirements of any other nondiscrimination statute(s) which may apply to the services provided under this Agreement.

iii. Service Provider shall comply with the MDHHS non-discrimination statement: MDHHS will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, gender identity or expression, sexual orientation, political beliefs, or disability. The above statement applies to all licensed and unlicensed caregivers and families and/or relatives that could potentially provide care or are currently providing care for MDHHS supervised children, including MDHHS supervised children assigned to a contracted agency.

a. Under MCL 710.23g, MCL 722.124e, MCL 722.124f, and MCL 722.127, Service Provider has the sole discretion to decide whether to perform or engage in services related to a referral from WMPC that would conflict with the Service Provider's sincerely held religious beliefs. Nothing in this Agreement limits or expands the application of these statutory sections.

iv. Service Provider is prohibited from engaging in any discrimination against minority-owned and women-owned businesses and businesses owned by persons with disabilities. Any such discrimination is a material breach of this Agreement.

v. Additionally, Service Provider shall ensure that proactive efforts will be made to identify and encourage the participation of minority owned and women-owned businesses, and businesses owned by persons with disabilities in contract solicitations. Service Provider shall incorporate language in all contracts awarded: (1) prohibiting discrimination against minority-owned and women-owned businesses and businesses owned by persons with disabilities in subcontracting; and (2) making discrimination a material breach of contract.

D. Debarment and Suspension

Service Provider will comply with Federal Regulation, 2 CFR part 180 and certifies to the

best of its knowledge and belief that it, its employees and its subcontractors:

i. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department or contractor;

ii. Have not within a three-year period preceding this Agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction; violation of federal or state antitrust statutes, or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

iii. Are not presently indicted or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses enumerated under this Agreement; and

iv. Have not within a three-year period preceding this Agreement had one or more public transactions (federal, state, or local) terminated for cause or default.

E. Federal Requirement: Pro-Children Act

i. Service Provider will comply with Public Law 103-227, also known as the Pro-Children Act of 1994, 20 USC 6091 et seq., which requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 19, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are proved in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where Women, Infants, and Children (WIC) coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

ii. Service Provider also assures, in addition to compliance with Public Law 103-227, any service or activity funded in whole or in part through this Agreement will be delivered in a smoke-free facility or environment. Smoking shall not be permitted anywhere in the facility, or those parts of the facility under the control of Service Provider. If activities or services are delivered in facilities or areas that are not under the control of Service Provider (e.g. a mall, restaurant, or private work site), the activities or services shall be smoke-free.

F. National Defense Authorization Act Employee Whistleblower Protections

Service Provider will comply with the National Defense Authorization Act "Pilot Program for Enhancement of Grantee Employee Whistleblower Protections".

i. This Agreement and employees working on this Agreement will be subject to the whistleblower rights and remedies in the pilot program on contractor employee whistleblower protections established at 41 U.S.C. 4712 by section 828 of the National Defense Authorization Act for Fiscal Year 2012 and FAR 3.908.

ii. Service Provider shall inform its employees in writing, in the predominant language

of the workforce, of employee whistleblower rights and protections under 41 U.S.C. 4712, as described in section 3.908 of the Federal Acquisition Regulation.

iii. Service Provider shall insert the substance of this clause, including this paragraph (iii), in all subcontracts over the simplified acquisition threshold.

G. Clean Air Act and Federal Water Pollution Control Act

Service Provider will comply with the Clean Air Act (42 U.S.C. 7401-7671q.) and the Federal Water Pollution Control Act (33 U.S.C. 1251-1387), as amended.

i. This Agreement and anyone working on this Agreement will be subject to the Clean Air Act and Federal Water Pollution Control Act and must comply with all applicable standards, orders, or regulations issued pursuant to these Acts. Violations must be reported to WMPC.

H. Subcontracting

Service Provider may not delegate any of its obligations or subcontract under this Agreement without the prior written approval of WMPC. Service Provider must notify WMPC prior to the proposed delegation, and provide WMPC any information it requests to determine whether the delegation is in its best interest. If approved, Service Provider must:

i. Be the sole point of contact regarding all contractual matters, including payment and charges for all Agreement activities;

ii. Make all payments to the subcontractor; and

iii. Incorporate the terms and conditions contained in this Agreement in any subcontract with a subcontractor. Service Provider remains responsible for the completion of the Agreement Activities, compliance with the terms of this Agreement, and the acts and omissions of the subcontractor.

I. Health Insurance Portability and Accountability Act

To the extent that the Health Insurance Portability and Accountability Act (HIPAA) is applicable to services and activities of the Service Provider under this Agreement:

i. Service Provider must operate in compliance with requirements of HIPAA as applicable.

ii. Service Provider must not share any protected health information provided by WMPC or MDHHS that is covered by HIPAA except as permitted or required by applicable law and as appropriate under the Grant Agreement and this Agreement.

iii. Service Provider must only use the protected health data and information for the purposes of this Agreement.

iv. Service Provider must have written policies and procedures addressing the use of protected health data and information that falls under the HIPAA requirements. The policies and procedures must meet all applicable federal and state requirements including the HIPAA regulations. These policies and procedures must include restricting access to the protected health data and information by the Service Provider's employees.

v. Service Provider must have a policy and procedure to immediately report to WMPC and MDHHS any suspected or confirmed unauthorized use or disclosure of protected health information that falls under the HIPAA requirements of which the Service Provider becomes aware. Service Provider will work with WMPC and MDHHS to mitigate the breach, and will provide assurances to WMPC and MDHHS of corrective actions to prevent further unauthorized uses or disclosures. WMPC and MDHHS may demand specific corrective actions and assurances and Service Provider must provide the same to WMPC and MDHHS.

vi. Failure to comply with any of these contractual requirements may result in the termination of this Agreement.

vii. In accordance with HIPAA requirements, Service Provider is liable for any claim, loss, or damage relating to unauthorized use or disclosure of protected health data and information, including without limitation WMPC's and MDHHS's costs in responding to a breach, received by Service Provider from WMPC and MDHHS or any other source.

viii. Service Provider will enter into a business associate agreement with its business associates to the extent required by HIPAA or if MDHHS determines such an Agreement is required under HIPAA.

J. Survival

The provisions of this Agreement that impose continuing obligations will survive the expiration or termination of this Agreement.

K. Non-Disclosure of Confidential Information

i. Service Provider agrees that it will use Confidential Information solely for the purpose of this Agreement. Service Provider agrees to hold all Confidential information in strict confidence and not to copy, reproduce, sell, transfer or otherwise dispose of, give or disclose such Confidential Information to third parties other than employees, agents, or subcontractors of a party who have a need to know in connection with this Agreement or to use such Confidential Information for any purpose whatsoever other than the performance of this Agreement. Service Provider must take all reasonable precautions to safeguard the Confidential Information. These precautions must be at least as great as the precautions Service Provider takes to protect its own confidential or proprietary information.

ii. For the purpose of this Agreement, the term "Confidential Information" means all information and documentation of a party that:

a. Has been marked "confidential" or with words or similar meaning, at the time of disclosure by such party;

b. If disclosed orally or not marked "confidential" or with words of similar meaning, was subsequently summarized in writing by the disclosing party and marked "confidential" or with words of similar meaning;

c. Should reasonably be recognized as confidential information of the disclosing party;

d. Is unpublished or not available to the general public; or

e. Is designated by law as confidential.

iii. The term "Confidential Information" does not include any information or documentation that was:

a. Subject to disclosure under the Michigan Freedom of Information Act (FOIA);

b. Already in the possession of the receiving party without an obligation of confidentiality;

c. Developed independently by the receiving party, as demonstrated by the receiving party, without violating the disclosing party's proprietary rights;

d. Obtained from a source other than the disclosing party without an obligation of confidentiality; or

e. Publicly available when received or thereafter became publicly available (other than through an unauthorized disclosure by, through or on behalf

of, the receiving party).

iv. Service Provider must notify WMPC within one (1) business day after discovering any unauthorized use or disclosure of Confidential Information. Service Provider shall at its own cost provide notice to affected parties as soon as possible, but no later than fourteen (14) calendar days following the determination of any potential breach of personal or Confidential Information. Service Provider shall require the same notification requirements of all subcontractors. Service Provider shall cooperate with WMPC in every way possible to assist the Service Provider in regaining possession of the Confidential Information and prevent further unauthorized use or disclosure.

L. Unobligated Funds

i. In the event that the Provider's revenue, as reported in the quarterly cost reports and verified by the Provider, exceeds actual expenditures in connection with this Agreement, the Provider must use the excess funds for one of the following two purposes:

a. Create or maintain the Provider's risk pool for future Kent County welfare system expenses per guidelines established by WMPC; or

b. Reinvest in the child welfare system in Kent County.

ii. On an annual basis, the Provider shall report to WMPC, on an approved template, excess funds received from WMPC over the expenditures reported in the quarterly cost reports. Additionally, the Provider shall describe the percentage of excess funds retained for the risk pool, how that amount was determined, and/or the plan for reinvestment in the Kent County child welfare system with the corresponding anticipated outcomes for children and families.

3. Agreement Termination

WMPC may cancel this Agreement without further liability or penalty to WMPC as prescribed below:

A. This Agreement may be terminated by either party by giving 30 days written notice to the other party stating the reasons for termination and the effective date.

B. This Agreement may be terminated immediately upon any loss, reduction, or change in funding provided to WMPC or in the event available funds in WMPC's reasonable judgement appear insufficient to permit continuation of all of WMPC's contractual obligations.

4. Stop Work Order

WMPC may suspend any or all activities under this Agreement at any time. WMPC will provide Service Provider with a written stop order detailing the suspension. Service Provider must comply with the stop work order upon receipt. WMPC will not pay for activities, Service Provider's lost profits, or any additional compensation during a stop work period.

5. Final Reporting Upon Termination

Should this Agreement be terminated by either party, within 30 days after the termination Service Provider shall provide WMPC with all financial, performance, and other reports required as a condition of this Agreement. Service Provider shall immediately refund WMPC any monies paid to Service Provider that Service Provider was not authorized to use and are not due and owing in excess of funds advanced.

6. Transition Activities

Continuity of service is critical when service under this Agreement ends and service commences

under a new agreement. Accordingly, when service will continue through another provider upon the expiration or earlier termination of this Agreement, the Service Provider shall complete and cooperate in all actions necessary to smoothly transition service to the new provider. The Service Provider shall be required to support an orderly transition to the next provider no later than the expiration or earlier termination of this Agreement and shall submit a transition plan to WMPC for approval. Such activities will be without additional compensation and will include consultation on the resources needed to support transition, including identifying a transition manager and the reasonably necessary characteristics of transactions, data, and file transfer.

7. Severability

If any part of this Agreement is held invalid or unenforceable by any court of competent jurisdiction, that part will be deemed deleted from this Agreement. The remaining Agreement will continue in full force and effect.

8. Waiver

Failure to enforce any provision of this Agreement will not constitute a waiver.

9. Amendments

This Agreement is subject to amendment due to changes in the contracts between MDHHS and WMPC. WMPC has the authority to unilaterally amend this Agreement upon notice to the Service Provider to reflect changes, including but not limited to changes in funding or in the Grant Agreement between MDHHS and WMPC. All other amendments will be valid only if made in writing and accepted by all parties to this Agreement.

10. Liability

All liability to third parties, loss, or damage as a result of claims, demands, costs, or judgments arising out of the activities, such as direct service delivery, to be carried out by the Service Provider in the performance of this Agreement shall be the responsibility of the Service Provider, and not the responsibility of WMPC, if the liability, loss, or damage is caused by, or arises out of, the actions or failure to act on the part of the Service Provider, any subcontractor, vendor, or anyone directly or indirectly employed by the Service Provider. WMPC is not liable for consequential, incidental, indirect, or special damages, regardless of the nature of the action.

11. General Indemnification

Service Provider agrees it will defend, indemnify, and hold harmless WMPC, officers, directors, employees, and agents, from and against, without limitation, any and all actions, claims, losses, liabilities, damages, costs, actual attorney fees, and expenses (including those required to establish the right to indemnification), arising out of or relating to:

A. Any breach by Service Provider of any of the promises, agreements, representations, warranties, or insurance requirements contained in this Agreement;

B. Any infringement, misappropriation, or other violation of any intellectual property right or other right of any third party;

C. Any bodily injury, death, or damage to real or tangible personal property resulting wholly or in part from any action or inaction by Service Provider; and

D. Any acts or omissions of Service Provider.

For purposes of the preceding subparagraphs (A) through (D) of this Section, "Service Provider" includes any of Service Provider's employees, agents, subcontractors or any other person or entity acting under actual or apparent authority for Service Provider. WMPC will notify Service Provider in writing if indemnification is sought; however, failure to do so will not relieve Service Provider of its obligations hereunder except to the extent that Service Provider is materially prejudiced by the lack of or delay in receiving notice. Service Provider must, to the satisfaction of WMPC, demonstrate its financial ability to carry out these obligations.

With respect to any claim asserted against WMPC, WMPC is entitled to:

i. Employ counsel of its selection; and
ii. Retain control of the defense.

If WMPC deems necessary, Service Provider will not, without WMPC's written consent (not to be unreasonably withheld), settle, compromise, or consent to the entry of any judgment in or otherwise seek to terminate any claim, action, or proceeding in which a claim that is or may be subject to this indemnification has been raised or presented, whether directly or indirectly.

12. Applicable Laws, Jurisdiction, and Venue

This Agreement is made in and must be exclusively governed and construed by the laws of Michigan, excluding Michigan's choice-of-law principles. All claims related to or arising out of this Agreement, or its breach, whether sounding in contract, tort, or otherwise, must likewise be governed exclusively by the laws of Michigan, excluding Michigan's choice-of-law principles. Service Provider and WMPC consent to the personal jurisdiction of and to venue in the state and federal courts located in the County of Kent, State of Michigan for any legal or equitable proceeding arising out of or in connection with this Agreement.

ATTACHMENTS

Attachment A – Statement of Work

Attachment B – Payment and Financial Reports

Attachment C – Billing and Census Reporting

Attachment D – Reporting Requirements

Attachment E – Program Policy

Attachment F – Credentialing and Staff Training

Attachment G – Program Performance Goals and Review

Attachment H – Adoption Services To Be Provided

Attachment I – Enhanced Foster Care

Attachment J – Glossary of Terms

Attachment K - CFDA

STATEMENT OF WORK

Service Provider shall deliver a continuum of comprehensive foster care, independent living, guardianship, and adoption services in accordance with the MDHHS Foster Care, Adoption, and Guardianship Manuals to eligible children and families under the care and supervision (under the jurisdiction) of Kent County MDHHS.[1] These services include, but are not limited to: full case management, independent living, foster care, enhanced foster care, trial reunification/reunification services, foster family recruitment and retention, foster home certification, adoption, adoptive family recruitment; and coordination of and delivery of services to the child and parents based upon identified needs.

When one or more children of a family are placed in foster care and other children remain at home and a need for further services exists, Service Provider must provide services and case planning to the:

- Child(ren) in foster care.
- Parent(s).
- Foster parents/relative/unrelated caregivers.
- Children who remain in the home with the parent, as needed, regardless of court wardship.

Foster care supervision includes developing and implementing a treatment plan and service agreement to comply with the Foster Care Manual, which facilitates permanency planning according to the following guidelines:

- Reunification
- Adoption
- Guardianship
- Permanent Placement with a Fit and Willing Relative
- Another Planned Permanent Living Arrangement (AAPLA)

All services performed under this Agreement shall be provided within the framework of MiTEAM Child Welfare Case Practice Model.

1. Overview

A. Service Provider shall provide culturally competent services statewide in Michigan.

B. Direct foster care and adoption services shall be provided in client, relative caregiver, and foster parent homes.

C. Service Provider shall document all recruitment and licensing activities into MiSACWIS.

D. Service Provider will provide WMPC information on licensing timeframes as requested and in formats determined by WMPC.

Understanding the over representation of children of color in foster care and corresponding racial inequities present in their outcomes, Service Provider shall commit to building organizational capacity as an anti-racist and inclusive organization.

[1] The legal authority for such services can be found at 42 USC 671(10), MCL 712A.2, MCL 722.124, MCL 400.115a, and 2015 PA 84, Article X, Section 503(7) and 504(2).

2. Client Eligibility

A. Client Eligibility Criteria

Eligible Clients to be served through this Agreement include:

Children for whom the Kent County Circuit Court-Family Division has issued an order that makes MDHHS responsible for the child's placement, care, and supervision;

OR

Children for whom the family court has authorized a placement in the parental home with WMPC continuing to provide Aftercare services. ;

OR

Children for whom the Kent County Circuit Court-Family Division issued an order making MDHHS responsible for the child's placement, care, and supervision, whose case closed and who re-entered care (in any county) within 12 months of dismissal of court jurisdiction.

The period of time eligible for Aftercare shall not exceed 180 days from the date of the child(ren)'s placement in a parental home. Child(ren) must enter Aftercare directly from foster care and the family court must retain jurisdiction with care and custody continuing with WMPC.

B. Determination of Eligibility

Determination of eligibility shall be made by WMPC.

C. Title IV-E Eligibility

MDHHS shall maintain initial Title IV-E eligibility and ongoing Title IV-E reimbursability determinations.

Service Provider shall provide MDHHS with specific income and asset information for the removal household within 30 days of a child's placement in foster care. This includes, but is not limited to unearned income, child support income, daycare payments, vehicle information (if owned), home value (if owned), checking, saving account balances.

Service Provider shall provide MDHHS Title IV-E eligibility information within five calendar days of request, if additional information is needed. MDHHS will make all final Title IV-E eligibility determinations.

3. Referral Process

A. Foster Care Management Services

WMPC shall:

Upon placement, WMPC shall provide the Service Provider the Case Acceptance and Referral Individual Service Agreement (WMPC-3600), and all known information about the child and family.

Service Provider shall:

i. Be available 24 hours per day, seven (7) days a week for eligible referrals.

ii. Maintain an after-hours contact number available to WMPC for referrals or other identified emergencies. Service Provider must assure a response within 15 minutes to all after-hours contacts.

iii. Accept or decline the referral within one hour of receipt of the referral. Any reasons given for declining a referral may be documented in MiSACWIS. If a need for placement is imminent, WMPC may make referrals for placement concurrently to other contracted providers.

Service Provider accepts a referral from WMPC by doing either of the following:

Submitting to WMPC a written agreement to perform the services related to the particular child or particular individuals that the WMPC referred to the Service Provider.

OR

Engaging in any other activity that results in WMPC being obligated to pay the Service Provider for the services related to the particular child or particular individuals that the WMPC referred to the Service Provider.

After acceptance of a referral for foster care case management services, the Service Provider may not transfer the case to another child placing agency or refer the case back to the WMPC except for the reasons outlined in the WMPC's Child Placing Network protocol or upon the written approval of the WMPC's Chief Executive Officer or his or her or designee.

B. Adoption Services

Service Provider shall:

i. Accept or decline the referral within seven (7) days after receipt of the referral. Any reasons given for declining a referral must be documented in MiSACWIS.

ii. Not transfer adoption cases to another child placing agency. After acceptance of an adoption referral, the Service Provider may not transfer the case back to WMPC except upon the written approval from the WMPC Chief Executive Officer or his or her designee.

iii. Service Provider accepts a referral from WMPC by doing either of the following:

- Submitting to WMPC a written agreement to perform the services related to the particular child or particular individuals that the WMPC referred to the Service Provider; Or
- Engaging in any other activity that results in WMPC being obligated to pay the Service Provider for the services related to the particular child or particular individuals that the WMPC referred to the Service Provider.

4. Service Standards for Aftercare

Aftercare is a court-ordered placement where the child is returned from an out-of-home placement to the care of the parent from whom he or she was removed. The child remains under court supervision during the Aftercare period with WMPC retaining placement care and custody.

A. The Service Provider shall provide the following services to children in Aftercare:

i. Assist in preparing the parent, child, and caregiver for the transition to Aftercare. See FOM 722-7B

ii. A Family Team Meeting prior to placement of a child in the parental home to develop a transition plan with the parent, caregiver, and child, if age appropriate. The Service Provider shall have Family Team Meetings quarterly until case closure. See FOM 72-06B.

iii. Complete a new Family Assessment of Needs and Strengths, Child Assessment of Needs and Strengths, and Safety Assessment and Safety Plan. See FOM 722-8A, 722-8B, and 722-9B.

iv. Continue case worker visit expectations as required in FOM 722-6H

v. Maintain support services until case closure. The Service Provider shall document services needed to continue to meet the child's needs and identified providers for such services to provide continuity of services. See FOM 722-B

vi. Continue assessing and monitoring of the case plan and safety plan.

PAYMENT AND FINANCIAL REPORTS

Payment

FOSTER CARE SERVICES

1. WMPC's Administrative Rate must be made outside the MiSACWIS system and tracked by the WMPC.
2. WMPC will pay the Service Provider a 1/12th payment for staffing and administrative costs. This 1/12 payment will be calculated quarterly based on the greater of the prior 3 month's average month end census or the prior month multiplied by a daily staffing rate of $46.20. Example, April, May, and June month end censuses are used to calculate the monthly rate to be paid in July, August and September. Any child returning to the care of WMPC and the Service provider within 12 months of their discharge from court jurisdiction will not be included in this calculation.
3. Service Provider will submit an invoice to the WMPC according to invoicing protocol determined by WMPC.
4. WMPC shall open and process foster care placement payment within thirty (30) days of placement, with payment authorization effective the date of the child's placement with the Service Provider.
5. No original request for payment submitted by the Service Provider more than sixty days (60) after the close of the of the two-week billing period during which services were provided shall be honored for payment.
6. The Service Provider must forward the age appropriate rate, determination of care to the foster parent/ caregiver in accordance with the Service Provider's agency foster parent payment schedule no later than 30 days from the date payment is received from WMPC.
7. The entire rate paid to the Service Provider for board and care, clothing and allowance shall be paid by the Service Provider to the foster families providing the family foster care.
8. If the Service Provider fails to register a child on the Michigan Adoption Resource Exchange (MARE) as required in this Agreement, the Service Provider's Foster Care administrative rate for that child shall be reduced by 20% until the child is registered.
9. If a Service Provider does not submit the financial cost reports as described below, payments to the Service Provider may be reduced or withheld until Service Provider becomes compliant with the reporting requirements.
10. Service Provider shall be paid for family foster care services specified in this Agreement at a board and care rate established by WMPC. A WMPC determination of care rate may be established in accordance with the Foster Care Manual ("FCM") when extraordinary care or expense is required of the foster parent. Level III and IV rates must have the approval of WMPC.
11. Payment for additional service costs not included in the staffing rate may be authorized in accordance with the WMPC fiscal and payment policies.
12. Upon placement, Service Provider shall ensure that the child(ren) has adequate clothing as defined by the Clothing Inventory Checklist (WMPC -3377) or shall request reimbursement from WMPC up to the approved limit allowed for clothing.
13. The Service Provider agrees to retain documentation to support all charges, expenditures, and prior

approvals for any case service. The Service Provider shall immediately report changes to WMPC and MDHHS that may affect the payment status of the child.

14. Inability of WMPC to comply with the federal reporting requirements of AFCARS due to failure of the Service Provider to fulfill AFCARS related reporting requirements may result in the WMPC reducing or withholding payment until the failure is corrected.

ADOPTION PAYMENTS

1. WMPC shall make the following payments to the Service Provider:

Rate Category	Placement	Finalization	Permanency
Early Adoption Level 2	$7,590	$3,795	$1,265
Early Adoption Level 1	$6,600	$3,300	$1,100
Baseline	$5,940	$2,970	$990
Late Adoption Level 1	$5,280	$2,640	$880
Late Adoption Level 2	$3,300	$1,650	$550
Late Adoption Level 3	$2,640	$1,320	$440
Late Adoption Level 4	$1,980	$990	$330
MARE	$13,464	$6,732	$2,244
Residential	$8,778	$4,389	$1,463
In-State Transfer Services	$3,300		
ICPC Existing Services	$3,300		
ICPC New Services Michigan	$3,850		
ICPC – Case from another ICPC participating state through ICPC (non-Michigan ward) Adoptive Home Study Denial	$2,200		
ICPC – Case from another ICPC participating state through ICPC (non-Michigan ward) Adoptive Home Study Approval	$2,200		
ICPC case from another ICPC participating state through ICPC (non-Michigan ward) – Adoption Supervision with applicable reports	$550 at Placement $550 at Finalization		

2. Placement Disruption

Payment after placement for adoptions ending in disruption will only be made in the following cases:

A. Disruption Due to Medical Condition of Prospective Family Member: If the adoptive family experiences a documented chronic medical condition requiring long term care or a condition anticipated to result in the death of a family member after the adoptive

placement of a child, the Service Provider shall be eligible for a per-diem rate. The payment shall be a portion of the appropriate rate for finalization, which shall be established by dividing the duration (number of days) of the adoptive placement until disruption by one hundred eighty-two (182) days. The disruption rate shall not exceed the rate that would have otherwise been paid had finalization occurred.

B. Death of an Adoptive Child: In cases where a child dies between order placing in the adoptive home and the final order of adoption, the Service Provider shall be eligible for a per-diem from the date of placement to the date of death (unless cause of death is determined to be neglect or abuse) not to exceed the rate that would have otherwise been paid had finalization occurred.

C. Disruption after Order Placing Child in the Adoptive Home: When the disruption order is issued more than one hundred eighty-two (182) days from the date of the order placing the child in the adoptive home, the Service Provider shall be paid the full finalization rate.

D. Disruption of Placement Determined by MCI Superintendent: In a case where the child is placed in a home based on the decision of the MCI Superintendent, against the recommendation of the Service Provider, the Service Provider shall be eligible for a per-diem rate. The payment shall be a portion of the appropriate rate for finalization, which shall be established by dividing the duration (number of days) of the adoptive placement until disruption by one hundred eighty-two (182) days. The disruption rate shall not exceed the rate that would have otherwise been paid had finalization occurred. Payment for subsequent placements will not reflect a disruption.

3. Adoption Dissolution

WMPC shall recover, from the Service Provider, the Permanency Unit Rate for adoptions that end in dissolution within 182 days of issuance of an Order of Adoption.

4. Re-placement of Child after Disruption by the Same Service Provider

Subsequent adoptive placement and finalization by the same Service Provider (that placed the child in the disrupted/dissolved home) for a child previously reimbursed at one of the MARE rates or the Residential rate, shall not exceed the Baseline rate for a second adoptive placement/finalization. The maximum rate for any re-placement of a child photo listed on MARE or from a Residential facility beyond the second placement shall not exceed the Late Adoption Penalty Level 3 rate if paid to the same Service Provider.

Re-placement by the same Service Provider of a child under any rate other than a MARE or Residential rate shall not exceed the Baseline rate.

Exceptions may be made to the re-placement rate. The Service Provider must submit documentation of efforts that were required to prepare a child for subsequent placement and the recruitment of an adoptive family. Submit request for exceptions to the Contract and Financial Analyst at WMPC and stipulate the rate requested.

5. Unit Definition

A. Unit Title: Per Diem Payments

For each child where the adoption case is referred to the Service Provider by WMPC, the Service Provider shall receive payment of $20.00 per diem for each day of adoptive services

from acceptance of the case (signed WMPC 3600 for cases referred on or after October 2016, or earlier if applicable) to date of the signed documentation from the court (DHHS 5308 or petition date stamped from the court) verifying that the court has accepted the adoption petition and support documentation, or for one hundred fifty (150) days, whichever comes first. The maximum per diem payment amount per child is $3,000.

The total amount paid for the per diem rate will be deducted from the applicable placement rate when the child is placed for adoption.

For adoption cases referred on or after October 2016, the Service Provider may bill for the full per diem amount of $3,000. In the event that the Service Provider receives the full per diem amount on a case which is not assigned to the Service Provider for one hundred fifty (150) days, the Service Provider will be responsible for repayment of the per diem at a rate of $20.00 for each day for which they received a per diem payment and were no longer assigned to the case.

Billing for Per Diems require the following documentation to be uploaded into MiSACWIS:

i. MDHHS-5602, which included the number of days being billed, the date range, and the number of per diem billings previously submitted on the case.
ii. Signed agency invoice
iii. Copy of the Order Terminating parental Rights (Permanent Court Ward/Commitment).
iv. Signed DHS-3600 (for adoption services) with the date of acceptance indicated for cases referred on or after May 2016, or earlier if applicable.
v. Matched Per Diems require the signed DHS-4809, Intent to Adopt form signed by the identified adoptive family and verifications from MARE that a complete "hold" registration was submitted on the case.
vi. Unmatched Per Diems require verification from MARE that a complete photo listing was submitted on the case.

B. Unit Title: Placement

All unit definitions below are based on the length of time from the receipt of the written order from the court terminating all parental rights or, the date on which the WMPC-3600 is fully executed, whichever is later; to the date of the signed documentation from the court (DHS 5308 or petition or petition date stamped from the court) verifying that the court has accepted the adoption petition and support documentation.

If the child's goal changes from adoption to another goal and then changes back to the goal of adoption, the Service Provider must obtain a new WMPC-3600 for adoption services for the updated goal of adoption.

C. Unit Title: Finalization

Unit Definition: One-unit equals receipt of an Order of Adoption for a child for whom a Placement rate was paid.

D. Unit Title: Permanency

Unit Definition: One unit equals an adoption that does not end in dissolution within one

hundred eighty-two (182) days of the issuance of an Order of Adoption. The Permanency Unit Rate shall be paid at the same time as the Finalization Unit Rate. The Service Provider will be responsible for repayment of the Permanency Unit Rate for those cases for which the adoption ended in dissolution.

E. Unit Title: Early Adoption – Level 1

Unit Definition: The DHS-5308 or Adoption Petition documentation or Order Placing Child, whichever is earliest, is signed by the court more than one hundred eighty (180) days but less than two hundred forty (240) days after the date of placement as defined in Adoption Payments item 1 above.

F. Unit Title: Early Adoption – Level 2

Unit Definition: The DHS-5308 or Adoption Petition documentation or Order Placing Child, whichever is earliest, is signed and dated by the court one hundred eighty (180) or fewer days after the date of placement as defined in Subsection 3.C.6.a above.

G. Unit Title: Baseline

Unit Definition: The DHS 5308 or Adoption Petition documentation or Order Placing Child, whichever is earliest, is signed and dated by the court more than two hundred forty (240) days, but three hundred (300) or fewer days after the date of placement as defined in Subsection 3.C.6.a above.

H. Unit Title: Late Adoption – Level 1

Unit Definition: The DHS 5308 or Adoption Petition documentation or Order Placing Child, whichever is earliest, is signed and dated by the court more than three hundred (300) days, but three hundred sixty-five (365) or fewer days after the date of placement as defined in Subsection 3.1.g.ii above.

I. Unit Title – Late Adoption – Level 2

Unit Definition: The DHS 5308 or Adoption Petition documentation or Order Placing Child, whichever is earliest, is signed and dated by the court more than three hundred sixty-five (365) days, but five hundred forty-five (545) or fewer days after the date of placement as defined in Subsection 3.C.6.a above.

J. Unit Title – Late Adoption – Level 3

Unit Definition: The Adoption Petition documentation or Order Placing Child, whichever is earliest, is signed and dated by the court more than five hundred forty-five (545) days, but seven hundred thirty (730) or fewer days after the date of placement as defined in Subsection 3.C.6.a above.

K. Unit Title – Late Adoption – Level 4

Unit Definition: The Adoption Petition documentation or Order Placing Child, whichever is earliest, is signed and dated by the court more than seven hundred thirty (730) days after the date of placement as defined in Subsection 3.C.6.a above.

L. Unit Title – MARE

Unit Definition: The Order Placing Child is signed and dated by the court for a child who

has been registered for photo listing on MARE. The Service Provider is not eligible for the MARE rate if the Service Provider photo lists the child. The exception to allow for payment of the MARE rate to the supervising agency requires the Service Provider to submit a written request verifying that the child was photo listed for six (6) months and documentation must be provided to demonstrate the family is a newly approved recruited family and the following conditions are true:

i. The identified family is not a relative or foster parent to the adoptive child.

ii. The identified family has either not previously provided care for the child or has previously provided care and during the time that the child was photo listed had indicated in writing that they were not interested in adopting the child. The written document from the family must be submitted with the MARE payment request.

The Service Provider is eligible for the MARE rate if at the time of referral, there was no identified adoptive resource. The Service Provider must register the child for photo listing within thirty (30) days of acceptance of the case if no adoptive resource has been identified. If the Service Provider applies for the MARE rate there must be a written explanation of why the adoptive family was not identified as a potential adoptive resource within the first thirty (30) days after acceptance of the case.

M. Unit Title: Residential

Unit Definition: The Order Placing Child is signed and dated by the court for a child who has been placed in residential care (defined as staffed institutional care, not including foster group homes) and the child is under the Service Provider's supervision for Adoption Service.

N. Unit Title: MARE and Residential Rate with Pre-placement

Unit Definition: When a child photo-listed with MARE or in a Residential facility is placed into a prospective adoptive home through a foster care placement to allow for a period of adjustment and supervision (prior to petition to place for adoption), the reimbursement for the appropriate rate shall be calculated based on the date the pre-placement began. The MARE and Residential Rate will be applied when the court signs the Order Placing Child within two hundred seventy (270) days of placing the child in the home for foster care services.

O. Unit Title: In-State Transfer Services

Unit Definition: The Service Provider completes satisfactory services requested for pre-placement activities for a child under the supervision of the Service Provider and referred for adoptive placement to another subcontractor or MDHHS local office. The WMPC Care Coordinator for the foster care case shall define satisfactory services.

P. Unit Title: Interstate Existing Services

Unit Definition: A child under the adoption services supervision of the Service Provider is referred for adoptive placement through a private or public agency in the state where the adoptive family resides and the child has previously been placed with the family through Interstate foster/relative care prior to termination of parental rights and assignment of an

adoption worker.

Q. Unit Title: Interstate New Services

Unit Definition: A child under the adoption services supervision of the Service Provider is referred for adoptive placement through a private or public agency in the state where the adoptive family resides and the child has not been placed with the family through Interstate foster/relative care prior to termination of parental rights and assignment of an adoption worker

R. Unit Title: Competing Parties

More than one party is interested in adopting a particular child or sibling group and is assessed by the Service Provider in one of the following formats: Preliminary Adoptive Family Assessment, BCAL 3130 Initial Foster Home/Adoption Evaluation, or DHS 612, Adoptive Family Assessment Addendum. The rate paid on a competing parties' case shall not fall below the "Baseline" rate category, unless an agency has failed to act according to the timeframes outlined in policy.

S. Unit Title: Recruitment – No-Photo Listed

The Service Provider is eligible for the Recruited- Non-Photo-listed rate when an identified adoptive family assessed by the Service Provider is matched with a child assigned to another agency and the child is not photo-listed with MARE. The eligible rate is based on the number of days from the date the DHS-4809, Intent to Adopt is signed by the prospective adoptive family and the date of the signed documentation from the court (DHS 5308 or petition or petition date stamped from the court) verifying that the court has accepted the adoption petition and support documentation or the date of the Order Placing Child, whichever is earliest.

SERVICE PROVIDER SHALL COMPLY WITH ANY METHOD-OF-PAYMENT REQUIREMENTS CONTAINED IN THE GRANT AGREEMENT OR IMPOSED BY WMPC.

Financial Reporting

COST REPORTING

The Service Provider shall submit quarterly financial cost reports based on the MDHHS's fiscal year which begins October 1 and ends September 30 in the following calendar year. The reports shall contain the actual costs incurred by providers in delivering services required in this Agreement to WMPC clients for the reporting period. Costs for non-MDHHS/non-WMPC children are not to be included.

Reports will be submitted using a template created by MDHHS and provided by WMPC. The cost reports shall be submitted quarterly and will be due by the end of the following month after each calendar quarter or three business days before WMPC must submit the combined Cost Report to the State of Michigan, whichever is sooner.

The Service Provider must comply with all other program and fiscal reporting procedures as are or may hereinafter be established by WMPC. Reports shall be submitted electronically to accounting@wmpc.care with the subject line: Quarterly Cost Report.

Service Provider will follow all WMPC financial policies and procedures. Failure to meet reporting responsibilities as identified in this Agreement may result in delay or withholding of future payments.

The Service Provider shall separate direct foster care payments from other service delivery expenses and keep records that are readily reviewable and traceable to source documentation in a form acceptable to WMPC and MDHHS including, but not limited to, payments to foster parents by check, electronic funds transfers, or payment types.

1. Recording Expenditure

   The Service Provider shall input all paid expenditures related to children that tie to its financial statements into MiSACWIS system within five (5) business days of the expenditure.

2. Service Provider shall comply with any financial-reporting requirements contained in the Grant Agreement or imposed by MDHHS.

Audits

Because Service Provider is in a contractual relationship with the WMPC, which derives its funding through a grant from MDHHS, Service Provider must immediately report to the MDHHS, with a copy to WMPC, any audit findings of a Going Concern or accounting irregularities, including noncompliance with provisions of this Agreement.

1. Required Audit or Audit Status Notification Letter

Service Provider must submit to the WMPC either a Single Audit, Financial Statement Audit, or Audit Status Notification Letter as described below. If submitting a Single Audit or Financial Statement Audit, the Service Provider must also submit a Corrective Action Plan prepared in accordance with Title 2 Code of Federal Regulations, Section 200.511(c) for any audit findings that impact MDHHS or WMPC-funded programs, and management letter (if issued) with a response.

A. Single Audit

Service Providers that are non-profit organizations and that expend $750,000 or more in federal awards during the Service Provider's fiscal year must submit a Single Audit to the WMPC and MDHHS, regardless of the amount of funding received from the MDHHS. The Single Audit must comply with the requirements of Title 2 Code of Federal Regulations, Subpart F.

B. Financial Statement Audit

Service Providers exempt from the Single Audit requirements with fiscal years that receive $500,000 or more in total funding from the WMPC and/or MDHHS in State and Federal grant funding must submit to the WMPC and MDHHS a Financial Statement Audit prepared in accordance with generally accepted auditing standards (GAAS).

C. Audit Status Notification Letter

Service Providers exempt from the Single Audit and Financial Statement Audit requirements in subsections (a) and (b) above must submit to the WMPC and MDHHS an Audit Status Notification Letter that certifies these exemptions. The template Audit Status Notification Letter and further instructions are currently available at http://www.michigan.gov/MDHHS by selecting Inside MDHHS, then MDHHS Audit, then Audit Reporting, and Audit Reporting again.

2. Due Date and Where to Send

The required audit and any other required submissions (i.e. Corrective Action Plan and management letter with a response), or Audit Status Notification Letter must be submitted to WMPC within nine (9) months after the end of the Service Provider's fiscal year by e-mail to WMPC at accounting@wmpc.care. The required submission must be assembled as one document in a PDF file that is compatible with Adobe Acrobat (read only). The subject line must state the agency name and fiscal year end. WMPC and MDHHS reserve the right to request a hard copy of the audit materials if for any reason the electronic submission process is not successful.

3. Penalty

Failure to meet reporting responsibilities as identified in this Agreement may result in delay or withholding of future payments.

4. Other Audits

The MDHHS or federal agencies may also conduct or arrange for "agreed upon procedures" or additional audits to meet their needs.

Financial System

The Service Provider shall install and maintain an accounting system to identify and support all expenditures billed to WMPC under this Agreement. The accounting system must record all income and expenses for the Service Provider's total program of which services provided under this Agreement are a part. The accounting system, as a minimum, shall consist of a chart of accounts, cash receipts journal, cash disbursements journal, and general ledger all expenditures and income must be supported by vouchers and receipts that detail the reason for the transaction.

The Service Provider shall maintain, within the accounting system, salary and fringe benefits accounts that break out positions, hospitalization, retirement, workmen's compensation and other fringe benefits. The Service Provider shall establish and maintain payroll records for all employees. The Service Provider shall maintain payroll records to support amounts billed to WMPC in accordance with the federal timekeeping requirements described in the OMB Uniform Guidance, or as codified in the Code of Federal Regulations.

The accounting system shall maintain a record system that documents the total number of units of service as defined in this Agreement and delivered during the term of this Agreement. These records shall also document the specific units billed to WMPC under thisAgreement.

The Service Provider shall provide budget oversight of all subcontractors individually and as a whole. The Service Provider shall implement a Budget Management Plan, as well as process and policy by which its subcontractors will be able to request, be approved for, and receive funds. The Service Provider shall track the amount and use of each fund type and ensure that funds appropriated to, and used by, subcontractors are done so in accordance with state and federal eligibility criteria. Documentation of fund type, amount, and justification for appropriations provided to each subcontractor must be provided to WMPC asrequested.

Budget

The Service Provider shall submit a prospective budget annually due September 1 of each year for the upcoming fiscal year. The Service Provider shall review the budget quarterly and notify WMPC of substantial changes. The budget details the amount and object of anticipated expenditures for which the Service Provider shall use funds paid under this Agreement.

BILLING AND CENSUS REPORTING

FOSTER CARE SERVICES

The Service Provider will provide foster care services for the contracted number of children to be served. This number will be based on the census of Kent County children served thirty (30) days prior to the start of the contract or the average census of Kent County children served of the prior three months, whichever is greater.

The Service Provider will provide documentation of their budgeted cost model to WMPC annually. The General Foster Care staffing models for each Agency will be approved by the WMPC and Board Treasurer prior to the contract begin date.

When the Service Provider's financial records reveal that payment for a staffing/administrative rate has not been provided by WMPC within ninety (90) days of the date of service, the Service Provider will seek payment resolution by contacting WMPC in writing. Any concerns over a payment authorization or issuance that cannot be resolved within thirty (30) days of the written notice must be reported to the WMPC CFO for immediate resolution. The Service Provider will apprise WMPC of any ongoing, unresolved payment concerns.

ADOPTION SERVICES

The Service Provider shall maintain a record system that documents the total number of units of service as defined in this Agreement and delivered during the term of this Agreement. These records shall also document the specific units billed to WMPC under this Agreement.

The MDHHS-1582A shall indicate the title of the service provided and the pre-adoptive and case ID and date of birth of the child served. The MDHHS-1582A and any subsequent corrections must be completed and received in at WMPC within one hundred twenty (120) days of the date of the placement or finalization, whichever is applicable.

Billing for all designated services including: per diem, placement, finalization, permanency, and disruptions, require a copy of the Order Terminating Parental Rights (Permanent Court Ward/Commitment), the signed DHS3600 for cases referred on or after May 2016, or earlier if applicable, and with the exception of per diems, the signed and dated documentation by the court (DHS 5308 or petition date stamped from the court) verifying the date that the court has accepted the adoption petition and support documentation.

1. The MARE rates require a copy of the MARE photo listing and the subsequent MARE "Hold" document.
2. The Residential rate requires a copy of the discharge summary from the residential facility, a copy of the placement record including placement with the prospective adoptive parent prior to filling the petition and the required documentation listed above.
3. The ICPC rate(s) require the following documentation to be uploaded into MiSACWIS:
    - A. MDHHS 5602
    - B. Signed agency invoice
    - C. Copy of the ICPC referral
    - D. DHS-3600 (for Adoption Services)
    - E. Order Terminating Parental Rights
4. Billing for placement requires the following to be uploaded into MiSACWIS:

A. MDHHS-5602
B. Signed agency invoice
C. Order Terminating Parental Rights (Permanent Court Ward/Commitment)
D. Signed DHS3600 (for adoption services_ with the date of acceptance indicated for cases referred on or after May 2016, or earlier if applicable.
E. Signed and dated documentation by the court (DHS-5308 or petition dated stamped from the court) verifying the date that the court accepted the adoption petition and supporting documentation.
F. Order Terminating Parental Rights
G. Order Placing Child
H. Adoption Assistance Agreement, if applicable. If not applicable, include copy of MiSACWIS case funding screen.
I. If there was a per diem payment for the case prior to placement the Service Provider must note the per diem amount previously billed on the MDHSS-5602.

5. Billing for finalization requires the following to be uploaded into MiSACWIS:

A. MDHHS- 5602
B. Signed agency invoice
C. Order Terminating Parental Rights (Permanent Court Ward/Commitment)
D. Signed DHS-3600 (for adoption services) with the date of acceptance indicated for cases referred on or after May 2016
E. Signed and dated documentation by the court (DHS-5308 or petition date stamped from the court) verifying the date that the court has accepted the adoption petition and supporting documentation
F. Order of Adoption
G. Adoption Assistance Agreement, if applicable. If not applicable, include copy of MiSACWIS case funding screen.
H. For cases in which the agency has previously billed for the placement, the following documentation is required:
    i. MDHHS- 5602
    ii. Signed agency invoice
    iii. Order of Adoption
    iv. Verification of amount paid in per diems and placement.
    v. Adoption Assistance Agreement, if applicable. If not applicable, include a copy of MiSACWIS case funding screen.

6. Disruptions require an Ex Parte Order, or order dismissing, a copy of the initial placement order, initial commitment order, documentation verifying the medical condition of the family member if appropriate, a copy of the placement check and agency disruption report.

7. Legal Risk–Order Placing Child Filed: In cases where a birth parent, individually or through an attorney, has filed a petition to appeal the termination of parental rights, the Service Provider shall include a copy of the Claim filed in conformity with MCR 7.203 when requesting payment at placement and a copy of the appeal decision order when requesting payment at finalization.

8. When billing for the per diem, each payment voucher shall be child specific. Attached to the initial payment voucher the following documents must be uploaded into MiSACWIS:

A. MDHHS-5602, which includes the number of days being billed, the date range, and the number of per diem billings previously submitted on the case
B. Signed agency invoice.
C. Copy of the Order Terminating Parental Rights (Permanent Court Ward/Commitment)
D. Signed DHS-3600 (for adoption services) with the date of acceptance indicated for cases referred on or after May 2016, or earlier if applicable.
E. Matched Per Diems require the signed DHS-4809, Intent to Adopt form signed by the identified adoptive family and verifications from MARE that a complete "hold" registration was submitted on the case.
F. Unmatched Per Diems require verification from MARE that a complete photo listing was submitted on the case.

9. When requesting an exception to the payment rate, it is the responsibility of the Service Provider to demonstrate that requests for adoption assistance eligibility determination or MCI consent or obtaining fingerprint results delayed the adoption placement. If the delay was caused by submission of incomplete paperwork or a lack of response to requests for information, the consideration for exception will be denied. There is a thirty (30) day standard of promptness for adoption assistance eligibility determinations, MCI regular and expedited consent requests, a fourteen (14) day standard of promptness for obtaining fingerprint results and a ninety (90) day standard of promptness for MCI consent requests on competing parties. If information is missing, incomplete, or unclear and needing follow-up, the standard of promptness timeframe will not begin until all needed information is available for review, including legal documents and information needed to fulfill policy requirements. Delays caused by the local MDHHS office will be considered on an individual case basis. The Adoption Payment Exception Request, DHS 832 form and supporting documents must be submitted with the completed MDHHS-5602.

10. Billings for competing parties, in which the case would be eligible for a rate less than the Baseline rate and the Service Provider is requesting the Baseline rate, requires the Service Provider to submit a Competing Party Rate Exception Request (DHHS-5445) and copies of the following to be uploaded into MiSACWIS:

    A. Case acceptance documentation
    B. Dates of initial inquiry
    C. DHS-4809, Intent to Adoption from each competing party.
    D. Copies of the adoption assessment(s) for each competing party.
    E. Required placement or finalization documentation listed above.

CENSUS REPORTING

By the 15th of the following month, in order to calculate the Administrative Rate (see Attachemnt B.2), each Service Provider shall electronically submit the prior month end's case listing on an Excel spreadsheet prepared by Service Provider that contains the following information:

1. Agency Name
2. Child last name
3. Child first name
4. Child date of birth
5. MiSACWIS person ID

REPORTING REQUIREMENTS

Service Provider shall utilize program-specific report forms and reporting formats required by WMPC from the effective date of this Agreement. WMPC shall provide any report forms and reporting formats required by MDHHS from the effective date of this Agreement, and provide to the Service Provider any new report forms and reporting formats proposed for issuance thereafter at least sixty (60) days prior to their required usage. Service Provider agrees to maintain program records required by WMPC or MDHHS, program statistical records required by WMPC or MDHHS, and to produce program narrative and statistical data at times prescribed by, and on forms furnished by, WMPC or MDHHS.

ADOPTION AND FOSTER CARE ANALYSIS REPORTING SYSTEM (AFCARS) REQUIREMENTS

1. Service Providers shall enter all child and family information into MiSACWIS to enable WMPC and MDHHS to comply with federal AFCARS reporting requirements.

2. Service Provider shall ensure that private agency staff has access to the Michigan Statewide Automated Child Welfare Information System (MiSACWIS) through a web-based interface, henceforth referred to as the "MiSACWIS application." Requirements for MiSACWIS for CPA contracts may be found at http://www.michigan.gov/WMPC/0,5885,7-339-71551_7199---,00.html.

   For all agency assigned cases in MiSACWIS, the Service Provider shall enter all case management activities, including payments and all required documentation per policy in MiSACWIS.

3. AFCARS Disallowance

   Inability of WMPC or MDHHS to comply with the federal reporting requirements of AFCARS due to failure of the Service Provider to fulfill AFCARS-related reporting requirements may result in a financial penalty of a one percent reduction to each case rate installment payment for the six month period subsequent to the due date of the AFCARS report to the federal government.

   A. Foster Home Licensing Data Entry

      Service Provider shall document all recruitment and licensing activities into MiSACWIS.

   B. Critical Incident

      Service Provider shall follow WMPC's Critical Incident Reporting Policy as outlined in WMPC's Program Operations Guide.

   C. Unlicensed Relative Tracking

      Service Provider shall report to WMPC, on an ongoing basis, information about unlicensed relative homes and the children in those homes, and on progress in licensing the homes as requested by MDHHS.

CHILD PROTECTION LAW REQUIREMENTS, IN ADDITION TO ANY REQUIREMENTS REQUIRED BY 1975 PUBLIC ACT 238, AS AMENDED, BEING MCL 722.621 ET SEQ.:

1. Service Provider shall ensure that all employees who have reasonable cause to suspect child abuse or neglect shall report any suspected abuse or neglect of a child in care to MDHHS for investigation as required by Public Acts of 1975, Act Number 238, as amended being MCL 722.621.

2. Failure of the Service Provider or its employees to report suspected abuse or neglect of a child to WMPC and MDHHS shall result in an immediate investigation to determine the appropriate corrective action up to and including termination of the Agreement.

3. Failure of the Service Provider or its employees to report suspected child abuse or neglect two or more times within a one-year period shall result in a review of the Service Provider's violations by a designated Administrative Review Team, which shall include the Director of CSA, WMPC, and the Director of DCWL or its successor agency, that shall consider mitigating and aggravating circumstances to determine the appropriate corrective action up to and included license revocation and contract termination.

PROGRAM POLICY

Service Provider shall comply with all applicable WMPC policy, in addition to MDHHS policy in the Children's Foster Care (FOM), Guardianship (GDM), Services General Requirements (SRM), Interstate Compact (ICM), Native American Affairs (NAA), and Adoption (ADM), Adoption Subsidy (AAM) Manuals and MDHHS policy amendments (including interim policy bulletins or successor policies), as well as all applicable provisions in the Implementation, Sustainability, and Exit Plan or its successor entered in *Dwayne B v Snyder, et al*., Case No.: 2:06-cv-13548 (ED Mich)

Throughout the term of this Agreement, Service Provider shall ensure that it provides all applicable MDHHS policy and MDHHS policy amendments (including interim policy bulletins) and applicable Administrative Codes to social service staff. Service Provider shall ensure that social service staff complies with all applicable requirements.

MDHHS policies, amendments, and policy bulletins, are published on the following internet link: http://www.michigan.gov/dhs. Administrative Codes are published at on the following internet link: http://michigan.gov/lara/0,4601,7-154-35738_5698-118524--,00.html.

1. Compliance Requirements with the Indian Child Welfare Act (ICWA)

Service Provider shall provide case management services in accordance with the "Active Efforts" requirements established in the ICWA; Public Law 95-608 being 25 U.S.C. 1901 *et seq*. These requirements include but are not limited to the following:

A. Establish an American Indian child as a member of a Tribe in accordance with ICWA and as defined in the MDHHS Native American Affairs (NAA) manual.

B. Provide "Active Efforts" case management services in accordance with ICWA and as defined in the NAA manual.

C. Provide placement of American Indian children in accordance with "Placement Priorities" as established in ICWA and defined in the NAA manual.

D. Provide "Expert Witness" testimony in accordance with ICWA and as defined in the NAA manual.

E. Provide services to American Indian families within the context of their culture and ethnicity, maintaining knowledge in the following:

i. How culture and rituals influence parenting decisions.

ii. Determine what services and supports will be most effective.

iii. Knowledge and respect of tribal practices.

2. Additional Compliance Requirements

SERVICE PROVIDER SHALL COMPLY WITH THE PROVISIONS OF:

A. 1984 Public Act, 114, as amended being MCL 3.711 et seq., Interstate Compact on the Placement of Children.

B. 1975 Public Act 238, as amended, being MCL 722.621 et seq., Child Protection Law.

C. 1982 Public Act 162, as amended, being MCL 450.2101 et seq., Michigan Nonprofit Corporation Act.

D. 1994 Public Act 204, as amended, being MCL 722.921 et seq., Michigan Children's Ombudsman Act.

E. 1973 Public Act 116, as amended by 2015 PA 53, being MCL 722.111 et seq., Michigan Child Care Organization Act.

F. 1939 Public Act 288, Chapter X, being MCL 710.1 et seq., Michigan Adoption Code.

G. 1984 Public Act 203, as amended, being MCL 722.951 et seq., Michigan Foster Care and Adoption Services Act.

H. The Social Security Act as amended by the Multiethnic Placement Act of 1994 (MEPA); Public Law 103-382, and as amended by Section 1808 of the Small Business Job Protection, the Interethnic Adoption Provision (IEAP).

I. The Indian Child Welfare Act (ICWA); Public Law 95-608 being 25 USC 1901 *et seq*.

J. 1976 Public Act 453, as amended, being MCL 37.2101 *et seq*., Elliott-Larsen Civil Rights Act.

K. Fostering Connections to Success Act of 2008.

L. Preventing Sex Trafficking and Strengthening Families Act, Federal PL 113-183.

M. Social Security Act, 42 USC 671(a)(20).

N. Federal Bureau of Investigation (FBI), Criminal Justice Information Services (CJIS) Security Policy located at the following link: https://www.fbi.gov/about-us/cjis/cjis-security-policy-resource-center.

3. Intercultural Competence

Service Provider will provide services to all families within the context of their culture and ethnicity, maintaining knowledge in the following:

iv. How culture and rituals influence parenting decisions.

v. Culturally-specific services and supports.

vi. Knowledge and respect for the unique cultural traditions practiced by the families we serve.

4. Human Trafficking

The Network Provider shall participate with WMPC in regional, local and community level activities related to prevention of and response to human trafficking.

5. Time Study

Service Provider shall participate in random moment time studies (RMTS). An RMTS is a process where participants are emailed short surveys and asked to indicate what they were doing at an assigned time. The time study is required to determine the amount of time spent on various activities. Based on these results, MDHHS determines the amount that can be charged to various funding sources.

6. Case Record

A. Service Provider is responsible for ensuring the maintenance of a case record for each

family referred that is consistent with the standards in the Foster Care Manual and contains all information necessary to keep MiSACWIS accurate and up to date.

B. Service Provider's case file shall only be accessible to Service Provider and its personnel performing tasks related to the contract.

C. Service Provider is responsible for ensuring maintenance of adequate, legible, genuine, current, and complete records of services rendered under the terms of the Agreement in accordance with the more restrictive requirements for case record retention timeframes as outlined in the Foster Care Manual section 722-15, Case Closure or the appropriate Michigan Administrative Code as identified in the Licensing Rules for Child Placing Agencies even after the expiration of this contract.

7. Court

A. Service Provider shall ensure all directives and services ordered by the court are completed within the timeframes ordered.

B. Fines or costs ordered by the court against the Service Provider, or an employee thereof, shall be the responsibility of the Service Provider.

C. To the extent permitted by law, MDHHS may involve WMPC and Service Provider in matters relating to any legal or court activities concerning the child while in the Service Provider's care. If WMPC or Service Provider are to be involved in the court proceedings, WMPC or MDHHS shall request from the Service Provider a written report for court use, subject to confidentiality requirements imposed by state or federal law.

D. Service Provider shall provide, without additional compensation, as a normal and necessary part of the services to be performed under this Agreement, expert and/or other testimony, including provision of written reports, records, and/or exhibits, at the request of the WMPC, MDHHS, or other courts as indicated periodically.

8. WMPC and MDHHS Staff

Service Provider shall cooperate with all WMPC and MDHHS staff who support foster care cases. This includes the Health Liaison Officers, Child Welfare Financial Specialists, Performance-Based Funding Specialist, and other WMPC, county, and state staff who may need access to caseworkers, foster parents, records, and financial information.

9. Requests for Information

A. Service Provider may be required to meet and communicate with WMPC representatives and from time to time WMPC may require that the Service Provider create reports or fulfill requests for information as necessary to fulfill the MDHHS's obligations under statute and/or applicable provisions in the Implementation, Sustainability, and Exit Plan or its successor entered in *Dwayne B v Snyder, et al.*, Case No.: 2:06-cv-13548 (ED Mich), herein referred to as the Modified Implementation, Sustainability, and Exit Plan (MISEP).

B. Service Provider shall make available to WMPC copies of any outside reviews, unredacted FOIA requests, subpoenas, or audits relating to the contracted program.

C. If and to the extent WMPC and/or Service Provider are deemed to be a "public body" within the meaning of Section 2(d) of the Michigan Freedom of Information Act, MCL 15.321 *et seq.*, the parties agree that they shall exempt from disclosure and withhold all

information and records permitted to be exempted under MCL 15.243, including but not limited to trade secrets, commercial and financial information submitted by either of them to the other, and that all such information has been or will be submitted under a promise of confidentiality authorized by the chief administrative officer of the receiving party and recorded in compliance with MCL 15.243(f)(iii).

10. Caseload Ratios

Service Providers shall maintain the following caseload ratios:

A. Foster care workers shall have a caseload assigned to them of no more than thirteen (13) children, as their regular, ongoing caseload. A regular, ongoing caseload shall be defined as the cases assigned to a specific worker for ongoing casework responsibility, not cases being temporarily covered for the purposes of worker leave or departure. Even in cases of temporary coverage, an assigned caseload shall not exceed fifteen (15) children at any time. A mixed caseload comprised of more than one program type shall not exceed the prorated total equal to one full caseload.

B. Foster care/social services supervisors shall supervise no more than five (5) foster care/social services staff at any time.

11. Service Documentation

Service Provider agrees and is responsible for ensuring the maintenance of records required by WMPC and MDHHS, program statistical records required by WMPC and MDHHS, and to produce program narrative and statistical data at times prescribed by, and on forms furnished by WMPC and MDHHS.

12. Program Evaluation

Service Provider shall cooperate with WMPC or its designee in an official program evaluation. Service Provider may be required to respond to data requests, participate in interviews, focus groups, or meetings, or other activities to support a comprehensive program evaluation of this pilot.

13. Licensing Requirements

The MDHHS Division of Child Welfare Licensing (DCWL) is the licensing agency for Child Placing Agencies (CPA). A license is issued to a certain person or organization at a specific location, is non-transferable, and remains the property of the MDHHS. Therefore, a child placing agency must be established at a specific location.

Service Provider shall ensure that, for the duration of this Agreement, it shall maintain a license for those program areas and services that are provided for in this Agreement. If Service Provider fails to comply with this section, WMPC may terminate this Agreement for default.

Service Provider is required to inform WMPC of the dates of the annual DCWL audit and any DCWL special investigation. Service Provider is also required to inform WMPC of the dates and times of any DCWL entrance conference and exit conference for audits and special investigations. WMPC staff will attend DCWL entrance and exit conferences.

Service Provider is licensed to provide service under this Agreement under the following license number: CB410200976

14. Accreditation

WMPC is committed to ensuring provision of the highest quality services to persons we serve. Accordingly, WMPC has expectations that where WMPC, in its judgment and discretion, believes accreditation is generally accepted nationwide as a clear indicator of quality service, Service Provider will either be accredited, be in the process of seeking and receiving such national accreditation, or will initiate that process within an agreed upon reasonable period of time.

15. Staffing Levels, Qualifications, and Changes

Services securing safety, well-being, and reunification or permanency for children in foster care or in-home placement must be maintained 24 hours a day, seven days a week. To do so, the Service Provider shall maintain an adequate level of staff (administrative and programmatic) that is properly trained, screened, and certified to meet the contractual responsibilities and in compliance with all applicable administrative rules and statutes. Moreover, to prevent business interruption, the Service Provider must maintain adequate staff coverage to ensure no deficiency or gap in any WMPC required service delivery aspect exists on a daily operating basis or an emergency need basis. The Service Provider shall notify WMPC in writing within twenty-four (24) hours of Service Provider's receipt of notice of an anticipated vacancy of the Executive Director, Program Director, or other significant staff to the provision of contractual services. The Service Provider shall provide the name of the interim contact person or permanent replacement in the notice.

16. MiTEAM

The Service Provider shall provide services within the framework of Michigan's Child Welfare Practice Model, MiTEAM. The Service Provider shall utilize the skills of engagement, assessment, teaming, and mentoring in partnering and building relationships with families and children by exhibiting empathy, professionalism, genuineness, and respect. Treatment planning shall be from the perspective of family/child centered practice.

17. Care Connect 360

The Service Provider shall assure the coordination of all services based on an assessment of the parent's needs. The Service Provider shall utilize Care Connect 360 (CC360) to assure the coordination and provision of all treatment services required based on an assessment of each child's needs and shall execute and comply with the terms of the CC360 Data Use Agreement. Treatment services include, but are not limited to the provision of counseling/therapy for each child. The Service Provider shall ensure the provision of all medical, dental, and behavioral health services required based on an assessment of each child's needs. The Service Provider may utilize Medicaid (or private insurance) reimbursable services to comply with this requirement. If a counseling or therapy service is not available or accessible for each child, the Service Provider is responsible for the direct provision of the service.

18. Health Liaison Officer

The Service Provider shall designate an individual to act as a point of contact for the Health Liaison Officer (HLO) and notify WMPC of the individual's name. The point of contact shall be familiar with current case assignments and have authority to ensure follow-up by the Service Provider's staff.

19. Prudent Parent Expectations

The Service Provider shall ensure prudent parent expectations are followed as outlined in FOM 722-11, Prudent Parent Standard & Delegation of Parental Consent.

20. Foster Home Licensing Data Entry

The Service Provider shall document all recruitment and licensing activities into the tracking system identified by MDHHS.

21. Relative Licensing

The Service Provider will facilitate licensure of relative caregivers providing care to children in out-of-home placements that are under the direct care and supervision of WMPC. Service Providers will report on the number and characteristics of unlicensed relative homes and the children in those homes, and on progress in licensing the homes as requested by WMPC and MDHHS.

21. Shelter Care

A. For any child placed in shelter, or at risk of placement in shelter, the Service Provider will follow action steps outlined in the WMPC Shelter Protocol.

B. For any child referred to shelter, the Service Provider shall coordinate with the attending medical provider to ensure the youth has a minimum of a 14-day supply of prescribed medication AND a prescription for all current medications, OR a 30 day supply of all medications, within 24 hours of shelter placement.

CREDENTIALING AND STAFF TRAINING

CREDENTIALS

The Service Provider shall assure all staff performing functions under this Agreement, including Service Provider employees, volunteers and/or subcontractor employees, are appropriately screened, credentialed, and trained in accordance with licensing rules and the Implementation, Sustainability, and Exit Plan entered in *Dwayne B v Snyder, et al*., Case No.: 2:06-cv-13548 (ED Mich).

1. Criminal Background Check

   As a condition of this Agreement, the Service Provider shall conduct or cause to conduct, prior to any individual performing work under this Agreement, the following checks for each new employee, subcontractor, subcontractor employee, or volunteer who directly works with clients, has access to client information, or works with children:

   A. An Internet Criminal History Access Tool (ICHAT) check and a National and State Sex Offender Registry check.

      Information about ICHAT can be found at http://apps.michigan.gov/ichat

      The Michigan Public Sex Offender Registry web address is https://www.michigan.gov/msp/0,4643,7-123-1878_24961---,00.html

      The National Sex Offender Public Website address is http://www.nsopw.gov.

   B. An employment history check.

      For each new employee, subcontractor, subcontractor employee, or volunteer that works with children, Service Provider shall also conduct or cause to conduct, the following check:

   C. A Central Registry (CR) check.

      Information about CR can be found at: https://www.michigan.gov/mdhhs/0,5885,7-339-73971_7119_50648_48330-159490--,00.html

      The Service Provider shall require each employee, subcontractor, subcontractor employee, or volunteer who works directly with clients or who has access to client information, under this Agreement to notify the Service Provider within one (1) business day in writing of criminal convictions (felony or misdemeanor) and/or pending felony charges or placement on the CR as a perpetrator.

      Additionally, the Service Provider shall require each new employee, subcontractor, or volunteer who works directly with clients under this Agreement or who has access to client information and who has not resided or lived in Michigan for each of the previous ten (10) years to sign a waiver attesting to the fact that they have never been convicted of a felony or identified as a perpetrator, or if they have, the nature and recency of the felony.

      The Service Provider further certifies that the Service Provider shall not submit claims for or assign duties under this Agreement to any employee, subcontractor, subcontractor employee, or volunteer for whom Service Provider has found a positive ICHAT, a CR response, a reported criminal felony conviction, and/or a perpetrator identification, any

of which make the individual ineligible to provide services.

The Service Provider must have a written policy consistent with Mich Admin Code R400.12212 (e) through (h) describing the criteria on which its determinations shall be made and must document the basis for each determination. The Service Provider may consider the recency and type of crime when making a determination. Failure to comply with this provision may be cause for immediate cancellation of this Agreement. In addition, the Service Provider must further have a clearly defined written policy regarding acceptable screening practices of new staff members and volunteers who have direct access to clients and/or clients' personal information, which serve to protect the organization and its clients. The Service Provider must also assure that any subcontractors have both of these written policies.

If WMPC determines that an individual provided services under this Agreement for any period prior to completion of the required checks as described above, WMPC, in addition to any other remedies, may require repayment of that individual's salary, fringe benefits, and all related cost of employment for the period that the required checks had not been completed.

2. MITEAM LIAISON

A. The Service Provider shall designate a Program Manager, Supervisor, or child welfare staff person in each office location to act as a MiTEAM Liaison with MDHHS and WMPC to:

i. Consult with their assigned Analyst in MDHHS Central Office.

ii. Attend trainings specific to MiTEAM/CQI and the liaison role.

iii. Provide/Collaborate with others to offer training to their agency staff regarding MiTEAM/CQI

iv. Actively engage as the fidelity tool support person.

v. Lead Quality Improvement Activities (QIA) within your agency.

a. Gather additional information from assigned MDHHS Central Office analyst to share with your internal CQI/PQI team.

b. Seek opportunities to collaborate with local MDHHS CQI Team.

vi. Convey the MiTEAM/CQI information and activities to agency administration.

vii. Be responsible for contributing to policy and program development and sustainment.

viii. Maintain knowledge and expertise of all policies and programs impacting the agency.

ix. Be aware of agency trends that impact practice and share information with the agency's CQI team.

x. Respond to questions and share updates related to MiTEAM/CQI

3. STAFF TRAINING

The Service Provider shall comply with SRM 103, Staff Qualifications, and Training.

A. OWDT-CWTI: Registration Process

i. The Service Provider shall register staff training through OWDT Learning Management System (LMS). In some cases, OWDT will provide a form to be completed and provided to OWDT, who will then perform the function within LMS.

ii. The Service Provider's supervisor and/or the Service Providers training facility coordinator can register Service Provider staff directly for in-service training. To cancel or change training registration, the subcontractor will need to make the changes in the LMS directly, unless the trainee was registered by OWDT. The Service Provider will need to contact the help desk at MDHHSTraining@michigan.gov for changes to registrations completed by OWDT.

iii. All training completed externally shall be added to the LMS so that it may be included in in-service training hour calculations. The name of the training, a short description, the total number of hours spent in training, and the completion date must be documented in LMS. All qualified training shall be training that improves child welfare practice.

iv. Confirmations, with specific details on times and locations, will be emailed to the Service Provider/trainee by OWDT at least seven days before the training commences.

B. Completion of Security Awareness Training (SAT)

i. The Service Provider shall require each employee, subcontractor, subcontractor employee, or volunteer who works directly with clients or who is authorized to have access to client fingerprint-based criminal history record information (CHRI) under this Agreement to successfully complete security awareness training (SAT) within six months of appointment to a position with (CHRI) access and every two years thereafter. Documentation of successful SAT completion is to be located in the personnel record.

ii. Security awareness training is located through the Learning Management System or on the following internet link:

iii. https://michigan.csod.com/client/michigan/default.aspx

C. The Service Provider shall participate in trainings, application activities, fidelity assessments, etc. as provided regarding the Child Welfare Practice Model, MiTEAM.

D. The Service Provider shall ensure child welfare caseworkers:

i. Complete each training module on the MiTEAM Virtual Learning Site located at https://michigan.csod.com/client/Michigan/default.aspx

a. In the order recommended;

b. Participates in the Individual Field Application Exercises discussed with their supervisor;

c. Completes the caseworker self-assessment exercise as conducted by their supervisor; and

ii. Apply the MiTEAM competencies and Key Caseworker Activities during everyday contact with team members, including families and professionals.

iii. Have their competencies reviewed by their supervisor using the MiTEAM Fidelity Tool.

E. The Service Provider shall ensure that all **child welfare supervisors and/or program managers**

i. Complete in the order recommended each training module on the MiTEAM Virtual Learning Site, located at: https://michigan.csod.com/client/Michigan/default.aspx.
ii. Apply the MiTeam competencies during everyday contact with staff and team members, including families and professionals.
iii. Conduct the caseworker self-assessment exercise with each caseworker on their staff.
iv. Review competencies as demonstrated by their staff using the MiTEAM fidelity Tool.
v. Supervisors shall complete the required number of fidelity tools as directed by MDHHS.
vi. Supervisors shall enter results of completed fidelity tools int eh identified system as directly by MDHHS
vii. Supervisors shall provide feedback to his/her assigned staff and provide coaching opportunities to enhance skills in each competency.

F. The Service Provider shall ensure that the **child welfare director,** in the order recommended, reviews each training module on the MiTEAM Virtual Learning Site: https://michigan.csod.com/client/michigan/default.aspx.

i. Supports the practice of applying MiTEAM competencies during everyday contact with staff and team members, including families and professionals.

G. The Service Provider shall ensure child welfare caseworkers attend annual training in relation to the negative effects of childhood adversity, trauma-informed approaches, or how to build protective factors and resilience. This requirement can be met by trainings offered by MDHHS, WMPC, the Service Provider, or through external trainings that cover the identified content. The Service Provider shall ensure the applied training is documented in LMS in a way that indicates it meets the subject matter required.

H. The Service Provider shall ensure child welfare caseworkers attend annual training in implicit bias, cultural intelligence, and structural and institutional racism. The Service Provider will have a DEI Committee and a commitment to anti-racism which is included in its strategic plan.

I. The Service Provider shall ensure child welfare caseworkers attend annual training as schedule on the WMPC Network Training calendar. New child welfare case workers shall attend New Employee Orientation scheduled by WMPC.

J. Training Documentation

The Service Provider shall maintain training documentation as outlined in SRM 103, Staff Qualifications and Training

PROGRAM PERFORMANCE GOALS AND REVIEW

Program Performance Goals

1. General

   The Service Provider shall provide case management services that are designed to ensure the safety and well-being of all children served, including those remaining in the home, and shall ensure least restrictive placement environment, stability, and permanency for those children who are placed in out-of-home care.

2. Outcomes to be Measured

   During the period of this Agreement, the Service Provider shall work toward the achievement of the outcomes and key performance indicators (KPIs) listed below. Annual contract compliance shall be assessed using MDHHS Infoview Reports or other MDHHS data reports; the assessment will focus on performance trends and KPI achievements in the prior twelve months.

   If the Service Provider is not meeting the outcomes or KPIs listed below, the Service Provider shall include in its annual assessment a written performance improvement plan – as required by Mich Admin Code, R 400.12207 – with specific activities the Service Provider shall implement to demonstrate improvement in the outcome and KPI measures. The Service Provider shall submit the written plan to DCWL and WMPC by October 1 of each year.

   The targets for the Worker-Parent visit and Parent-Child visit measures, are network targets. The PQI Team will identify Service Provider specific targets for these measures by November 30th, 2020. These targets will be provided to the directors at each Service Provider and will be tracked and reviewed quarterly.

3. Safety in Foster Care and Permanency

   The Service Provider shall meet the following performance outcome indicators:

   A. Maltreatment in Care

      Of all children in care during a 12-month period, supervised by the Service Provider, the rate of maltreatment in care shall not exceed 9.67, as defined in the federal Child and Family Service Review, Round 3, by FY22.

      The Service Provider shall achieve the following annual goals at the conclusion of each fiscal year:

      i. Rate of 9.67 or below in FY20
      ii. Rate of 9.0 or below in FY21
      iii. Rate of 8.5 or below in FY22

   B. Relative Placements

      Relatives successfully completing the license process will increase 30 percent to the end of FY2022.

      The Service Provider shall achieve the following annual goas at the conclusion of each fiscal year:

      i. 10 percent increase in FY20

ii. 10 percent increase in FY21
iii. 10 percent increase in FY22

C. Permanency within 12 Months for Children Entering Care

At least 30 percent of children supervised by the Service Provider shall achieve permanency within 12 months for children entering foster care, as defined in the federal Child and Family Service Review, Round 3 by the end of FY22

The Service Provider shall achieve the following annual goals at the conclusion of each fiscal year

i. 24 percent in FY20
ii. 27 percent in FY21
iii. 30 percent in FY22

D. Worker-Parent Visits

At least 82 percent of parents whose children have a permanency goals of reunification and are supervised by the Service Provider, shall have face-to-face contact by the assigned caseworker by the end of FY22.

The Service Provider shall achieve the following annual goals at the conclusion of each fiscal year:

i. 71 percent in FY20
ii. 76 percent in FY21
iii. 82 percent in FY22

E. Parent Child Visits

At least 65 percent of children supervised by the Service Provider with a goal of reunification shall have visitation with their parent(s) by the end of FY22.

The Service Provider shall achieve the following annual goals at the conclusion of each fiscal year:

i. 55 percent in FY20
ii. 59 percent in FY21
iii. 65 percent in FY22

F. Reduced Days in Care in Emergency Shelter

The total number of children placed in emergency shelter will reduce by 16 percent by the end of FY22.
The Service Provider shall achieve the following annual goals the conclusion of each fiscal year:

i. 2 percent reduction in FY20
ii. 5 percent reduction in FY21
iii. 9 percent reduction in FY22

G. Reduce Percentage of Children First Placed in Shelter

The percentage of children for whom shelter is their first placement will not exceed 15 percent by the end of FY22

The Service Provider shall achieve the following annual goals the conclusion of each fiscal year:

i. Not exceed 25 percent in FY20
ii. Not exceed 20 percent in FY21
iii. Not exceed 15 percent in FY22

H. Reduced Days in Care in Residential

The total number of days children placed in residential care will reduce by 24 percent by the end of FY22.

The Service Provider shall achieve the following annual goals the conclusion of each fiscal year:

i. 8 percent reduction in FY20
ii. 8 percent reduction in FY21
iii. 8 percent reduction in FY22

I. Increase in County Placements

Of all placements supervised through the Service Provider, 72 percent of placements will remain in Kent County by the end of FY22.

The Service Provider shall achieve the following annual goals the conclusion of each fiscal year:

i. 68 percent in FY20
ii. 70 percent in FY21
iii. 72 percent in FY22

4. Performance Outcomes

Service Provider shall meet and/or maintain compliance in the following measures:

A. Permanency in 12 Months for Children in Foster Care 12 to 23 Months

At least 43.6 percent of children supervised by the Service Provider, in care 12 to 23 months shall achieve permanency within 12 months, as defined in the federal Child and Family Service Review, Round 3.

B. Permanency in 12 months for Children in Foster Care for 24 Months or Longer

At least 30.3 percent of children supervised by the Service Provider, in foster care 24 months or longer, shall achieve permanency within 12 months as defined in the federal Child and Family Service Review, Round

C. Re-entry into foster care in 12 months

At least 8.3 percent of children supervised by the Service Provider, shall not re-enter foster care within 12 months as defined in the federal Child and Family Service Review, Round 3.

D. Placement Stability

Children supervised by the Service Provider shall have no more than 4.12 placement moves as defined in the federal Child and Family Service Review, Round 3.

If the Service Provider is not meeting the standard for permanency within 12 months and is required to complete a program improvement plan, the Service Provider shall provide a plan to monitor re-entry as these are companion outcomes. For example: If the agency improves their permanency within 12 months this cannot negatively impact the re-entry rate. Timely achievement of permanency is not considered successful if the child re-enters care. The inverse is also true regarding re-entry program improvement plans.

5. Key Performance Indicators to be Measured

A. Medical – Initial

No fewer than 85 percent of children supervised by the Service Provider will have an initial medical examination within 30 days of removal.

B. Medical – Periodic (Well Child)/Yearly (14 Months)

Following an initial medical examination, at least 95 percent of children supervised by the Service Provider shall receive periodic medical examinations and screenings according to the guidelines set forth by the American Academy of Pediatrics and/or yearly (up to 14 months from the previous exam) medical examinations and screenings. (FOM 801 Policy)

C. Dental - Initial

No fewer than 90 percent of children supervised by the Service Provider shall have an initial dental examination within 90 days of removal unless the child has had an exam within 6 months prior to placement or the child is less than one years of age.

D. Dental – Yearly

No fewer than 95 percent of children supervised by the Service Provider shall have a dental examination at least every 6 months (FOM 801 Policy).

E. Worker-Child Visits

No fewer than 95 percent of children supervised by the Service Provider will be visited by their assigned worker.

F. Children's Foster Care Service Plans – Timely Case Plans

No fewer than 95 percent of children supervised by the Service Provider shall have an initial service plan completed within 30 days of entry into foster care and quarterly thereafter.

G. Children's Foster Care Timely Case Service Plan Approvals

No fewer than 95 percent of children supervised by the Service Provider shall have a case service plan approved within 14 days of case worker submission to the supervisor for review.

H. Supervisor Oversight

No fewer than 95 percent of children supervised by the Service Provider shall meet at least monthly with each assigned case worker to review the status and progress of each case on the worker's caseload.

I. Adoption Disruption

Fewer than 5% of placements for adoption shall end in disruption.

J. Adoption Finalizations

By September 30 of the fiscal year, at least 80 percent of the number of children with a goal of adoption who were legally free for adoption on September 30 of the previous fiscal year, shall have adoptions finalized

6. Network Performance Measures

A. Increased Days Community Placements:
The percentage of days the Service Provider's children placed in community-based foster care in the most family-like setting must increase by at least 3% from the previous year OR the percentage of days the Service Provider's children placed in community0based foster care in the most family-like settings must exceed 94%.

B. Increased Days in Relative Placements:
The percentage of days children placed in relative care must increase by at least 6% from the previous year OR at least 35% of all children served by the Service Provider are in relative care each year.

C. Licensed Foster Homes: The Service Provider must license at least the number of foster homes required to meet their benchmark for total number of homes to be licensed as determined by the Kent County AFPRR licensing calculator.

Data Source

1. Official outcomes and KPI data shall come from MDHHS via Infoview and/or other data reports produced by MDHHS.
2. The Service Provider shall conduct validation activities on an ongoing basis to assure the outcome and key performance indicator measures have been entered in MiSACWIS accurately.
3. For all assigned cases in MiSACWIS, Service Provider shall be responsible for ensuring accurate and timely data entry into MiSACWIS. The Service Provider is responsible for notifying MDHHS of identified MiSACWIS coding or system issues which prevent the Service Provider from entering accurate and timely data.
4. Service Provider shall ensure its payment staff and appropriate child welfare staff have access to the MiSACWIS through a web-based interface, henceforth referred to as the "MiSACWIS application." Requirements for MiSACWIS for CPA contracts may be found at http://www.michigan.gov/mdhhs/0,5885,7-339-71551_7199---,00.html

Reviews

1. Service Provider Compliance with State and FederalReviews

   A. The Service Provider shall participate in and cooperate with program evaluation and improvement, including on-going record keeping, evaluation, and reporting for any performance initiative required under federal and state law, rules, orregulations.

   B. The Service Provider shall supply the case record for any case selected for review as requested by, WMPC, the State of Michigan or federal government.

2. Quality Service Review (QSR)

   A. The Service Provider and its subcontractors shall participate in QSR at the discretion of WMPC.

   B. Following the completion of the QSR process, WMPC will provide a report outlining strengths and areas of improvement to the Service Provider and applicable subcontractors. Within 60 days of the report being issued, the Service Provider and their applicable subcontractor shall provide WMPC with a joint response, including a plan of action with timeframes for each of the identified recommendations/areas for improvement. WMPC shall follow-up with the Service Provider on the status of each response at its discretion to ensure that identified areas of improvement are being acted upon as indicated

Performance Improvement Plans

The Service Provider shall comply with WMPC policies and procedures for creating and implementing Performance Improvement Plans as part of its Continuous Quality Improvement plan. The Service Provider shall participate in ongoing Continuous Quality Improvement planning with WMPC.

Performance Evaluation and Monitoring

The services provided by the Service Provider under this Agreement shall be evaluated and assessed at least annually by WMPC.

WMPC shall perform contract monitoring through activities such as:

1. Auditing expenditure reports.
2. Conducting on-site monitoring.
3. Conducting case reviews.
4. Reviewing and analyzing reports.
5. Interviewing staff and clients.

The Service Provider must adhere to WMPC contract review policies as outlined in the Performance and Quality Improvement Handbook.

Failure to Meet Performance Outcomes and Indicators

If a program review by WMPC or MDHHS reveals a lack of compliance with the requirements of this Agreement, the Service Provider shall:

1. Meet with WMPC to discuss the noncompliance;
2. Prepare a corrective action plan within 15 days of receiving WMPC's or MDHHS's written findings; and
3. Achieve compliance within 60 days of receipt of WMPC and/or MDHHS approval of the corrective action plan (unless other time frames are agreed to in writing by WMPC) or the WMPC may take further action, including but not limited to: reducing placements, enacting a moratorium on placements, implementing financial penalties, terminating this Agreement.

Corrective Action Requirements

If a program review by WMPC or MDHHS reveals a lack of compliance with the requirements of this Agreement, the Service Provider shall:

1. Meet with WMPC to discuss the noncompliance;
2. Prepare a corrective action plan within 15 days of receiving WMPC's or MDHHS's written findings; and
3. Achieve compliance within 60 days of receipt of WMPC and/or MDHHS approval of the corrective action plan (unless other time frames are agreed to in writing by WMPC) or the WMPC may take further action, including but not limited to: reducing placements, enacting a moratorium on placements, implementing financial penalties, terminating this Agreement.

The Division of Child Welfare Licensing (DCWL)

DCWL shall be responsible for review of the Service Providers compliance with licensing rules, Implementation, Sustainability, and Exit Plan (ISEP) regulations, and MDHHS contract provisions. If DCWL monitoring reveals that the Service Provider has not complied with these requirements, the following procedures will be implemented:

1. DCWL shall notify the Service Provider of the Agreement or court noncompliance. This notification shall occur verbally during an exit conference and be followed with a written report of the findings. The Service Provider may request a meeting to discuss and examine the identified Agreement or court noncompliance.
2. Following the identification of the Agreement or court noncompliance, DCWL will request the Service Provider submit a Corrective Action Plans (CAP) to DCWL within fifteen (15) days of receiving the written report of findings.
3. After the Service Provider's CAP has been reviewed and approved by DCWL, the Service Provider's compliance with the CAP shall be reviewed in accordance with time frames established by DCWL in the written notification of acceptance of the CAP.
4. Based on the severity or repeated nature of cited violations, a recommendation may be made by DCWL at any time to place a moratorium on new placements with the Service Provider or to cancel the contract. If either recommendation is made, a meeting will be convened with the director of the contracted agency, the division director of DCWL and the CSA director or designee to provide the Service Provider with the opportunity to provide documented information on why the moratorium or cancellation of the contract should not occur.

5. If a moratorium on new placements is put into place, it shall be for a minimum of 90 days to allow the Service Provider to remedy cited violations and comply with any agreed-on CAP. If the cited violations are not corrected during the period of the moratorium or additional serious violations are cited, consideration shall be given to cancellation of the Service Provider's contract. Final decisions regarding the cancellation of a contract shall be made by the CSA director.

ADOPTION SERVICES TO BE PROVIDED

GENERAL

1. Place the child for adoption under the provisions of this Agreement.
2. The Service Provider that has the identified adoptive family shall be the agency to perform adoptive activities including: placement, case management, supervision, and court related requirements.
3. When the Service Provider has an identified adoptive family for a child under supervision of another agency, the Service Provider shall work cooperatively and develop a written plan with the child's agency to coordinate and share responsibility for pre-placement activities and associated costs for transportation and other case services.
4. When a placement for adoption disrupts or a finalized adoption dissolves within eighteen (18) months of the date of the order for placement or finalization, the Service Provider, unless ordered or directed otherwise by the Court or WMPC, shall be responsible to provide full adoption services for the child/youth as detailed in this contract. The responsible Service Provider is defined as the Service Provider that had adoption planning responsibilities for the child when the initial adoption placement occurred. For cases involving a child agency and a family agency, the responsible contractor is the child's agency, unless it is agreed upon by both agencies that the case will remain with the family agency. The exception shall be in a contested case where a child is placed in an adoptive home against the recommendation of the Service Provider.
5. Provide guidance to the child's foster parent in preparation of the child for adoption or in facilitating a transfer of the child's attachment to the adoptive parents.
6. In instances where the child's agency has performed pre-placement activities for the adoptive family's agency, the adoptive family's agency shall provide the child's agency with a copy of the court order placing the child in the adoptive home within thirty (30) working days, after receipt of said order.
7. The Service Provider shall develop plans for the effective use of cross- jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children. This shall include photo listing on the MARE website, networking with other private agencies in determining availability of resource families and other recruitment activities that are statewide and national in nature. The Service Provider shall respond to and actively work with, prospective adoptive parents outside of the State of Michigan.
8. The Service Provider shall maintain documentation of completion of the above-listed requirements in the child's adoption case file for review by WMPC.

ADOPTION, RECRUITMENT, ORIENTATION AND TRAINING

1. The Service Provider shall develop and implement a plan for adoptive home recruitment, retention, and support consistent with the MDHHS DCWL Licensing Standards specific to the Service Provider's license specified in Section 1.2(D).
2. The Service Provider shall provide adoption recruitment activities in collaboration with other private agencies and MDHHS local offices to focus on children photo-listed on the Michigan Adoption Resource Exchange (MARE).
3. The Service Provider shall work cooperatively with other contracted adoption agencies, WMPC, MDHHS and trained adoptive parents to provide orientation and training, specifically considering

the cultural heritage of the child and culturally-appropriate services It is recommended that adoptive parent peer mentors be matched to prospective and new adoptive parents. The Service Provider shall retain in the case record verification of training provided to the adoptive family including but not limited to:

A. Type of training provided;

B. Date training provided;

C. Subject material covered during training.

4. The Service Provider shall involve youth in the planning and organizing of adoption recruitment events.

5. The Service Provider shall develop supports for children and youth moving to permanency through adoption. Best practice research indicates that support groups, peer mentors, informational sessions and individual counseling are effective tools. Developing appropriate rituals and recognition for the transitions experienced shall be part of the adoption process.

6. The Service Provider shall be responsible for providing information to the prospective adoptive parent(s) regarding the adoption assistance programs on behalf of all children available for adoption. If the Service Provider fails to provide information, fails to apply for adoption assistance or finalizes an adoption prior to the execution of an adoption assistance contract, and it is later determined that the child was eligible for adoption assistance, the Service Provider shall be responsible for providing financial support to the family equal to the adoption assistance amount and eligible Medicaid coverage, from the time the family makes the request for the re-determination of eligibility and the date MDHHS Adoption Guardian Assistance Office determines that an error occurred based on the Service Provider's failure to inform or apply for adoption assistance.

MARE RELATED RESPONSIBILITIES

The Service Provider shall cooperate with MARE related activities and responsibilities, including but not limited to:

1. The Service Provider shall register children with MARE per policy timeframes and requirements.

2. The Service Provider shall appropriately inform and prepare children concerning the process of photo listing. Children shall be adequately attired and well groomed. Adequately attired is defined as that which a parent would provide for their child in a school photo. The Service Provider is responsible for securing photography services and may request coupons or assistance from the MARE office. The Service Provider is responsible for facilitating transportation to key photo sites and supervision of the child(ren) during the process.

3. The Service Provider shall, as appropriate to the child's ability, involve youth over age nine (9) in developing individual recruitment materials and narratives for MARE photo listing.

4. The Service Provider must submit a copy of the Order Placing Child after Consent and the Order of Adoption to the MARE office within ten (10) working days of issuance by the court.

5. Upon determination by the Service Provider that the MARE potential family 'match' is appropriate, the child and family agencies shall begin the process towards adoption within ten (10) working days.

6. The Service Provider shall provide a written brochure (developed by MARE) to adoptive families regarding their right to be included in the MARE prospective family registry and provide an explanation of this process during orientation. This brochure and information shall again be provided to the prospective family during the formal training process.

7. The Service Provider shall ensure all age appropriate youth available for adoption have knowledge of and access to the MARE newsletter for youth.

8. The Service Provider shall notify MARE no less than quarterly of planned adoption related events, scheduled or tentatively scheduled for the next quarter. These activities shall include but are not limited to orientation, training dates, workshops, adoption fairs, recruitment activities, post adoption support activities and guest speakers. The Service Provider will indicate if the events are open to the public or limited to a specific audience and any costs for family participation.

9. If the local court is participating, the Service Provider shall cooperate with MARE during planning and implementation of National Adoption Day activities and regionally based adoption events.

10. The Service Provider shall ensure MARE staff has access to case records, the child, child's worker, and other material or persons necessary for the development and updating of the child's MARE file and recruitment material.

11. The Service Provider shall submit the completed Disruption/Dissolution survey to MARE within thirty (30) days of receipt of the survey from MARE.

12. The Service Provider shall annually provide to MARE by October 30 the following:

    A. The address of all offices.

    B. Names, telephone numbers and email addresses of all adoption workers and supervisors.

    C. Types of services provided by the Service Provider.

13. The Service Provider shall ensure that a supervisor attends the regionally based MARE sessions on changes to MARE processes and services. This individual shall then be responsible to disseminate MARE information and material to appropriate agency staff

ENHANCED FOSTER CARE

SERVICE PROVIDER RESPONSIBILITIES

1. Service Description

Enhanced Foster Care (EFC) is a family-based service that provides individualized treatment for children in general foster care who present with intensive behavioral or emotional needs. EFC incorporates training and support for families to implement important aspects of treatment in the context of family and community life. EFC services will assist families in creating a living environment designed to minimize the occurrence of behaviors and implement coaching of alternative skills for children to utilize. Intensive case management services and concentrated clinical support will be provided through a partnership with Community Mental Health and the Service Provider, in addition to the general foster care staff assigned to the case. Services provided by the Service Provider will be child-specific, focused on addressing the identified emotional and behavioral concerns, and thoroughly documented in the Initial and Updated Services Plans. Service Providers will document EFC services provision and staffing model in their Program Statement.

2. Client Eligibility Criteria

EFC is a specialized service targeted at a sub-set of children placed in general foster care. EFC is designed to provide an intensive foster care community-based approach in lieu of an intensive out of community institutional approach. The EFC model will be employed to stabilize current foster youth, divert youth from being placed out of the community, and to deliberately return youth from institutional care back into the community.

A. Determination of Eligibility

WMPC refers youth for foster care case management services to subcontracted child placing agencies. The Service Provider will utilize all assessment methods to identify children that meet EFC eligibility criteria. If a need for EFC services is imminent, WMPC may authorize a 30-day provisional approval to promote placement of children with complex presenting needs.

Youth entering care are assessed through a trauma screening tool to identify the level of need presenting and pathway to clinical services. To ensure treatment is provided to children in need, the screening tool will be conducted promptly upon a child's entrance to care. Children presenting with an elevated level of need will be recommended for a mental health assessment by the assigned MDHHS Liaison and will be considered for EFC services and assessed for a Serious Emotional Disturbance (SED) Waiver.

Additionally, children will be considered eligible for EFC services:

- upon discharge from residential treatment, and/or
- that qualify for a SED Waiver https://www.michigan.gov/documents/mdch/SED_Waiver_TA_Manual_5-9-07_FINAL_196150_7.pdf), and/or
- when placed in a foster home or with a relative at risk of placement break due to behavioral or emotional issues and exhibit some or all the following:
    - history of two placement breaks due to behavioral or emotional issues,

- CANS score in Mental Health and Well-Being -3 or lower, and/or
- CAFAS score of 80 or more on the Child/Adolescent Section.

- WMPC can also authorize EFC to improve placement stability for a child when it is assessed to be in the best interest of the child.

All referrals for EFC services will be authorized through the collaboration of Service Provider staff and the Care Coordination team. Available information describing the need for proposed services will be provided to the Service Provider's assigned Care Coordinator.

When a placement has been secured for a youth to discharge from residential care, EFC services can be arranged to begin upon discharge to the home. To promote a strong transition plan that includes consistent supports, the caregiver will receive a $500.00 incentive when a referral to EFC services is made thirty days prior to discharge from the residential facility. The Service Provider will receive a $500.00 incentive in these cases to support EFC case management and programming. This payment will compensate for time and resources spent facilitating a positive transition into the home.

3. Service Level Design

A. Treatment Planning

A strengths-based, trauma-informed, and goal-oriented approach to treatment, beyond symptom reduction, will be employed through EFC. Assessment methods will be utilized by the entire treatment team to identify a diagnosis, determine needs and therapeutic interventions, and measure progress. Treatment team members may include but are not limited to: foster parents, biological parents, an EFC clinical case manager, behavioral specialist, other case staff, teachers, medical professionals, therapists, psychologists, psychiatrists, and supervisors.

B. Levels of Care

Initial authorization for EFC can be determined using the Child and Adolescent Functional Assessment Scale (CAFAS) score or CANS score. If a need for EFC services is imminent for a child being removed and neither of these assessments are available, WMPC may authorize a 30-day provisional approval to promote placement of children with complex presenting needs. All available information at time of intake or authorization will be utilized to determine the appropriate level of care. When provisional authorization is given, the CAFAS will be completed within 30 days to confirm or adjust the initial level of care. In all other cases, the CAFAS score and CANS score will be utilized upon referral to determine the level of service and in-home behavioral support necessary for the child. The CAFAS score and supporting documentation will be submitted upon referral and on a quarterly basis (or more if needed) to monitor progress and the on-going need for services.

Three levels of care offer the Service Provider the ability to construct service provision standards that are flexible in meeting the needs of individual children. The levels reflect high, medium, and low additional treatment needs beyond traditional foster care services. WMPC will approve a program statement created by the Service Provider that outlines the services provided at each level. An EFC Clinical Case Manager's caseload will be no more than 8 EFC cases. When calculating a blended caseload, EFC cases are considered weighted 2:1. All available information at time of intake or authorization will be utilized to determine

the appropriate level of care. The CAFAS completed within 30 days of authorization will confirm or adjust the initial level of care.

- Level 3: Children with high treatment needs who require intensive services to be maintained in a community setting. Psychiatric or behavioral issues, including frequent acting out behaviors and/or history of multiple hospitalizations. Unable to attend school without added services and a structured environment.
    - CANS score -5 in Mental Health and Well-Being
    - CAFAS score 120 or more on the Child/Adolescent Section
- Level 2: Children with moderate treatment needs, who have significantly disrupted functioning in school or placement, aggressive behaviors or require frequent behavioral intervention.
    - CANS score -3 or -2 in Mental Health and Well-Being
    - CAFAS score 80 or more on the Child/Adolescent Section
- Level 1: Children are generally stable and able to function well at home and school. Ideally used to step down youth receiving EFC services that show tremendous progress and stability.
    - CANS score 0 or higher in Mental Health and Well-Being
    - CAFAS score less than 80 on the Child/Adolescent Section

The partnership of caregivers involved in the treatment of EFC youth is essential to providing care in the community. Once the child has been authorized for EFC by WMPC, the following rates will be provided as a per diem to foster parents in relation to the level of care for the youth placed in their home to enable them to dedicate the needed time to attend required services and provide additional supervision to the youth:

EFC Level 1	EFC Level 2	EFC Level 3
$75.00	$88.00	$100.00

A service agreement will be created when EFC services are authorized in conjunction with the caregivers providing placement. The service agreement will outline the additional responsibilities that the caregivers are committing to provide to the child receiving EFC services. If a caregiver is not willing to facilitate the additional needs for the child within the treatment plan, the Service Provider can designate that their daily rate be reduced to an alternative rate determined by the Service Provider (including a lower EFC rate, DOC, or general foster care rate) and maintain placement, as well as EFC services. Services provided by caregivers at each level include increased supervision, behavior management, involvement in school, and participation in training that specifically pertain to the identified child(ren) placed in the home.

- Level 3: Caregiver engages in additional case services provided through EFC, as well as additional clinical services provided to the youth several times per week unless another frequency is recommended by the EFC Clinical Case Manager. A child assessed at this level displays severe impairment, which may include causing property damage in the

school or home, destructive or aggressive behavior towards self or others, intense mood irregularity, and/or distorted thinking. Examples of a caregiver's interventions could include: engaging with the EFC Case Manager and behavioral specialist multiple times per week, participating in wraparound services and therapy with youth, using de-escalation techniques, responding to emergencies at school, and implementing crisis safety plan when needed.

- Level 2: Caregiver engages in additional case services provided through EFC, as well as additional clinical services provided to the youth more than weekly unless another frequency is recommended by the EFC Clinical Case Manager. A child assessed at this level displays moderate impairment, which may include persistent non-compliant or irresponsible behaviors, sexually inappropriate or delinquent behavior, angry outbursts, or frequent mood disruption. Examples of a caregiver's interventions could include: engaging with the EFC Case Manager and behavioral specialist each weekly, using positive behavior supports, transporting the youth to needed treatment, and incorporating treatment plan components in the home.
- Level 1: Caregiver engages in additional case services provided through EFC, as well as additional clinical services provided to the youth at least weekly unless another frequency is recommended by the EFC Clinical Case Manager. A child assessed at this level displays mild impairment, which may include occasional disobedience, argumentative or annoying interaction with caregiver, problems at school or in relationships, or emotional distress. Examples of a caregiver's interventions could include: engaging with the EFC Case Manager and behavioral specialist weekly, attending Family Team Meetings at a higher frequency, exercising good control when provoked, providing consistency and predictable behavior towards the youth, and setting realistic expectations for the youth.

Additional discretionary funds can be requested on a case by case basis to provide for auxiliary needs for a child (example: assisted care, weighted blanket, higher per diem). The provision of these funds will be determined per request by the WMPC Care Coordination Team.

Managing services provided to youth that meet EFC eligibility criteria is an extensive role fulfilled by the Service Provider. The provision of successful services that support youth with high needs in a community setting will require a creative and flexible treatment team and interventions. A focused teaming approach will be vital to ensure non-duplicative services, as well as coordination of service goals to meet outcomes. Once the child has been authorized for EFC by WMPC, the Service Provider will receive an additional administration rate of $70, in addition to the general staffing rate, per day for each youth receiving the EFC services, regardless of the EFC level.

Instability can have substantial effects on the timeliness of reaching permanency; however, progress towards a child's permanency goal is essential to providing responsible care. The additional provision of EFC staff tied to complex cases will allow for increased availability for general foster care staff assigned to focus on case progression. Further, progression towards permanency will be supported by extensive work with biological families to become equipped to care for the child's level of need. A focus on preparing biological families will be emphasized in EFC to reduce the length of time youth spend in care.

Services provided by the Service Provider at each level include, but are not limited to the following:

The Service Provider provides support and coordinates the services necessary to maintain a youth in a community setting. The Service Provider gives added crisis response support or coordination for a child that may be at risk of harm to self or others. The Service Provider prepares the caregiver through training and coaching to create a conducive environment for the youth's treatment needs and planned responses to behaviors that arise.

- Level 3: The Service Provider provides an assigned EFC Clinical Case Manager, Behavioral Specialist, and other staff as needed to deliver intensive child-specific support focused on addressing the identified emotional and behavioral concerns several times a week, unless another frequency is recommended by the EFC Clinical Case Manager.
- Level 2: The Service Provider provides an assigned EFC Clinical Case Manager, Behavioral Specialist, and other staff as needed to deliver intensive child-specific support focused on addressing the identified emotional and behavioral concerns more than weekly, unless another frequency is recommended by the EFC Clinical Case Manager.
- Level 1: The Service Provider provides an assigned EFC Clinical Case Manager, Behavioral Specialist, and other staff as needed to deliver intensive child-specific support focused on addressing the identified emotional and behavioral concerns at least weekly, unless another frequency is recommended by the EFC Clinical Case Manager.

Coordination of services will focus on the supports offered to the child, as well as their effectiveness. Emphasis on identifying effective and evidence based practices in EFC will be vital to case progress and the stabilization of youth in care.

4. Treatment Team Criteria

A. Caregivers

Appropriate placements will be emphasized for children that present with intensive therapeutic needs. Children are eligible for EFC whether they are placed in a relative home or with an unrelated caregiver. Treatment will be provided by caregivers who can provide attention, nurturance, supervision and support. Connections will be strengthened when caregivers encourage the child's religious preference and strive to meet the cultural needs of the child and his/her family.

The Service Provider will provide the training and support necessary to the caregivers to produce an environment conducive to the care and treatment of the individual child placed in the home, considering the cultural heritage of the child and culturally-appropriate services. All families that have completed the Pressley Ridge Treatment Parenting Model are considered qualified caregivers to provide EFC services. However, EFC services will be authorized based on eligibility criteria regarding a child and provided even when the associated caregivers have not completed this training module. These instances will be documented as exceptions in the file and be approved on an individual basis by the Service Provider Director. On-going training that includes trauma informed parenting techniques will be provided to caregivers as needed.

Upon authorization of EFC services, the Service Provider will develop and implement a service agreement to address the training needs of the caregiver(s) to provide treatment to the youth placed in the home. If the placement is with an unlicensed relative, this service agreement will incorporate a plan for licensure. If a relative waiver is approved, this will be noted in the service agreement along with the corresponding alternative plan for the foster parent to receive training. A trauma-informed approach is required for any caregiver participating in EFC services.

Documentation of the families providing EFC services and their training credentials as well as the Service Provider's program statement indicating training requisites for EFC caregivers will be reviewed by WMPC.

B. EFC Staff

Successful EFC services will provide comprehensive supports to the caregivers and children involved, necessitating a committed team of professionals. One major component of this support will be through a designated EFC Clinical Case Manager, in addition to the general foster care staff assigned to the case. Additionally, the support and guidance of the EFC Supervisor will be central to the success of EFC services. EFC will also incorporate a Behavioral Specialist to aid in treatment planning and delivery specific to a child's behavior and mental health needs.

Additional qualifications will be considered when selecting staff, including a demonstrated history of experience, stability, positive case outcomes, and strong crisis management skills. Staff will be considered that have a proven history of facilitating strengths-based and trauma-informed treatment and the ability to partner constructively with a diverse interdisciplinary team. The Service Provider will aim to recruit and retain staff that represent the diversity of the community.

C. Additional Supports

Interdisciplinary involvement will be essential to the coordination of treatment for children receiving EFC services. High intensity services and supports will be needed to maintain the youth in a community setting. Assessment and allocation of mental health services will be determined by the Clinical Pathways process promptly upon entrance into care. The level of mental health services and supports will be considered throughout the provision of EFC services. Quarterly reviews of services will be directed by the Care Coordination team and utilized to gauge if an appropriate level of service is being provided and to facilitate collaboration across case team members.

GLOSSARY OF TERMS

Adoption Assistance

The purpose of subsidy programs is to provide financial support to families who adopt children from foster care through the public child welfare system, see Adoption Assistance Manual (AAM).

Adoption Finalization

The final legal step in the adoption process through which a court confirms that adoptive parent or parents are a child's legal parent(s).

Adoption Placement

Placement of a child with an approved family as ordered by a court through issuance of a PCA 320 - Order Placing Child After Consent.

Adoption Services

Adoption Services are a comprehensive and coordinated set of activities designed to place and supervise children for adoption. Adoption services include activities outlined in the Adoption Manual (ADM).

Calculated Capacity

Calculated Capacity for monthly foster care administrative/staffing payments shall be the previous three months' average of the number of children receiving foster care at the end of each month from the Service Provider or the number of kids receiving foster care at the end of the previous month, whichever is higher.

Case Management

Case management includes all phases of the child welfare work including but not limited to: locating and supporting a child's placement, assessment of the child and family, case plan development, coordinating and/or delivering services to address issues that brought the family to the attention of the department, achievement of timely permanency, monitoring and evaluation of service delivery provided to the child and family.

Case Rate

A case rate is a fixed payment rate or rates that is set to cover, on average, the cost of an individual child's contractually required service and placement needs. Payments are made prospectively and are based on projected costs for the child that reflect both the child's level of care as well as estimated treatment duration.

Child Welfare Services

Child welfare services is a set of services including foster care.

Enhanced Foster Care

Enhanced foster care is a specialized level of foster care to be developed in Kent County by the Service Provider.

Full Case Management

Full case management refers to the Service Provider being responsible for a case from removal through case closure with no opportunity for rejecting the referral from MDHHS. The Service Provider, by and through its subcontractors and service providers, must provide all case management, placement and service delivery.

Foster Care Services

Foster care services provides a comprehensive and coordinated set of activities designed to place and supervise children in out-of-home placement. Foster care services include activities outlined in the Children's Foster Care Manual (FOM).

Guardianship Services

Guardianship services includes activities outlined in the Guardianship Manual (GDM).

Independent Living Services

Independent living services includes providing a comprehensive and coordinated set of activities designed to place and supervise children and youth in independent living placements and develops the youth's ability to become self-sufficient. Independent Living services include activities outlined in the Children's Foster Care Manual (FOM).

Service Delivery

Service delivery is the coordination and/or provision of services to a child and his/her parent based upon identified needs to resolve the reasons the child was removed from his/her home. Services can include but are not limited to counseling, therapy, substance abuse testing, parent education, etc.

Trial Reunification

Trial Reunification is a court-ordered placement where the child is returned from and out-of-home placement to the care of the parent or guardian. The child remains under court supervision during the Trial Reunification period with the MDHHS retaining placement care and custody.

WEST MICHIGAN PARTERNSHIP FOR CHILDREN
SERVICES SCHEDULE OF FINANCIAL ASSISTANCE

Source of Funds		Catalog of Federal Domestic Assistance (CFDA)		Federal Award				
Federal / State	**Federal Agency Name**	**Number**	**Title**	**Award Number**	**Title**	**Federal Award Identification No.**	**Award Date**	**Amount**
State General Funds (01000)	NA	To Be Determined	To Be Determined	To Be Determined	To Be Determined	To Be Determined	To Be Determined	To Be Determined
			Total Allocation					

Per Diem Rate Schedule 2020-2021
Bethany Christian Services (BCS) of Central Pennsylvania

Cert #	Services Provided	Levels/ Unit ID	Per Diem Rate	Allowable Maint.	Allowable Admin.
363470 331220 330570 332780	Foster care* for children birth to two years of age. Monthly visits from BCS caseworker. Reunification and/or SWAN services can be provided with referral. Children have no medical or behavioral needs at this time. **	Level 1 AC	$32.27	$15.09	$17.18
363470 331220 330570 332780	Foster care* for children between the ages of birth and eighteen years of age. These children have a low acuity of behavioral, mental health, mental retardation, and/or physical challenges that are well controlled with or without medication. Intervention services are provided in the school setting. Monthly visits from BCS caseworker. Reunification and/or SWAN services can be provided with referral. **	Level 2 BC	$42.65	$19.25	$23.40
363470 331220 330570 332780	Foster care* for children between birth and eighteen years of age. These children will have minimal behavioral, mental health, mental retardation, physical aggression and/or physical challenges where a single supportive services is needed/ recommended to promote development. Therapeutic/supportive intervention is defined as medication management, outpatient counseling, wrap-around services, occupational therapy, physical therapy, early intervention services, speech therapy. Monthly visits from BCS caseworker. Reunification and/or SWAN services can be provided with referral. **	Level 3 CC	$71.95	$32.25	$39.70
363470 331220 330570 332780	Foster care* for children between the ages of birth and eighteen years of age. These children will have moderate behavioral, mental health, mental retardation, physical challenges, physical aggression and/or multiple mental health diagnoses requiring increased supportive services. BCS caseworker will identify and refer for appropriate services to ensure all needs are met. Biweekly visits from caseworker are maintained. Multiple therapeutic intervention Services are necessary to meet physical, emotional or psychiatric needs of the child. Service plan reviewed and updated quarterly. Reunification and/or SWAN services can be provided with referral. **	Level 4 DC	$85.24	$39.39	$45.85
363470 331220 330570 332780	Foster care* for children between the ages of birth and twenty-one years of age. These children will be displaying, physical aggression, diagnosed with Reactive Attachment Disorder, diagnosed on the Autism spectrum or diagnosed with multiple mental health/ behavioral health diagnoses requiring supportive services in all settings. Any child coming from a failed adoption situation or a child stepping down from a congregate care facility or treatment facility. BCS caseworker will identify and refer for appropriate services to ensure all needs are met. Visits from caseworker a minimum of three times per month with support as needed to resource family for provision of supportive services. Multiple services and therapeutic interventions are required to meet needs of the child and ensure permanency. Service plan reviewed and updated quarterly. Reunification and/or SWAN services can be provided with referral.	Level 5 EC	$135.65	$46.53	$89.12

363470 331220 330570 332780	Foster care* for children between the ages of birth and twenty-one years of age. Children eligible for medical foster care services a child must be eligible to receive Medical Assistance (MA) funded foster care services must be enrolled in medical assistance, have been diagnosed by a licensed practitioner as having a special or chronic medical condition or physical disability and require medical foster care services to remain in a foster care placement that is less restrictive than an institution or hospital. ***The board rate is reimbursed by MA as follows: Level 1 $19.36 (total$ 36.86) ; Level 2 $29.66 (total $ 53.42) ; Level 3 $49.31 (total $93.03) ; Level 4 $77.00 (total $122.04).	Medical 1	***	***	$17.50
		Medical 2	***	***	$23.26
		Medical 3	***	***	$43.72
		Medical 4	***	***	$55.85

*Upon placement of a child into foster care, assigned caseworker will meet with child and resource family on a weekly basis for the first month, and then biweekly for month two through four, if necessary for ongoing adjustment.**Upon request, reunification services can be added which increase the child by one placement level. Reunification services include: more than 1 visits per week with identified birth family resources, monthly casework services with birth family resource, and identification of community resources with referral for birth family needs.

Therapeutic/Treatment Foster Care Model Best Practices

Texas: Treatment Family Care Services (TFFC)

In 2018, the state of Texas implemented the Treatment Foster Family Care model to encourage contracted Child Placing Agencies to build capacity for younger children who demonstrate higher needs and might otherwise be difficult to secure placement.

Treatment Foster Family Care (TFFC) was created to deliver intensive level services to children in a highly structured home environment, opposed to a Residential Treatment Center (RTC) placement. The TFFC model initially sought to support children who are ten years and younger who have mental health diagnoses and/or socio-behavioral needs that cannot be met in traditional foster care settings. This age requirement was later increased to age 17 to support the adolescent population who demonstrate the need for a program like TFFC. The TFFC model strives to incorporate innovative, multi-disciplinary treatment services that are evidence-based and research-supported. It is intended to be a time-limited program that promotes the stabilization and preparation of children to transition into a less restrictive or permanent placement successfully. The TTFC model incentivizes foster parents and child-placing agency contractors to receive a higher reimbursement rate due to the additional requirements of comprehensive training, an increase in treatment plan reviews, and the ongoing support required following the discharge of a child.

Treatment Foster Family Care Services (TFFC) is a time-limited service by which placement providers will be held accountable for reducing the acuity of need and facilitating placements into a less restrictive, more family-like setting. The Texas Department of Family and Provider Services (DFPS) has awarded three contracts for services across the state for Treatment Foster Family Care Services effective September 1, 2018, including Arrow Family Ministries, CK Family Services, and The Bexar Foundation. Each contractor has a capacity growth plan with targeted milestones for both the number of treatment foster family homes certified to offer this service and the number of children served under each contract. They are all licensed foster care providers.

The three contractors supporting TFFC report that training and preparing the foster families takes longer than anticipated. The model also works best with one rather than two children in the home receiving this service. As such, the program continues to grow but at a slower pace than initially anticipated.

As of January 25, 2021, 212 unique children have been placed in a Treatment Foster Family Care placement through the legacy system not inclusive of the contracts with the Single Source Continuum Contractors (SSCC) supporting Community Based Care.[1]

As of October 15, 2020, there are 101 active Treatment Family Foster Care foster homes and 68 children placed among the three contracted Child Placing Agencies in the non-Community Based Care legacy system.

1 DFPS Rider 24 Utilization of Appropriate Levels of Care in Foster Care (state.tx.us). These organizations deliver similar outsources case management services as Omaha region.

Texas Treatment Foster Family Care Service Requirements:

The Texas Administrative Code § 700.1335 Section 700.1335 defines the treatment model by:

"Treatment Foster Family Care is a program designed to provide innovative, multi-disciplinary treatment services to a child or youth in a highly structured family home environment.

(a) Caregivers who participate in the Treatment Foster Family Care Program have specialized training in providing services to children with mental health and/or socio-behavioral needs that cannot be met in traditional foster care settings, including:

(1) 24-hour supervision to ensure the child's safety and sense of security, which includes frequent one-to-one monitoring with the ability to provide immediate on-site response;

(2) individualized, strengths-based therapeutic services and case management;

(3) time-limited services which include wrap-around services designed to transition children to a permanent and stable placement; and

(4) other training specified in the contract.

(c) A Treatment Foster Family Care home includes:

(1) at least one foster parent who does not work outside of the home and is highly-trained to meet the specific needs of this child population;

(2) a limitation of no more than two foster children at one time; and

(3) other characteristics and limitations specified in the contract.

(d) Child placing agencies providing Treatment Foster Family Care Services must:

(1) have a 24-hour on-call crisis person available to provide in-home crisis intervention and placement stabilization services, available to the child and family;

(2) a formal respite system, both routine and available upon request, when determined appropriate;

(3) a standardized caseload to support this population of children; and

(4) other requirements specified in the contract. Adopted by Texas Register, Volume 42, Number 34, August 25, 2017, TexReg 4309, eff. September 1, 2017[2]"

Pay Reimbursement:

[2] Section 700.1335 - What is the Treatment Foster Family Care Program?, 40 Tex. Admin. Code § 700.1335 | Casetext Search + Citator

The reimbursement rates for Treatment Foster Care total $277.37. A minimum of $137.52 from the total must be paid (reimbursed) to the foster family allowing the CPA to keep the remaining as an administrative payment for operations.

The Texas Health and Human Services Commission (HHSC) developed the following payment rates for the 24-Hour Residential Child Care (Foster Care) program operated by the Department of Family and Protective Services (DFPS). HHSC authorized DFPS to implement these recommended payment rates effective **September 1, 2019**.

24-Hour Residential Child Care Rates

Service Level	Type of Care	Rate
Basic	Child Placing Agency	$49.54
	Foster Family	$27.07
	General Residential Operation (excluding Emergency Shelters)	$45.19
Moderate	Child Placing Agency	$87.36
	Foster Family	$47.37
	General Residential Operation (excluding Emergency Shelters)	$108.18
Specialized	Child Placing Agency	$110.10
	Foster Family	$57.86
	General Residential Operation (excluding Emergency Shelters)	$197.69
Intense	Child Placing Agency	$186.42
	Foster Family	$92.43
	General Residential Operation (excluding Emergency Shelters)	$277.37
Intense Plus	General Residential Operation/Residential Treatment Center (GRO/RTC)	$400.72
Other	General Residential Operation/Emergency Care Services (GRO/ECS)	$137.30
	Intensive Psychiatric Transition Program (IPTP)	$374.33
	Treatment Foster Family Care - Agency	$277.37

Minimum Daily Amount to be Reimbursed to a Foster Family *

Service Level	Payment Rate
Basic	$27.07
Moderate	$47.37
Specialized	$57.86
Intense	$92.43
Treatment Foster Family Care	$137.52

* Effective September 1, 2017, the amounts above are the minimum amounts that a child-placing agency must reimburse its foster families for clients receiving services under a contract with the Texas Department of Family and Protective Services.

While Treatment Foster Family Care is a program for which Child Protective Services determines eligibility, they are time-limited programs with a review by YFT built into the process.[3]

Description of the Specialized Service Level[4]

- The Specialized Service Level consists of a treatment setting, preferably in a family, in which caregivers have specialized training to provide therapeutic, habilitative, and medical support and interventions, including:
    - 24-hour supervision to ensure the child's safety and sense of security, which includes close monitoring and increased limit setting;

[3] DFPS Rider 24 Report for Utilization of Appropriate Levels of Care in Foster Care (December 2019) (state.tx.us)
[4] DFPS - Service Levels for Foster Care (state.tx.us)

    - Affection, reassurance, and involvement in therapeutic activities appropriate to the child's age and development to promote the child's well-being;
    - Contact, in a manner that is deemed in the best interest of the child, with family members and other persons significant to the child to maintain a sense of identity and culture; and
    - Therapeutic, habilitative, and medical intervention and guidance that is regularly scheduled and professionally designed and supervised to help the child attain functioning appropriate to the child's age and development.
- In addition to the description in the Section above, a child with primary medical or habilitative needs may require regular interventions from a caregiver who has demonstrated competence.

Characteristics of a child that needs the Specialized Services

A child needing specialized services has severe problems in one or more areas of functioning. The children needing specialized services may include:

- A child whose characteristics include one or more of the following:
    - Unpredictable non-violent, anti-social acts;
    - Frequent or unpredictable physical aggression;
    - Being markedly withdrawn and isolated;
    - Major self-injurious actions to include recent suicide attempts; and
    - Difficulties that present a significant risk of harm to self or others.
- A child who abuses alcohol, drugs, or other conscious-altering substances whose characteristics include one or more of the following:
    - Severe impairment because of the substance abuse; and
    - A primary diagnosis of substance abuse or dependency.
- A child with intellectual or developmental disabilities whose characteristics include one or more of the following:
    - Severely impaired conceptual, social, and practical adaptive skills to include daily living and self-care;
    - severe impairment in communication, cognition, or expressions of affect;
    - Lack of motivation or the inability to complete self-care activities or participate in social activities;
    - Inability to respond appropriately to an emergency; and
    - Multiple physical disabilities including sensory impairments.
- A child with primary medical or habilitative needs whose characteristics include one or more of the following:

- Regular or frequent exacerbations or interventions in relation to the diagnosed medical condition;
- Severely limited daily living and self-care skills;
- Non-ambulatory or confined to a bed; and
- Constant access to on-site, medically skilled caregivers with demonstrated competencies in the interventions needed by children in their care.

Description of the Intense Service Level:

- The Intense Service Level consists of a high degree of structure, preferably in a family, to limit the child's access to environments as necessary to protect the child. The caregivers have specialized training to provide intense therapeutic and habilitative supports and interventions with limited outside access, including:
  - 24-hour supervision to ensure the child's safety and sense of security, which includes frequent one-to-one monitoring with the ability to provide immediate on-site response.
  - Affection, reassurance, and involvement in therapeutic activities appropriate to the child's age and development to promote the child's well-being;
  - Contact, in a manner that is deemed in the best interest of the child, with family members and other persons significant to the child, to maintain a sense of identity and culture;
  - Therapeutic, habilitative, and medical intervention and guidance that is frequently scheduled and professionally designed and supervised to help the child attain functioning more appropriate to the child's age and development; and
  - Consistent and frequent attention, direction, and assistance to help the child attain stabilization and connect appropriately with the child's environment.
- In addition to the supports and interventions listed in the Section above:
  - Children with intellectual or developmental disabilities needs require professionally directed, designed and monitored interventions to enhance mobility, communication, sensory, motor, and cognitive development, and self-help skills.
  - Children with primary medical or habilitative needs require frequent and consistent interventions. The child may be dependent on people or technology for accommodation and require interventions designed, monitored, or approved by an appropriately constituted interdisciplinary team.

Characteristics of a child that needs Intense Services:

A child needing intense services has severe problems in one or more areas of functioning that present an imminent and critical danger of harm to self or others. The children needing intense services may include:

- A child whose characteristics include one or more of the following:
  - Extreme physical aggression that causes harm;

    - Recurring major self-injurious actions to include serious suicide attempts;
    - Other difficulties that present a critical risk of harm to self or others; and
    - Severely impaired reality testing, communication skills, cognitive, affect, or personal hygiene.
- A child who abuses alcohol, drugs, or other conscious-altering substances whose characteristics include a primary diagnosis of substance dependency in addition to being extremely aggressive or self-destructive to the point of causing harm.
- A child with intellectual or developmental disabilities whose characteristics include one or more of the following:
    - Impairments so severe in conceptual, social, and practical adaptive skills that the child's ability to actively participate in the program is limited and requires constant one-to-one supervision for the safety of self or others; and
    - A consistent inability to cooperate in self-care while requiring constant one-to-one supervision for the safety of self or others.
- A child with primary medical or habilitative needs that present an imminent and critical medical risk whose characteristics include one or more of the following:
    - Frequent acute exacerbations and chronic, intensive interventions in relation to the diagnosed medical condition;
    - Inability to perform daily living or self-care skills; and
    - 24-hour on-site medical supervision to sustain life support.

Youth for Tomorrow Authorization Process:

The Level of Care Service System was Legislatively mandated before 1990. The intent was to stop the institutionalization of children and better ensure that children have the opportunity to be placed in the least restrictive, most family-like setting possible. The LOC Service System was mandated and incorporated into the State of Texas Administrative Code, with DFPS being the Oversight Agency to ensure implementation. DFPS has contracted with Youth for Tomorrow for 29 years to assist with the implementation of this system. All services performed by YFT are according to the policies approved by DFPS.

Obtaining an Initial Service Level Authorization (ASL)

The initial service level is for children who are in DFPS conservatorship for the first time. The provider's request must include the following forms and documentation:

- Service Level authorization form (IMPACT path – Child's sub care stage, placement, service level)
- Form 2087 Application for Placement (See Attachment to this email for a copy of this form.)
- For children with emotional disturbance:
    - Psychological or psychiatric evaluations

Completed within 14 months, are required on initial service level authorizations.

- For children with primary medical needs:
  - An evaluation by a physician (MD), physician's assistant, or
  - Nurse practitioner, describing medical conditions or disabilities.
- (Optional) Information describing any extenuating circumstances, incident reports, and so on[5].

Utilization Reviews (URs)

YFT authorizes Specialized or Intense services for three months. Typically, utilization reviews are completed by YFT on a regularly scheduled basis in conjunction with Providers who have a contract with DFPS and are working with that child. This often means that children's authorization for services will continue uninterrupted. YFT does not conduct scheduled Utilization Reviews for children placed in emergency shelters, juvenile detention, hospitals, and placements with families or relatives.

Key Performance Indicators:

All three TFFC contracts are required to maintain internal data identifying the success of the TFFC program by the reason the child/youth was discharged from the TFFC home. Below is a snapshot of data for one TFFC Child Placing Agency that serves TFFC youth both within the Texas Department of Family and Protective Services' legacy system and the Community Based Care model since inception.

[5] Texas Service Levels Resource Guide (state.tx.us)

Discharge Reasons	Total (All Time)	DFPS FY 2019	DFPS FY 2020	DFPS FY 2021
Adoption Placement (internal or external)	**6**	1	5	0
Returned Home with biological family	**4**	1	3	0
Placed with Relatives/Fictive Kin	**2**	2	0	0
Internal Foster Home within our CPA	**24**	3	18	3
Non-Internal Foster Home outside our CPA	**6**	1	4	1
Foster Family Transferred to another CPA - Child Remains in Home	**1**	1	0	0
TFFC home with another agency	**2**	0	2	0
Psychiatric Hospital admission	**6**	3	2	1
Residential Treatment Center Placement	**6**	1	5	0
Count of Submoves	**13**	3	8	2
Total Discharges (including Submoves)	**70**	16	47	7
Total Discharges (excluding Submoves)	**57**	13	39	5

Discharge Category	Total (All Time)	DFPS FY 2019	DFPS FY 2020	DFPS FY 2021
Successful	**73.68%**	61.54%	76.92%	80.00%
Neutral	**1.75%**	7.69%	0.00%	0.00%
Unsuccessful	**24.56%**	30.77%	23.08%	20.00%

Length of Stay (LOS)	Total (All Time)	DFPS FY 2019	DFPS FY 2020	DFPS FY 2021
Discharged Clients by Discharge Date	**167.21**	120.50	175.81	210.13
All clients by Admission Dates	**202.03**	156.97	225.36	200.38

Average LOS (thru 2019 admits): 153.74

Washington: The WISe Wraparound Program Model

Background:

Washington State's Wraparound with Intensive Services (WISe) began implementation in 2014 as a result of the **T.R. ET AL. V. KEVIN QUIGLEY AND DOROTHY TEETER SETTLEMENT AGREEMENT.** WISe is designed to provide intensive support and services to assist youth and families in achieving wellness and safety, and to strengthen communities. WISe uses a team-based approach to providing services, and is available to youth under age 21 who are eligible for Medicaid. The goal of WISe is for eligible youth to live and thrive in their homes and communities, as well as to avoid or reduce costly and disruptive out-of-home placements.

The WISe Model (Wraparound with Intensive Services)

Attributes of the Washington WISe model and carve out Foster Care Managed Care Plan include:

- Cooperative and collaborative planning between DCYF and the Health Care Authority (state Medicaid agency), including active stakeholder participation (Foster Parents, Transition Youth, MCOs, and Providers) successfully developed the fidelity wraparound WISe program model that provides the necessary Behavioral Health Rehabilitation EBP services that a child/youth needing the Therapeutic/Treatment Foster Care level of care is assessed to need as well as support of the Therapeutic/Treatment Foster parents.
- There is a standard practice for DCYF case workers to follow to initiate the Therapeutic/Treatment level of foster care.
- DCYF, WISe, and MCOs utilize the CANS for BH assessment needs, services, and cost
- History of active and supportive Legislative oversight in partnership with DCYF, Medicaid, Foster Parents, Youth in Transition, CPAs, Providers that has created an on-going year to year dialogue and problem identification and improvement strategies.

Foster Care youth access all WISe services through a direct connection with the state's Medicaid Managed Care Plan for Foster Youth (Coordinated Care) thereby providing a seamless coordinated approach to meeting the Behavioral Health and general medical needs of children/youth in Foster Care.

- The WISe program model is based on certified community based agencies who meet all criteria to be a WISe program provider. There are currently 56 WISe community provider agencies across the state with at least one WISe provider in each of the state's 39 counties. WISe provider agencies must meet standards[6] in:
    1. Access
    2. Practice model
    3. Service array
    4. Staffing
    5. Community oversight and cross-system collaboration
    6. Documentation

Cross-System Collaboration:

WISe provider agencies are required to collaborate and include other child serving system partners (child welfare, juvenile justice, education, developmental disabilities support, etc.) on CFTs, as applicable to each youth and family, as identified in the Point of Identification section of the Access Model (hereafter system partners). The agency is to work with the youth, family and system partners to develop a single Cross System Care Plan (CSCP) for the youth and family. The CSCP can encompass the individual service plan requirements and will likely include a variety of other activities. Medicaid services

6 www.hca.wa.gov/assets/billers-and-providers/wise-wraparound-intensive-services-manual.pdf p. 8

must be prescribed clearly, according to Medicaid documentation standards, regardless of whether the individual service plan is incorporated into the CSCP or a separate document.[7]

Referrals to WISe [8]

A referral for a WISe screen must be made for Medicaid-eligible youth in the following circumstances:

1. When a youth is referred to Children's Long-Term Inpatient Program (CLIP) or Behavioral Rehabilitation Services (BRS).
2. While a youth is enrolled in BRS services only (not BRS and WISe concurrently), or receiving CLIP services: no less frequently than every six months, and during discharge planning.
3. Prior to a youth discharging from a psychiatric hospital.
4. When a step-down request has been made from institutional or group care.
5. When a youth receives crisis intervention or stabilization services, and there are past and/or current functional indicators of need for intensive behavioral health services.

If a youth is currently receiving Medicaid behavioral health services a referral for a WISe Screen can be completed in the following ways:

- The current provider can complete the CANS screen, if they are certified in the CANS, or
- The current provider can make a referral to a WISe-contracted provider agency that will complete the CANS Screening. If a youth does not meet the CANS algorithm, clinical judgment may be used to continue with a referral to WISe.

WISe Screenings[9]

All WISe screens will include:

1. Information gathering that utilizes the information provided by the referral source (i.e. the youth, a family member, a system partner, and/or an informal or natural support). Additional information may be gathered from the youth and family directly and others who have been involved with the family (including extended family and natural supports) and/or other service providers working with the youth and family.
2. Completion of the **Child Adolescent Needs and Strengths (CANS) Screen**, which consists of a subset of 26 questions, pulled from the Full CANS. The CANS screen must be completed by a CANS-certified screener.

Algorithm for CANS based Intensive Services Decision Making:

Washington's CANS Algorithm[10] 7/24/14 A child will be recommended for Wraparound with Intensive Services (WISe) if:

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7 Ibid, p. 10

8 Ibid, p. 14

9 Ibid, p. 15

10 Ibid, p. 75

Criterion 1. Behavioral/Emotional Needs

1a. Rating of 3 on “Psychosis” OR

1b. Rating of 2 on “Psychosis” and 2 or 3 on any other Behavioral/Emotional Needs item OR

1c. 2 or more ratings of 3 on any Behavioral/Emotional Needs items OR

1d. 3 or more ratings of 2 or 3 on any Behavioral/Emotional Needs items Note: Behavioral/emotional needs items we plan to include in our screener: Psychosis; Attention/Impulse; Mood Disturbance; Anxiety; Disruptive Behavior; Adjustment to Trauma; Emotional Control

Criterion 2. Risk Factors

2a. Rating of 3 on “Danger to Others” or “Suicide Risk” OR

2b. One rating of 3 on any Risk Factor item OR

2 or more ratings of 2 or 3 on any Risk Factor item Note: Risk factors included: Suicide Risk; Non-Suicidal Self-Injury; Danger to Others; Runaway;

Criterion 3. Serious Functional Impairment

3a. 2or more ratings of 3 on “Family”, “School”, “Interpersonal” or “Living Situation” OR

3b. 3 or more ratings of 2 or 3 on “Family”, “School”, “Interpersonal” and “Living Situation”

WISe Intake[11]

For any youth who is not currently enrolled in Medicaid for behavioral health services, in addition to the WISe screen, the following intake eligibility determinations must be made:

1. Establish Medicaid eligibility. The WISe service delivery model is a collection of Medicaid state plan services and can only serve youth who are up to 21 and covered by Medicaid.
2. Establish that the youth meets qualifying medical necessity criteria. All youth who meet the CANS algorithm and have a mental health diagnosis will be determined to meet WISe level of care. If a youth does not meet the CANs algorithm, clinical judgment may be used to continue with a referral to WISe if indicated. Indicate in BHAS comment section the reason youth is being offered entry into WISe. All youth, ages 5 through 20, who meet the CANS algorithm and are eligible for behavioral health services through Medicaid qualifying criteria noted above will be offered entry to WISe.

For those children under 5 years of age, this decision shall be made based on information from the CANS Screen and clinical judgment

Washington DCYF Definition: Therapeutic Or Treatment Foster Care:

Service Definition

11 www.hca.wa.gov/assets/billers-and-providers/wise-wraparound-intensive-services-manual.pdf

1. Therapeutic or treatment foster homes are those licensed foster families that have been identified to care for extremely behaviorally/emotionally disturbed children who cannot function in a family home without specialized treatment and expertise.
2. Therapeutic foster parents have specialized skills in managing these children. Often these homes have a pre-determined, designated intensive "package" of services that are delivered to every child placed in the therapeutic foster home.
3. Therapeutic foster care is provided directly through DCFS licensed foster homes and by contract or agreement with other agencies. These services do not include those accessed through Rehabilitative Treatment Services described in section 4533, following. If Treatment Foster Care is provided through a Rehabilitation Treatment Services contract, see section 4533 for provisions for access and management.

Eligibility

Eligibility is determined, in accordance with regional procedures, following assessment of service and placement options.

Procedures for Access

1. The social worker determines that appropriate relative care is not available prior to placement of the child in foster care.
2. The social worker locates and contacts an available, appropriate foster home parent utilizing the locally determined placement system.
3. The social worker informs the foster parent of DCFS responsibilities toward finding a relative that is similar and familiar to the child. The social worker assists the foster parent by providing clear information and consultation/resources if needed to care for a particular child.
4. In instances where placement is not emergent, the social worker must arrange pre-placement visits to reduce the anxiety of the child around the placement and to familiarize the child with the child's temporary family. When possible and appropriate, the social worker must involve parents in pre-placement visits. Unless emergency preempts such involvement, the child's social worker must be involved in the pre- placement visits and the actual placement in the foster home. See section 45282, paragraph H, for the requirement to contact the child placed after hours or on weekends within the next few days following placement.
5. To reduce conflict between DCFS and foster parents about the temporary nature of foster care, social workers need to be clear at the time of placement, and regularly thereafter, about the long term and permanency plan for the child.
6. To help the foster parent decide if they can care for the child, the social worker provides the foster home parent with information about the immediate condition of the child, the child's behaviors, school and medical information, and specifics of the permanency plan that will affect the child and the placement. See the Case Services Policy Manual, chapter 4000, section 4120, paragraph A, for requirements to disclose information regarding HIV infection and sexually transmitted diseases to the residential care provider for the child who is less than 14 years of age.

7. The social worker clarifies dates of future visits to the foster home and provides the foster home with written background information and emergency numbers when placing the child. Most regional offices have designated forms for providing information to foster parents. Specific information to be provided to the foster parents includes:
    i. Child's full name, birth date, and legal status.
    ii. Last school of attendance and eligibility for special education and related services.
    iii. Medical problems/history including name of doctor/ dentist and medical coverage.
    iv. Name and address of parent/guardian.
    v. Reason for placement.
    vi. Emergency procedures and any special instructions.
    vii. The name and telephone number of the social worker and of the social worker's immediate supervisor.
8. The social worker makes a contact with the foster home within three days following placement to see how the child is adjusting.
9. The social worker and the licenser encourage foster parents to keep a record of the child's stay in their home, including any medical reports received by the foster parent, significant developmental milestones, behavior, schools attended, names of all medical providers and dates of visits, grades/report cards, friends, pets, and pictures of the child.
10. Whenever possible or appropriate, the social worker must provide parents/guardians with information about the child's adjustment, health, and school progress while in foster care.
11. After the initial contact following placement, the social worker must visit the foster home and have face-to-face contact in the foster home with the foster parents and child every calendar month not to exceed 40 days between visits. The social worker conducts these on-site interviews to ensure the health and safety of the child, to assess the child's adjustment to placement, to assess services needed by the child or foster parent, and to provide casework support to assist foster parents in caring for the child. The social worker must document the activities in the case SER. When there are problems with a placement, the social worker works with foster parents to find resources for resolving problems. For example, specialized training, consultation, or other support may be needed at particular times with particular placements.
12. For children who are dependent under chapter 13.34 RCW, the social worker must notify the current caregiver of the date of scheduled court review hearings pertaining to the child. The social worker almost notify the caregiver of the caregiver's right to an opportunity to be heard in the review hearing and to provide the court with information. This right to notice of hearings and opportunity to be heard applies to foster parents, pre-adoptive parents, and relatives who are caring for the child at the time of the hearing. This hearing notice does not give the caregiver legal status as a party to the case. The court will make the final decision about whether and how the caregiver will provide input at the hearing.

13. When the child's social worker has a specific concern or complaint regarding a foster home, the worker conveys the concerns in writing to the foster care licenser for that home. When the complaint is an allegation of CA/N, the social worker shall make a CPS referral.
14. When a child is to be removed from a foster home, the social worker shall send five-day written notice to the foster parent prior to the date of the child's move unless a court order or concern for the child's health and safety requires that the child be moved immediately.
15. Procedures for contracted or other types of therapeutic foster care vary, depending on the contract or agreement with DCFS. The social worker consults their supervisor, the special placements coordinator, or home finder, and regional procedures for specific guidelines.

Washington DCYF Definition: Therapeutic Or Treatment Foster Care[12]

Michigan: Kent County PILOT

Background:

The Michigan Department of Human Services, Office of Child Welfare Policy and Programs has implemented the "Strengthening Our Focus on Children and Families"[13] improvement quality strategy focused on an Enhanced Trauma Informed Practice model, continuous quality improvement strategies, and development of a performance based child welfare system. MDHS/Child Welfare implemented the Kent County Performance Funding Pilot project specifically to develop innovative community based approaches that "fits into a set of state strategies, commonly referred to as the Strengthening Our Focus on Children and Families approach". A key component of the Kent County Pilot will create a system that takes a balanced and equitable approach in which the private and public sector agencies and tribes may be successful. Ultimately, producing better outcomes for children and families."[14]
In 2017 the West Michigan Partnership for Children[15] (WMPC) was created based on long-term collaboration between professionals, the Kent County Administrator's Office (, community leaders and partners, Michigan Child Welfare Partnership Council, and legislators). Like St. Francis Ministries in Nebraska, WMPC is the only private organization in the state that manages a network of foster care and service providers.

WMPC draws from national and local best practices to:

- Administer performance-based contracts that require foster care and service providers to meet key outcomes for children and families in an efficient and timely manner;
- Facilitate a funding model that prioritizes permanency, allows creativity and flexibility for needed services, and rewards early interventions that result in positive outcomes;
- Utilize cutting-edge technology and software for real-time case management and predictive analytics that identify client needs and mobilize resources to prevent crises;

12 www.dcyf.wa.gov/4500-specific-services/4532-therapeutic-or-treatment-foster-care

13 MDHHS - Strengthening Our Focus on Children & Families (michigan.gov)

14 MDHHS - Performance-Based Child Welfare System (michigan.gov)

15 Who We Are - West Michigan Partnership for Children (wmpc.care)

- Lead and empower a collaborative consortium, leveraging the talent, expertise, and historical knowledge of Child Placing Agency providers, Bethany Christian Services, Catholic Charities of West Michigan, D.A. Blodgett-St. John's, Samaritas, and Wellspring Lutheran Services.

The WPMC Enhanced Foster Care (Thereaputic) Model

In late 2017, Enhanced Foster Care (EFC) was developed through collaboration with Private Agency Foster Care (PAFC) providers, Network 180, and Michigan Department of Health and Human Services (MDHHS). EFC is an addition to the continuum of care in Kent county focused on supporting community placements for children with high and complex needs that may otherwise be placed in an institutional setting. The main service objectives are to stabilize children in their placement and sustainably return children placed in residential facilities to community placements. EFC is designed to be a time-oriented service that wraps intensive therapeutic services around the child and caregiver in the current placement. Clinical and behavioral specialists provide individualized services and support to the child and caregiver. EFC has a tiered approach to intensity of services and payments to caregivers and the foster care agencies. *See West Michigan Partnership for Children, Enhanced Foster Care Evaluation Report, September 2020.*

EFC has demonstrated promising results since its full implementation in February 2018. This evaluation is aimed at better understanding the service outcomes and additional effects of the program. The evaluation uses quantitative and qualitative methods to evaluate program impact on the target population, cost effectiveness, and differences in performance between the five foster care agencies providing the service in Kent County. The evaluation analyzes data for 164 youth between December 14, 2017 and March 18, 2020. Key findings from the evaluation are: 1. Improved placement stability for children who had a high number of placements moves before EFC intervention. 2. Improved functioning for children who receive EFC services. 3. Improved placement stability for children that moved from residential placements to community placements. 4. Savings of over $1 million across FY18 and FY19 due to decreased placement days in residential. Id.

EFC Services Operations Model

The WMPC developed a Services Operations Manual which includes the following definitions for their Enhanced Foster Care model:

10.2 Type of Youth Served EFC is a specialized service targeted at a sub-set of children in foster care who are at risk of placement instability or placement in an institutional setting. EFC will be considered when possible to stabilize current foster youth, divert youth from being placed out of the community, and to deliberately return youth from institutional care back into the community.

10.3 Determination of Eligibility Private agencies will identify children for the EFC program utilizing a multidisciplinary approach. This means that there may be multiple routes to an EFC referral. The referral process should not be a barrier to a child receiving appropriate supports. If a child is a risk for placement instability and/or the need for EFC services is imminent, WMPC may authorize a 30-day provisional approval to ensure that the child's needs are met and to promote placement stability in a family-like setting.

Youth Entering Care

Youth entering care will be assessed through the Clinical Pathways trauma screening tool to identify the level of need they are currently presenting. To ensure that treatment is provided to children right when they need it, the screening tool will be conducted promptly upon a child's entrance to care. Children presenting with an elevated level of need will be recommended for a mental health assessment by the WMPC Liaison and will be considered for EFC services as well as assessed for a SED Waiver. For children who have a demonstrated intensive level of need at removal, WMPC may grant a 30-day provisional EFC service approval for youth at time of removal, while the further assessment is conducted. During the 30-day period, the worker will ensure that a CAFAS is completed and submitted to confirm the child's current level of need. Additionally, EFC services will be considered any time a child:

- Is discharging from residential care
- Is at risk of placement break due to behavioral or emotional issues AND exhibits some or all the following:
    - A history of two or more placement breaks due to behavioral/emotional issues
    - CANS score in Mental Health and Well-Being -3 or lower or CAFAS score of 80 or more on the Child/Adolescent Section

The Child and Adolescent Functional Assessment Scale (CAFAS) will be used to determine the level of care for children in EFC. If a CAFAS was not completed before the initial authorization of EFC services, one must be completed and submitted to the assigned Care Coordinator within 30 days of authorization of EFC services.

In the case of a 30-day provisional authorization, the 30-day assessment period will be utilized to confirm or to re-determine the level of service and in-home behavioral support necessary for the child. During that time, EFC staff will complete an ISA, quarterly report, and a CAFAS or PECFAS score for the child. These documents will be uploaded in MiSACWIS under the EFC Placement in the document section and used to confirm or redetermine level of service prior to the end of the 30 day authorization. Ongoing Assessment and Reauthorization The clinical case manager will continuously evaluate the efficacy of interventions to assess if the child's needs are being fully met. The CAFAS score and supporting documentation will be submitted to WMPC on a quarterly basis (or more if needed) to monitor progress and the on-going need for services. The Clinical Case Manager will email the Care Coordinator reauthorization requests at least 5 business days prior to the 90-day reauthorization date. The Care Coordinator will process the reauthorization request within three business days. Reauthorization requests will address the continuing need for service through the case progress report and include the latest case progress report as well as any other relevant supporting documentation. Upon approval of the reauthorization, the caseworker will upload the documentation to MiSACWIS under the EFC Placement in the document section. The timetable for quarterly review will be begin upon the child's approval for EFC services.

10.6 Levels of Care

Each private agency will construct service provision standards that are flexible in meeting the needs of individual children. The levels reflect high, medium, and low treatment needs that are above and beyond traditional foster care services. The private agency will provide outlines of the services that they

provided at each level to WMPC for approval. All available information pertaining to the child's needs at time of intake or authorization will be utilized to determine the appropriate level of care. The level of care will be reassessed every time the CAFAS score is completed or if the child has a significant change in their needs.

Level 3: Level three is appropriate for children with high treatment needs who require intensive services to be maintained in a community setting. These children have psychiatric or behavioral issues, including frequent acting out behaviors and/or history of multiple hospitalizations. These children may require continuous behavioral intervention or 24-hour supervision. They are unable to attend school without added services and a structured environment. Scores that indicate a level three include:

- CANS score -5 in Mental Health and Well-Being
- CAFAS score 120 or more on the Child/Adolescent Section

Level 2: Level two is appropriate for children with moderate treatment needs, whom have significantly disrupted functioning in school or placement, aggressive behaviors or who require frequent behavioral intervention. These children may also need an increased level of supervision. Scores that indicate a level two include:

- CANS score -3 or -2 in Mental Health and Well-Being
- CAFAS score 80 or more on the Child/Adolescent Section

Level 1: Children at a level one are generally stable and able to function well at home and school. Level one is ideally used for youth that show tremendous progress and stability to step them down from EFC services. Scores that indicate a level one include:

- CANS score 0 or higher in Mental Health and Well-Being
- CAFAS score less than 80 on the Child/Adolescent Section

Per Diem

Children are eligible for EFC whether they are placed in a relative home or with an unrelated caregiver. If the caregiver is unwilling to participate in the service agreement, the child is still eligible for EFC services, however the caregiver is not eligible to receive the EFC per diem. The following rates will be provided as a per diem to foster parents in relation to the level of care for the youth placed in their home. This is intended to enable them to dedicate the needed time to the youth, including attendance at required services and providing additional supervision.

- EFC Level1: $75.00
- EFC Level 2: $88.00
- EFC Level 3: $100.006

If a caregiver is not willing to facilitate the additional needs for the child within the treatment plan, the private agency can designate that their daily rate be reduced to an alternative rate structure determined by the private agency (including a lower EFC rate, DOC, or general foster care rate) and maintain placement, as well as EFC services. This decision must be signed off on by an EFC supervisor and the family will be notified of the decision in writing. When a PAFC determines a reduced rate or to not provide the per diem to a family with placement of a child receiving EFC services, this decision will be

documented on the ISA. Payments Additional discretionary funds can be requested on a case by case basis to provide for auxiliary need.

Level 3 Caregiver Expectations

At a level three, the caregiver engages in additional case services provided through EFC, as well as additional clinical services provided to the youth several times per week, unless another frequency is recommended by the EFC Clinical Case Manager. A child assessed at this level displays severe impairment, which may include causing property damage in the school or home, destructive or aggressive behavior towards self or others, intense mood irregularity, and/or distorted thinking. Examples of a caregiver's interventions could include: seeing the EFC Clinical Case Manager and Behavioral Specialist multiple times per week, engagement in wraparound services and therapy with youth, using de-escalation techniques, responding to emergencies at school, and implementing crisis safety plan when needed.

Level 2 Caregiver Expectations

At a level two, the caregiver engages in additional case services provided through EFC, as well as additional clinical services provided to the youth more than weekly unless another frequency is recommended by the EFC Clinical Case Manager. A child assessed at this level displays moderate impairment, which may include persistent non-compliant or irresponsible behaviors, sexually inappropriate or delinquent behavior, angry outbursts, or frequent mood disruption. Examples of a caregiver's interventions could include: seeing the EFC Clinical Case Manager and Behavioral Specialist each weekly, using positive behavior supports, transporting the youth to needed treatment, and incorporating treatment plan components in the home.

Level 1 Caregiver Expectations

At a level one, a caregiver engages in additional case services provided through EFC, as well as additional clinical services provided to the youth at least weekly unless another frequency is recommended by the EFC Clinical Case Manager. A child assessed at this level displays mild impairment, which may include occasional disobedience, argumentative or annoying interaction with caregiver, problems at school or in relationships, or emotional distress. Examples of a caregiver's interventions could include: seeing the EFC Clinical Case Manager and Behavioral Specialist weekly, attending Family Team Meetings at a higher frequency, exercising good control when provoked, providing consistency and predictable behavior towards the youth, and setting realistic expectations for the youth.

Individual Service Agreement

An individual service agreement (ISA) will be created in conjunction with the caregivers providing placement both when EFC services are authorized and any time the level changes. The initial ISA will be created in conjunction with the family and completed within 30 days of authorization of EFC services. The ISA is intended to be part of the continuous case assessment process and will be updated whenever changes are needed to communicate expectations with the caregiver. The ISA will be reviewed and updated with the caregivers no less than quarterly and is to be reviewed with the caregiver at reauthorization even if the level has not changed. The ISA will be shared with and signed by the

caregiver for reauthorization or change of service level. The ISA will outline the additional responsibilities that the caregivers are committing to provide to the child receiving EFC services. Services provided by caregivers will include maintaining a youth with high needs in their home, as well as these factors at each level:

- Increased supervision,
- Behavior management,
- Involvement in school
- Participation in training that specifically pertains to the identified child(ren) placed in the home

The ISA will also address the training needs of the caregiver(s) who are providing treatment to the youth placed in the home. If the placement is with an unlicensed relative, this service agreement will incorporate a plan for licensure. If a relative waiver is approved, this will be noted in the ISA along with the corresponding alternative plan for the foster parent to receive training. The ISA will be uploaded quarterly in MiSACWIS under the documents hyperlink in the EFC placement. If the PAFC provider determines a reduced daily rate in accordance with a family's involvement in services, this decision will be documented in the ISA. Level 3 Caregiver Expectations

The 2020 Evaluation of the WMPC Enhanced Foster Care model can be found at: Policies, Procedures and Reports - West Michigan Partnership for Children (wmpc.care)

Florida: Specialized Therapeutic Foster Care Service Program

The Florida Agency for Health Care Administration (AHCA) implemented the Medicaid reimbursed Specialized Therapeutic Foster Care Services program in 2014. The program includes Therapeutic Foster Care parental and specialized group home services and is a benefit of and reimbursed by the statewide Sunshine Health Child Welfare Specialty Medicaid managed care plan.

Florida Specialized Therapeutic Foster Care

The following definitions are included in the Florida "Specialized Therapeutic Services and Limitations Handbook"[16]

Specialized Therapeutic Foster Care Services[17]: Specialized therapeutic foster care services are intensive treatment services provided to recipients under the age of 21 years with emotional disturbances who reside in a state licensed foster home. Specialized therapeutic foster care services are appropriate for long-term treatment and short-term crisis intervention.

The goal of specialized therapeutic foster care is to enable a recipient to manage and to work toward resolution of emotional, behavioral, or psychiatric problems in a highly supportive, individualized, and flexible home setting.

Specialized therapeutic foster care services incorporate clinical treatment services, which are behavioral, psychological, and psychosocial in orientation.

16 STS Proposed Rule (myflorida.com)

17 Ibid, p. 37

Services must include clinical interventions by the specialized therapeutic foster parent(s), a primary clinician, and a psychiatrist. A specialized therapeutic foster parent must be available 24 hours per day to respond to crises or to provide special therapeutic interventions.

There are two levels of specialized therapeutic foster care, which are differentiated by the supervision and training of the foster parents and intensity of programming required. Specialized therapeutic foster care levels are intended to support, promote competency, and enhance participation in normal, age appropriate activities of recipients who present moderate to serious emotional or behavior management problems. Programming and interventions are tailored to the age and diagnosis of the recipients. Specialized therapeutic foster care services are offered at Level I or Level II, with crisis intervention available at both levels. The multidisciplinary team must authorize specialized therapeutic foster care services.

Legal Authority: Specialized therapeutic services are authorized by section 409.906, Florida Statutes (F.S.), and in Rule 59G-4.295, Florida Administrative Code (F.A.C.).[18]

Multidisciplinary Team (MDT): The role of the MDT is to assess whether the recipient is appropriate for specialized therapeutic foster care (STFC). A MDT consists of a representative from the Department of Children and Families (DCF), or its designee, the local Medicaid area office, or the Department of Juvenile Justice (when applicable). Other MDT members should include the recipient, the recipient's case manager, a representative from the recipient's school, the recipient's biological or adoptive parents or relatives, the foster care parents or emergency shelter staff, assigned counselors or case managers, and the recipient's medical health care provider.[19][20]

Specialized Therapeutic Foster Parent Pre-Service Training:[21] Specialized therapeutic foster parent pre-service training must be approved by the DCF or their designee, or by a managed care plan for their network providers. The specialized therapeutic foster parent pre-service training must address at least the following areas:

- Program orientation, including the responsibilities of the treatment parent and provider agency

18 Ibid, p. 8

19 Ibid, p. 10

20 Note: Wrap Around Services are provided by the Sunshine Health Specialty Child Welfare Health Plan (https://www.sunshinehealth.com/members/child-welfare-plan/benefits-services.html) as:

Community-Based Wrap-Around Services *	Individualized care planning and care management service to support children with complex needs who are at risk of placement in a mental health treatment facility.	Children and youth up to age 21. One per day with no limits per calendar year.

21 Ibid, p. 11

- Normal childhood development
- Emotional disturbances in children and common behavioral problems exhibited • Behavior management, theory and skills
- Discipline, limit-setting, logical consequences, problem-solving, and relationship building skills • Communication skills
- Permanency planning
- Stress management
- Crisis intervention and emergency procedures
- Self-defense and passive physical restraint
- Working with biological or adoptive families
- Placement adjustment skills
- Confidentiality
- Cultural competency
- Behaviors and emotional issues of children who have been sexually abused.

Treatment Plan:[22] The treatment plan is an individualized, structured, and goal-oriented schedule of services with measurable objectives that promotes the maximum reduction of the recipient's disability and restoration to the best possible functional level. Individualized recipient treatment plans must directly address the primary diagnosis(es) that is(are) consistent with the assessment.

The provider must document efforts to coordinate services for behavioral health diagnoses outside their expertise that, if treated, would assist meeting the recipient's goals.

Specialized therapeutic foster care and therapeutic group care services must be prescribed on a treatment plan authorized by one of the group provider's treating practitioners. The treatment plan must be jointly developed by the recipient and the treatment team. The treatment plan must be recipient-centered and consistent with the recipient's identified strengths, abilities, needs, and preferences. The recipient's parent or guardian should be included in the development of the recipient's individualized treatment plan, if the recipient is under the age of 18 years. Treatment planning for a recipient under the age of 18 years that does not include the recipient's parent, guardian, or legal custodian in a situation of exception requires a documented explanation. The treatment plan must contain all of the following:

- Recipient's diagnosis code(s) consistent with assessment(s).
- Goals that are individualized, strength-based, and appropriate to the recipient's diagnosis, age, culture, strengths, abilities, preferences, and needs, as expressed by the recipient.
- Measurable objectives with target completion dates that are identified for each goal.
- List of the services to be provided (treatment plan development, treatment plan review, and evaluation or assessment services provided to establish a diagnosis and to gather information for the development of the treatment plan need not be listed).

22 Ibid, pp. 12-13

- Amount, frequency, and duration of each service for the six-month duration of the treatment plan (e.g., four units of therapeutic behavioral on-site services two days per week for six months). It is not permissible to use the terms "as needed," "p.r.n.," or to state that the recipient will receive a service "x to y times per week."
- Dated signature of the recipient.
- Dated signature of the recipient's parent, guardian, or legal custodian (if the recipient is under the age of 18 years).
- Signatures of the treatment team members who participated in development of the plan.
- A signed and dated statement by the treating practitioner that services are medically necessary and appropriate to the recipient's diagnosis and needs.
- Discharge criteria

Treating Practitioner:[23] Treating practitioners include:

- Physician
- Psychiatrist
- Psychiatric ARNP
- PPA
- LPHA
- Master's level CAP (for the authorization of substance use treatment only)

Comprehensive Behavioral Assessment: Ages 6 – 20:[24] Components for Recipients Ages 6 Years through 20 Years A comprehensive behavioral health assessment for recipients ages 6 years through 20 years, must include, at a minimum, the information listed below related to the recipient and the recipient's family. The use of a checklist or fill in the blank format in lieu of a narrative is prohibited.

- General identifying information (name, birth date, Medicaid identification number, sex, address, siblings, school, referral source, and diagnosis).
- Reason for referral.
- Personal and family history.
- Placement history, including adjustment and level of understanding about out-of-home placement.
- Sources of information (e.g., counselor, hospital, law enforcement).
- Interviews and interventions.
- Cognitive functioning (attention, memory, information, and attitudes), perceptual disturbances, thought content, speech and affect, and an estimation of the ability and willingness to participate in treatment.
- Previous and current medications, including psychotropic.
- Last physical examination and any known medical problems, including any early medical information which may affect the recipient's mental health status, such as prenatal exposure, accidents, injuries, hospitalizations, etc.

23 Ibid, p. 23

24 Ibid, pp. 34-35 (Ages 6 – 20). (Note BH Assessment criteria for ages 0 – 6 are located on pp. 32 – 34)

- History of mental health treatment of the recipient and the recipient's family. History of current or past substance use of the recipient and the recipient's family.
- Legal involvement and status of the recipient and the recipient's family.
- Resources including income, entitlements, health care benefits, subsidized housing, social services, etc.
- Emotional status, including psychiatric or psychological condition.
- Educational analysis, including school-based adjustment, performance history, and current status.
- Functional analysis, including presenting strengths and problems of both the recipient and the recipient's family.
- Cultural analysis, including discovery of the family's unique values, ideas, customs and skills that have been passed on to family members and that require consideration in working and planning with the family. This component includes assessment of the family's own operational style, including habits, characteristics, preferences, roles, and methods of communicating with each other.
- Situational analysis, including direct observation of the recipient at home, school or child care setting, work site, and community whenever the recipient routinely participates in these settings.
- Present level of functioning, including social adjustment and daily living skills.
- Reaction or pattern of reaction to any previous out-of-home placements.
- Activities catalog, including assessment of activities in which the recipient has interest or enjoys.
- Ecological analysis, including relationship of parents (guardians), parentchild relationship, sibling relationships, relationships with friends and family.
- Vocational aptitude and interest evaluation, previous employment and the acquired vocational skills, activities, and interests, if ages 14 years and older.

Assessment of the desired services and goals from the recipient and the recipient's family's viewpoint. An ICD diagnosis. If the recipient does not have a presenting ICD diagnosis, the provider must use the examination and observation diagnosis code.

For recipients ages 6 years through 20 years, completion of a standardized assessment tool, such as the Child & Adolescent Needs & Strengths An Information Integration Tool for Children and Adolescents with Mental Health Challenges CANS-MH Manual[25] (CANS-MH) or the Child and Adolescent Needs and Strengths-(CANS) Comprehensive Multisystem Assessment Manual (CANS-Comprehensive). The assessment includes the following:

- Problem presentation and symptoms
- Risk behavior
- Functioning
- Family and caregiver needs and strengths
- Recipient's strengths
- Summary of findings and recommendations.

25 A Comprehensive BH Assessment Provider must be trained in CANS by a certified CANS trainer; Ibid, p.20

Florida Specialized Therapeutic Foster Care 2021 Fee Schedule[26]

- Comprehensive Behavioral Health Assessment H0031 HA: $12.12 per quarter hour. The comprehensive behavioral health assessment may be reimbursed only once per state fiscal year (July 1 through June 30) per recipient. Reimbursement is limited to a total of 20 hours per recipient per fiscal year. The assessment is reimbursed on the date that the report is completed. The date of referral may be used as the date of service if the recipient entered the Statewide Inpatient Psychiatric Program or if the recipient loses Medicaid eligibility prior to completion of the assessment.
- Specialized Therapeutic Foster Care, Level I S5145: $87.30 per day. Medicaid will not reimburse a provider for days when a recipient is in a Juvenile Justice detention center. The community behavioral health services psychosocial rehabilitation and clubhouse will not be reimbursed as a separate service by Medicaid for recipients receiving specialized therapeutic foster care services.
- Specialized Therapeutic Foster Care, Level II S5145 HE: $135.80 per day.
- Specialized Therapeutic Foster Care, Crisis Intervention S5145 HK: $135.80 per day
- Therapeutic Group Care Services H0019: $180.00 per day Medicaid will not reimburse for therapeutic group care services when a recipient is in a Department of Juvenile Justice detention center placement. A provider may not be reimbursed for therapeutic group home services or any other community behavioral health service if the provider has been paid for the provision of the same service or type of service by another purchasing entity.

Florida Sunshine Specialty Child Welfare Medicaid Managed Care Plan

The Florida Sunshine Specialty Child Welfare Medicaid Managed Care Plan was designed by the Agency of Health Care Administration to work in unison with the Community Based Lead Agencies inclusive of the following populations[27]:

Specialty Population Eligibility Criteria

a. The specialty population eligible to enroll in this Specialty Plan shall consist of only those mandatory and voluntary recipients specified in Attachment II and its Exhibits, and who meet the following criteria:
   1) Is a child, under the age of twenty-one (21) years;
   2) Has a child welfare case or post adoption case open for services as identified in the FSFN database; and
   3) Has an FSFN eligibility indicator in FMMIS.

b. The Agency reserves the right to make adjustments to the eligibility requirements and criteria used to identify recipients eligible to enroll in a Specialty Plan. The Agency may, at its sole

26 Specialized_Therapeutic_Services_2021_Fee_Schedule.pdf (myflorida.com)

27 Exhibit_II_C_CW_2020-10-01.pdf (myflorida.com), p. 1

discretion, expand the eligibility criteria to include young adults who choose to remain in extended foster care up to the age of twenty-six (26) years.

Georgia: Development of Therapeutic Foster Care, Multi-Agency Alliance for Children (MAAC) PACT Program

The Stephen group was able to interview key leaders of the Georgia Division of Family & Child Services[28]while they are in the process of developing a Therapeutic Foster Care level of care. DFCS has an effective relationship with the Georgia Medicaid agency and there are weekly meetings during the development of the TFC model. The Georgia Families 360 Medicaid Managed Care Health Plan provides comprehensive health services for all children in Foster Care, receiving Adoption Assistance and select youth in the Juvenile Justice system.

Georgia DCFS Therapeutic Foster Care Development:

Georgia DCFS is in the process of developing a clinical model of a Therapeutic Foster Care level of service that provides more structure than currently available before preparing a child/youth to return home. Currently DCFS has a High Needs Kinds model in place that is based on "room, board, and watchful oversight" – group homes. GA CPAs currently use a 14 element Behavioral Health rating system. Therapeutic Foster Care level of care is being developed for children/youth stepping down from PRTFs who need a more clinical setting before returning home.
Level of care criteria is being developed based on Medicaid eligibility, medical necessity, and an initial Behavioral Health assessment and diagnosis on DSM V. DCFS is designing TFC for children 18 and under; are not Court ordered; youth between 18 and 21 who consent to continue in TFC if needed, and are an active Medicaid enrollee. At this time they are conceptualizing a contracted Behavioral Health organization (structured outside the MCO if possible) to perform the BH assessment, determine medical necessity, and provide BH services. A decision has yet to be made on the actual BH assessment instrument to be used for the initial BH TFS admission process; they are considering allowing the CANS, CAFAS, or other evidenced based BH assessment instrument. Once the child/youth has been admitted to the Therapeutic Foster Care LOC they are planning on the MCO using the CANs for an integrated assessment process into the future of the case.

The Georgia TFC model development considers THC caregivers as part of the Treatment Team as responsible to assure the objectives of the Individual Plan of Care are met:

- Integral partners
- Part of the clinical treatment team
- Keeping appointments
- Ensure the treatment plan is carried out
- Manage behaviors

28 Tom Rawlins, Colleen Mousinho, Shaun Johnson

- Supporting and tracking clinical progress/regression
- Maintaining placement stability
- Critical role: ensuring connection with birth/family/relatives that support efforts to permanency

DFCS uses 5 evidence based educational/training models and permits CPAs to choose one. There are 20 additional training hours for Level 1 and 2 of Therapeutic Foster Care they are still working on: 5 hours will be specifically based on diagnostic related needs, such as Autism or Medical Fragility, and the needs for stability based on how the child/youth clinically presents.

DCFS has intentionally excluded the Georgia Families 360 Managed Care entity out of the development of TFC. At this point in time DCFS prefers a carve out approach for TFC based on concerns about managed care Behavioral Health services. The GA TFC model under development intends to have Georgia Medicaid engage a contractor to pay CPAs a per diem for BH services; DCFS will pay the state match to Medicaid agency; Title IV E will continue to pay for room, board, and watchful oversight.

Georgia Families 360 pays for core medical services, pharmacy, high fidelity wrap around, and crisis stabilization. The DCFS TFC model is designed to move prior authorization and BH inpatient out of the MCO prior authorization process – the MCO is "pretty good with medical but we are not satisfied on BH services". The operational objective is to break out prior authorization as a carve out from the MCO. DCFS is still discussing the type of organization to do TFC related prior authorization – this provider would not be at risk – thinking of an ASO type organization working for DCFS. DCFS is looking outside of the current managed care model to achieve an objective medical necessity determination. There is concern with the carve out model regarding the IMD issue – there could be a need for a CMS IMD waiver given the Georgia Families 360 benefits platform and current CMS waiver status.

DCFS has been working on the development of the Therapeutic Foster Care LOC for less than a year to date. DCFS believe it has been a good thing to meet with Medicaid weekly for two hours (still on-going). "We have to take the time to think this through": BH services/carve out; clinical concerns; fiscal concerns, needs for foster homes. The DCFS goal is to "Bring therapy back to foster care!"

Georgia DCFS was able to generate support for the development of the Therapeutic Foster Care LOC by first we figuring out what was needed and then obtaining the Governor's and LT. Governor's support plus the Senate Budget office which was tired of paying pure state dollars.

Georgia Multi-Agency Alliance for Children PACT Program for High Needs Children/Youth

The Multi-Agency Alliance for Children (MAAC) is a collaborative effort focused on helping youth who have experienced foster care in the state of Georgia overcome their unique challenges and find success. We refuse to let these young people fall through the cracks. MAAC is dedicated to filling service gaps and building innovative solutions within the child welfare system by collaborating with partner agencies and focusing on providing care coordination and other services that emphasize youth voice and choice at the forefront of everything we do.

MAAC focuses on serving youth in foster care with high-end behavioral health needs, serving over 1,000 youth each month between ten core programs addressing needs such as placement, self-sufficiency, crisis recovery, and more.

MAAC's residential services network brings together ten highly qualified and accredited agencies (as well as numerous affiliate partners) from across the state of Georgia in order to secure the best possible outcomes for youth in care through dedicated placement planning. The MAAC team utilizes strengths-based planning to coordinate a unique, individualized approach for every MAAC youth, while maintaining youth voice and choice as the center of the work, placing them in the partner agency or affiliate best suited to meet their needs and personal goals. Each MAAC youth within the placement network is supported by a staff member dedicated to their unique situation, who will follow their case no matter where their placement moves take them.

MAAC's PACT Program was created based on the successful outcomes of a recent Pilot Project that included several program entities within MAAC. The purpose of the Pilot was to create a successful blend of services and supports for children in child welfare through an integrated approach, with the goal of helping youth reach stability in a community setting. MAAC literally makes a pact with youth and families to do the best work we can. The program is designed to work with youth to improve their success and sustainability in a community environment. Their ultimate goal is to ensure that each youth has a voice in their plan, has strong and consistent advocacy, is closer to accomplishing their goals and is stable and safe in a community setting.

The PACT Program explores ways to infuse key ingredients which aid youth and family success by primarily focusing on the following:

- Improving relationships between youth, families, community providers and DFCS staff partners
- Decreasing stays in higher level placements
- Effectively moving youth to permanent living arrangements
- Increasing sustainable connections

Eligibility

Youth may be eligible for PACT if they have been adopted or are in DFCS custody, have Amerigroup 360 insurance, an IQ of 70 or above, have placement at the time of referral, AND meet at least one of the following criteria::

- In DFCS custody, and at risk of having a placement disruption and/or has experienced multiple placements within the past twelve months
- In Psychiatric Residential Treatment Facility (PRTF) Assessment Beds and DO NOT meet Medical Necessity for continued PRTF Stay
- About to step down from a PRTF, and in need of placement and/or additional resources to support placement stability
- In Crisis Stabilization Units (CSUs) who do not qualify for a PRTF and can be safely served in the community in their identified placement
- In a Maximum Watchful Oversight Program/Child Caring Institution (MWO/CCI) for longer than 12 months, or youth who are about to step down from a MWO/CCI who are in need of placement and/or additional resources to support placement stability

- Youth who are receiving Adoption Assistance and need additional resources to maintain permanence.

TSG interview discussion with Heather Rowles – MAAC Executive Director and Sandy Corbin – PACT Program Director:

Program Background

- The MAAC program started 25 years ago with kids in Foster Care with high needs.
- Our foundation is an individualized-centric model:
- PACT model concept: "We figure out the needs of the child and piece together programs around the needs".
- PACT is funded by a capitated per diem rate from AmeriGroup: the Georgia 360 Foster Care managed care program. Each case is a negotiated per diem rate.
- In 2008 this approach started under a 1915 (c) Waiver program called Community Based Alternatives for Youth CBAY
- MAAC/PACT staff trained in High Fidelity Wrap – University of Maryland model
- MAAC added "youth voice and choice " to the case management model
- Fiscally responsibility to DCFS
- Because of MCO cap rate payment the PACT program has flexibility in our use of funds
- We developed our own practice model that is supported by DCFS and AmeriGroup/MCO
- The original PACT Pilot started with 24 random kids and two coordinators that followed the kids closely for a year; we used mostly wrap around services customized for the youth to meet their needs of permanency and normalcy and train and support the foster parents
- We incorporated Trauma Informed principles and programs, Wrap, and Youth Thrive into the model on an individualized case basis
- When AmeriGroup became the Foster Care Carve out MCO program we discussed a service package for highest needs children/youth and worked out a process where PACT could use flex funding through a case rate and covered administrative costs. As a result we are able to coordinate more effectively what is needed for each child/youth at the highest need level.
- Most of the Behavioral Health services are paid for by the Amerigroup MCO separate from the PACT per diem case rate.
- We have found that the core needed Behavioral Health services at the highest level of need are not customized enough and providers are not skilled enough at varying the delivery of BH services that meet the needs of these children in consideration of the treatment needs of these kids. For example, some of our kids would like and do so well with equine therapy, music therapy and dance therapy but difficult to arrange and be reimbursed.

- The program is able to bill into the contract needed social determinants of health to some extent.
- PACT is a mission driven care coordination entity
- The flexibility of our ability to spend based on the per diem case rate is the most important program element that we believe impacts the positive outcomes.
    - We have had over 150 of the highest BH kids in the state over the last year and only 9 out of 150 have ended up in the PRTFs
    - Our FC rates are different – they range between $40 to $50 a day for foster parents
    - We are receiving a case rate from AmeriGroup/MCO that is much less than the $140 per day we get for residential treatment facility
    - PACT averages less than 2 placements per year for our youth
- We work hard at placement stability and adoption and reunification are priorities.
- We emphasize good accountability in the system – hold the providers accountable.
- PACT does not provide any services – we coordinate the services
- "we are a needs based model rather than a service system model
- PACT Program Staff: five care coordinators per supervisor; one coordinator for no more than 10 kids

Services
Enhanced Foster Care

10.1 Overview of Enhanced Foster Care

It is WMPC's philosophy that it is in a child's best interest to have their needs met in a family-like setting whenever possible. Enhanced Foster Care (EFC) is a family-based service that provides individualized treatment for children in general foster care who present with intensive behavioral or emotional needs. EFC incorporates training and support for families to implement important aspects of treatment in the context of family and community life. EFC services assist families in creating a living environment designed to minimize the occurrence of behaviors and implement coaching of alternative skills. Intensive case management services and concentrated clinical support are provided, in addition to the general foster care staff assigned to the case. These services are intended to be child-specific so that they can be focused on effectively addressing the identified emotional and behavioral concerns for that child.

Each PAFC will be assigned a total number of allowable EFC cases, determined by the overall number of children in care that are assigned to the PAFC.

Any case cap exceptions must be approved by the WMPC Director of Care Coordination and Innovation.

10.2 Type of Youth Served

EFC is a specialized service targeted at a sub-set of children in foster care who are at risk of placement instability or placement in an institutional setting. EFC will be considered when possible to stabilize current foster youth, divert youth from being placed out of the community, and to deliberately return youth from institutional care back into the community.

10.3 Determination of Eligibility

Private agencies will identify children for the EFC program utilizing a multidisciplinary approach. This means that there may be multiple routes to an EFC referral. The referral process should not be a barrier to a child receiving appropriate supports. If a child is a risk for placement instability and/or the need for EFC services is imminent, WMPC may authorize a 30-day provisional approval to ensure that the child's needs are met and to promote placement stability in a family-like setting.

Youth Entering Care

Youth entering care will be assessed through the Clinical Pathways trauma screening tool to identify the level of need they are currently presenting. To ensure that treatment is provided to children right when they need it, the screening tool will be conducted promptly upon a child's entrance to care. Children presenting with an elevated level of need will be recommended for a mental health assessment by the WMPC Liaison and will be considered for EFC services as well as assessed for a SED Waiver. For children who have a demonstrated intensive level of need at removal, WMPC may grant a 30-day provisional EFC service approval for youth at time of removal, while the further assessment is conducted. During the 30-day period, the worker will ensure that a CAFAS is completed and submitted to confirm the child's current level of need.

Youth in Care

Additionally, EFC services will be considered any time a child:

- Is discharging from residential care
- Is at risk of placement break due to behavioral or emotional issues AND exhibits some or all the following:
    - A history of two or more placement breaks due to behavioral/emotional issues
    - CANS score in Mental Health and Well-Being -3 or lower
    - CAFAS score of 80 or more on the Child/Adolescent Section

10.4 Referral Process:

When a caseworker identifies that EFC services may be appropriate for a child, they will complete the EFC referral form in PSAM. A current CAFAS and CANS that has been completed within the last three months will be submitted with the referral along with any additional relevant documentation of the child's needs. Documentation may include but is not limited to; IEPs, trauma screens, psychological assessments, mental health records, safety plans, residential reports, or medical records. If the request for EFC service authorization is made at the time of removal and there is no CAFAS or CANS completed, the worker will indicate that the request is for a 30-day provisional approval. The Care Coordination team will work in collaboration with private agency staff to assess if EFC services are appropriate for the child. If a provisional approval is authorized, the 30-day period will be utilized to further assess the child's needs as well as obtain a CAFAS and CANS score.

Referrals for children in Residential Care

EFC services are intended to incorporate the structure and support necessary to assist children stepping down from residential care. When discharge from residential care is anticipated, children will be referred to EFC more than 30 days prior. Children with authorized EFC services can receive additional support during discharge planning to help transition them into the family environment.

10.5 Discharge from Residential Care

Children demonstrate better long-term outcomes with reduced time in residential care and when frequent contact with their familial systems is maintained. A child will maintain and build relationships with their support system during their time in residential care, through any available opportunity (family therapy, visits, phone calls, etc). This includes building supportive relationships with families identified for future placement.

When a foster family is identified as a placement for a child in a residential facility, the private agency will work with the family to provide orientation about the expectations and services associated with EFC. Upon identification of a placement, the private agency will encourage the family to begin building a relationship with the child through regular visitation. EFC services can be arranged to begin with the family as soon as the child is discharged to the home. As soon as discharge is determined to be appropriate for the child, the private agency will work with residential and treatment staff, as well as foster parents, to identify and implement a supportive transition plan.

To promote a strong transition plan that includes consistent supports, both the caregiver and private agency can receive an incentive payment for their participation in facilitating residential step-down transitions in advance. An EFC referral will be made to WMPC at least 30 days prior to the planned discharge. The referral will indicate that it is for a planned discharge and will include a section outlining

the caregiver's supportive involvement plan with the child. If the family participates in the transition plan for 30 days and the child is successfully placed in the home, then upon placement the family and the PAFC can each receive $500.00 as compensation for time and resources spent facilitating a positive transition. The incentive fund given to the private agency will support case management activities within the EFC program. The PAFC provider will invoice WMPC for both payments upon placement.

Treatment Planning

The focus of EFC is a strengths-based, trauma-informed, and goal-oriented approach to treatment, rather than simply symptom reduction. Regular use of assessment methods will be utilized by the entire treatment team to identify a diagnosis, determine needs and therapeutic interventions, and measure progress. Treatment team members may include but are not limited to: foster parents, biological parents, an EFC clinical case manager, behavioral aides, other case staff, teachers, medical professionals, therapists, psychologists, psychiatrists, and supervisors.

Initial Assessment

The Child and Adolescent Functional Assessment Scale (CAFAS) will be used to determine the level of care for children in EFC. If a CAFAS was not completed before the initial authorization of EFC services, one must be completed and submitted to the assigned Care Coordinator within 30 days of authorization of EFC services.

30 Day Provisional Assessment

In the case of a 30-day provisional authorization, the 30-day assessment period will be utilized to confirm or to re-determine the level of service and in-home behavioral support necessary for the child. During that time, EFC staff will complete an ISA, quarterly report, and a CAFAS or PECFAS score for the child. These documents will be uploaded in MiSACWIS under the EFC Placement in the document section and used to confirm or redetermine level of service prior to the end of the 30 day authorization.

Ongoing Assessment and Reauthorization

The clinical case manager will continuously evaluate the efficacy of interventions to assess if the child's needs are being fully met. The CAFAS score and supporting documentation will be submitted to WMPC on a quarterly basis (or more if needed) to monitor progress and the on-going need for services.

The Clinical Case Manager will email the Care Coordinator reauthorization requests at least 5 business days prior to the 90-day reauthorization date. The Care Coordinator will process the reauthorization request within three business days. Reauthorization requests will address the continuing need for service through the case progress report and include the latest case progress report as well as any other relevant supporting documentation. Upon approval of the reauthorization, the caseworker will upload the documentation to MiSACWIS under the EFC Placement in the document section. The timetable for quarterly review will be begin upon the child's approval for EFC services.

Case Progress Report

The case progress report will be completed prior to reauthorization of EFC services or for a request of level change. If the report is completed more than 14 business days prior to the reauthorization request, the caseworker must attach a memo documenting their current recommendations and the child's current level of need.

Level Change

The EFC team can request a change of service level at any time. A request for a change of level is treated as a reauthorization request and includes an updated case progress report, ISA, CAFAS score, and any

supporting documentation. If it is too early to update the official CAFAS score for the child, the caseworker will indicate that it is too early and provide a projected CAFAS score.

Temporary Bed Breaks

If a child in EFC temporarily breaks placement, the process for temporary bed holds will be utilized. Bed hold paperwork for over 6 days will be emailed to the care coordinator. Approved bed hold paperwork will be uploaded in the document section under the EFC placement.

WMPC can approve extended bed holds in special circumstances. The clinical case manager will consult with their care coordinator in these scenarios.

10.6 Levels of Care

Each private agency will construct service provision standards that are flexible in meeting the needs of individual children. The levels reflect high, medium, and low treatment needs that are above and beyond traditional foster care services. The private agency will provide outlines of the services that they provided at each level to WMPC for approval. All available information pertaining to the child's needs at time of intake or authorization will be utilized to determine the appropriate level of care. The level of care will be reassessed every time the CAFAS score is completed or if the child has a significant change in their needs.

Level 3

Level three is appropriate for children with high treatment needs who require intensive services to be maintained in a community setting. These children have psychiatric or behavioral issues, including frequent acting out behaviors and/or history of multiple hospitalizations. These children may require continuous behavioral intervention or 24-hour supervision. They are unable to attend school without added services and a structured environment.

Scores that indicate a level three include:

- CANS score -5 in Mental Health and Well-Being
- CAFAS score 120 or more on the Child/Adolescent Section

Level 2

Level two is appropriate for children with moderate treatment needs, whom have significantly disrupted functioning in school or placement, aggressive behaviors or who require frequent behavioral intervention. These children may also need an increased level of supervision.

Scores that indicate a level two include:

- CANS score -3 or -2 in Mental Health and Well-Being
- CAFAS score 80 or more on the Child/Adolescent Section

Level 1

Children at a level one are generally stable and able to function well at home and school. Level one is ideally used for youth that show tremendous progress and stability to step them down from EFC services.

Scores that indicate a level one include:

- CANS score 0 or higher in Mental Health and Well-Being

- CAFAS score less than 80 on the Child/Adolescent Section

10.7 Caregiver Partnership

The partnership of caregivers involved in the treatment of EFC youth is essential to providing care in the community. Appropriate placements that can meet a child's level of needs must be emphasized for children who present with intensive therapeutic needs. Treatment will be provided by caregivers who can provide the needed attention, nurturance, supervision and support to the child. As always, caregivers need to encourage the child's religious preference and strive to meet the cultural needs of the child and his/her family. A trauma-informed approach is required for any caregiver participating in EFC services. Effective caregivers who are maintaining stability in their home will also have access to EFC when the child placed in their home meets the required eligibility requirements. Early and frequent utilization of the service is intended to prevent burnout and increase the longevity of highly effective homes.

Training Expectations

The private agency will provide the training and support necessary to the caregivers to produce an environment conducive to the care and treatment of the individual child placed in the home. Families should be prepared for the challenges of providing EFC services though trauma informed parenting trainings.

All families that have completed the Pressley Ridge Treatment Parenting Model are considered qualified caregivers to provide EFC services. However, EFC services will be authorized based on eligibility criteria regarding a child and provided even when the associated caregivers have not completed this training module. These incidences will be documented as exceptions in the file and be approved on an individual basis by the PAFC Director.

On-going trainings that include trauma informed parenting techniques will be provided to all caregivers as needed and additional training may be required of the family in order to meet a child's specific needs. The private agency will document the plan for meeting training recommendations in the service agreement completed with the family.

Documentation of the families providing EFC services and their training credentials as well as the PAFC's program statement indicating training requisites for EFC caregivers will be periodically reviewed by WMPC.

Per Diem

Children are eligible for EFC whether they are placed in a relative home or with an unrelated caregiver. If the caregiver is unwilling to participate in the service agreement, the child is still eligible for EFC services, however the caregiver is not eligible to receive the EFC per diem.

The following rates will be provided as a per diem to foster parents in relation to the level of care for the youth placed in their home. This is intended to enable them to dedicate the needed time to the youth, including attendance at required services and providing additional supervision.

EFC Level 1	EFC Level 2	EFC Level 3
$75.00	$88.00	$100.00

If a caregiver is not willing to facilitate the additional needs for the child within the treatment plan, the private agency can designate that their daily rate be reduced to an alternative rate structure determined by the private agency (including a lower EFC rate, DOC, or general foster care rate) and maintain placement, as well as EFC services. This decision must be signed off on by an EFC supervisor and the family will be notified of the decision in writing. When a PAFC determines a reduced rate or to not provide the per diem to a family with placement of a child receiving EFC services, this decision will be documented on the ISA.

Payments

Additional discretionary funds can be requested on a case by case basis to provide for auxiliary needs for a child (example: assisted care, weighted blanket, higher per diem). The provision of these funds will be determined per request by the WMPC Care Coordination Team.

Per diem payments will be paid directly to the foster parent by the private agency and will be reimbursed by WMPC through the roster verification currently used for general foster care placements. The private agencies will be reimbursed the week following the roster being verified by the private agency.

The private agency will pay the incentive payment directly to the foster parent. PAFC will email an invoice to accounting@wmpc.care for reimbursement for the foster parent incentive payment as well as the separate incentive payment due to the PAFC.

Individual Service Agreement

An individual service agreement (ISA) will be created in conjunction with the caregivers providing placement both when EFC services are authorized and any time the level changes. The initial ISA will be created in conjunction with the family and completed within 30 days of authorization of EFC services. The ISA is intended to be part of the continuous case assessment process and will be updated whenever changes are needed to communicate expectations with the caregiver. The ISA will be reviewed and updated with the caregivers no less than quarterly and is to be reviewed with the caregiver at reauthorization even if the level has not changed. The ISA will be shared with and signed by the caregiver for reauthorization or change of service level.

The ISA will outline the additional responsibilities that the caregivers are committing to provide to the child receiving EFC services. Services provided by caregivers will include maintaining a youth with high needs in their home, as well as these factors at each level:

- Increased supervision,
- Behavior management,
- Involvement in school
- Participation in training that specifically pertains to the identified child(ren) placed in the home

The ISA will also address the training needs of the caregiver(s) who are providing treatment to the youth placed in the home. If the placement is with an unlicensed relative, this service agreement will incorporate a plan for licensure. If a relative waiver is approved, this will be noted in the ISA along with the corresponding alternative plan for the foster parent to receive training. The ISA will be uploaded quarterly in MiSACWIS under the documents hyperlink in the EFC placement. If the PAFC provider

determines a reduced daily rate in accordance with a family's involvement in services, this decision will be documented in the ISA.

Level 3 Caregiver Expectations

At a level three, the caregiver engages in additional case services provided through EFC, as well as additional clinical services provided to the youth several times per week, unless another frequency is recommended by the EFC Clinical Case Manager.

A child assessed at this level displays severe impairment, which may include causing property damage in the school or home, destructive or aggressive behavior towards self or others, intense mood irregularity, and/or distorted thinking. Examples of a caregiver's interventions could include: seeing the EFC Clinical Case Manager and Behavioral Specialist multiple times per week, engagement in wraparound services and therapy with youth, using de-escalation techniques, responding to emergencies at school, and implementing crisis safety plan when needed.

Level 2 Caregiver Expectations

At a level two, the caregiver engages in additional case services provided through EFC, as well as additional clinical services provided to the youth more than weekly unless another frequency is recommended by the EFC Clinical Case Manager.

A child assessed at this level displays moderate impairment, which may include persistent non-compliant or irresponsible behaviors, sexually inappropriate or delinquent behavior, angry outbursts, or frequent mood disruption. Examples of a caregiver's interventions could include: seeing the EFC Clinical Case Manager and Behavioral Specialist each weekly, using positive behavior supports, transporting the youth to needed treatment, and incorporating treatment plan components in the home.

Level 1 Caregiver Expectations

At a level one, a caregiver engages in additional case services provided through EFC, as well as additional clinical services provided to the youth at least weekly unless another frequency is recommended by the EFC Clinical Case Manager.

A child assessed at this level displays mild impairment, which may include occasional disobedience, argumentative or annoying interaction with caregiver, problems at school or in relationships, or emotional distress. Examples of a caregiver's interventions could include: seeing the EFC Clinical Case Manager and Behavioral Specialist weekly, attending Family Team Meetings at a higher frequency, exercising good control when provoked, providing consistency and predictable behavior towards the youth, and setting realistic expectations for the youth.

Services Post-Reunification

Biological families are an essential part of a child's treatment and support team. The Clinical Case Manager will involve biological families whenever possible in treatment and behavioral plans for their children. If appropriate, the Clinical Case Manager will build in treatment planning and support activities with the biological family in addition to the service agreement with the placement family.

While the biological family members on the petition are not eligible to receive the per diem, EFC services are intended to follow the child and can be authorized post-reunification. This is intended to assist the biological family with the training and support necessary to meet the needs of the child as they transition into their home. The EFC Staff will include recommendations for the timing of EFC

services considering the case discharge plan. Services post-reunification will focus on equipping the parent to address the identified emotional and behavioral needs of the child and building a sustainable support network in the community for the family.

10.8 Administrative Review Process

If the PAFC provider or caregiver disagrees with the approved EFC level or Per Diem Rate, or if the family is not notified of decisions in a timely manner, an administrative review process may be initiated within 30 calendar days of the decision. The caregiver will be notified of their right to an appeal upon initial authorization of EFC services.

The agency will initiate the request for the administrative review on behalf of the caregiver. It is the foster parents or relative caregiver's right to the administrative review. The request must be submitted even if the PAFC provider agrees with WMPC's decision. Administrative review decisions by WMPC regarding EFC levels or Per Diem are final and will be completed within 14 days of the review request. Once a WMPC decision is received, the PAFC must implement any change in service or payment, as determined by WMPC. If an administrative review is requested, payment will not be reduced until the administrative review is complete.

10.9 EFC Staff

Successful EFC services will provide comprehensive supports to the caregivers and children involved, necessitating a committed team of professionals, including EFC Clinical Case Managers, EFC Supervisor, and Behavioral Specialists. The EFC treatment team will work in partnership with service providers and caregivers to develop and implement treatment planning and delivery specific to a child's behavior and mental health needs.

EFC staff are expected to demonstrate case stability, positive case outcomes, and strong crisis management skills. Staff should have strong skills in facilitating strengths-based and trauma-informed treatment and the ability to partner constructively with a diverse interdisciplinary team.

EFC Clinical Case Managers

Each child in EFC will be assigned an EFC Clinical Case Manager in addition to their foster care case manager. The Clinical Case Manager will focus on the child's clinical and stability needs, as well as preparing the biological family to care for their child's level of needs. A focus on preparing biological families will be emphasized in EFC to reduce the length of time youth spend in care. In addition to developing the Individual Service Agreement with families, EFC Clinical Case Managers will provide quarterly case progress reports concerning the child's progress. Case Progress Reports can be completed on the same time schedule as the case's ISP or USPs, but must be updated to reflect current information about the child for reauthorization of EFC services. Case reports written more than 14 business days prior to reauthorization date must have an addendum attached to reflect the child's current needs. The most recent case progress reports and any addendums will be submitted for quarterly reviews of the EFC level through PSAM.

An EFC Clinical Case Manager's caseload will be no more than 8 EFC cases. When calculating a blended caseload, EFC cases are considered weighted 2:1.

Foster Care Case Manager Responsibilities

Instability can have substantial effects on the timeliness of reaching permanency; however, progress towards a child's permanency goal is essential to providing for the needs of children and families. The additional provision of EFC staff tied to complex cases will allow for increased availability for general foster care staff assigned to focus on case progression. As biological families become better equipped to care for the child's level of need, they will be supported in their progression towards permanency. The case manager will continue to document all progress by the child receiving EFC services in the ISP and USP reports.

10.10 PAFC Service Role

Managing services provided to youth that meet EFC eligibility criteria is an extensive role fulfilled by the private agency. The provision of successful services that support youth with high needs in a community setting will require a creative and flexible treatment team and interventions. A focused teaming approach will be vital to ensure non-duplicative services, as well as coordination of service goals to meet outcomes.

The role of the private agency is to provide support and coordinate the services necessary to maintain a youth in a community setting. The private agency will provide added crisis response support or coordination for a child that may be at risk of harm to self or others. The private agency will prepare the caregiver through training and coaching, to create a trauma-informed environment for the youth's treatment needs and help caregiver's plan responses to behaviors that arise.

Level 3 Services

At level three the private agency will assign an EFC Clinical Case Manager, Behavioral Specialist, and other staff as needed to deliver intensive child-specific support focused on addressing the identified emotional and behavioral concerns more than weekly, unless another frequency is recommended by the EFC Clinical Case Manager.

Level 2 Services

At level two the private agency will assign an EFC Clinical Case Manager, Behavioral Specialist, and other staff as needed to deliver intensive child-specific support focused on addressing the identified emotional and behavioral concerns at least weekly, unless another frequency is recommended by the EFC Clinical Case Manager.

Level 1 Services

At level one the private agency will assign an EFC Clinical Case Manager, Behavioral Specialist, and other staff as needed to deliver intensive child-specific support focused on addressing the identified emotional and behavioral concerns *at* least weekly, unless another frequency is recommended by the EFC Clinical Case Manager.

Additional Supports

Interdisciplinary involvement will be essential to the coordination of treatment for children receiving EFC services. High intensity services and supports will be needed to maintain the youth in a community setting. Assessment and allocation of mental health services will be determined by the Clinical Pathways process promptly upon entrance into care. The level of mental health services and supports will be considered throughout the provision of EFC services. Quarterly reviews of services will be directed by the Care Coordination team and utilized to gauge if an appropriate level of service is being provided and to facilitate collaboration across case team members.

Key Performance Indicators:

All three Texas TFFC contracts are required to maintain internal data identifying the success of the TFFC program by the reason the child/youth was discharged from the TFFC home. Below is a snapshot of data for one TFFC Child Placing Agency that serves TFFC youth both within the Texas Department of Family and Protective Services' legacy system and the Community Based Care model since inception.

Discharge Reasons	Total (All Time)	DFPS FY 2019	DFPS FY 2020	DFPS FY 2021
Adoption Placement (internal or external)	**6**	1	5	0
Returned Home with biological family	**4**	1	3	0
Placed with Relatives/Fictive Kin	**2**	2	0	0
Internal Foster Home within our CPA	**24**	3	18	3
Non-Internal Foster Home outside our CPA	**6**	1	4	1
Foster Family Transferred to another CPA - Child Remains in Home	**1**	1	0	0
TFFC home with another agency	**2**	0	2	0
Psychiatric Hospital admission	**6**	3	2	1
Residential Treatment Center Placement	**6**	1	5	0
Count of Submoves	**13**	3	8	2
Total Discharges (including Submoves)	**70**	16	47	7
Total Discharges (excluding Submoves)	**57**	13	39	5

Discharge Category	Total (All Time)	DFPS FY 2019	DFPS FY 2020	DFPS FY 2021
Successful	**73.68%**	61.54%	76.92%	80.00%
Neutral	**1.75%**	7.69%	0.00%	0.00%
Unsuccessful	**24.56%**	30.77%	23.08%	20.00%

Length of Stay (LOS)	Total (All Time)	DFPS FY 2019	DFPS FY 2020	DFPS FY 2021
Discharged Clients by Discharge Date	**167.21**	120.50	175.81	210.13
All clients by Admission Dates	**202.03**	156.97	225.36	200.38

Average LOS (thru 2019 admits): 153.74

Evidence Based Therapeutic Foster Care Training Approaches

Together Facing the Challenge

Background:

"Together Facing the Challenge" (TFTC) is a training and consultation educational program focused on improving the skills of foster parents and their agency support staff to effectively parent children/youth with high needs for mental health and emotional services and supports. The program was developed by Maureen Murray, LCSW, of the Services Effectiveness research program of the Department of Psychiatry and Behavioral Sciences at the Duke School of Medicine. The TFTC foster parent training program is listed as an Evidence Based Practice by the California Evidence-Based Clearinghouse for Child Welfare. TFTC has been implemented in over 40 agencies in North and South Carolina and more than 60 agencies in over 20 states.

The model focuses specifically on the in-home intervention elements (and creating adequate skill levels to implement these strategies effectively) and on the important role of supervision and coaching in helping foster parents work effectively. We don't ask agencies to "re-invent the wheel" — instead, the goal of *TFTC* is to work with agencies to enhance what they *already do well* by growing their knowledge & expertise with evidence-informed approaches to improve practice & outcomes for youth in care. Simultaneously, we strive to ensure that our model of care is not only approachable, but also feasible with the resources available to currently existing foster care programs.

This Train-the-Trainer model applies practical parenting and supervisory techniques that are sustainable in a variety of foster care settings. The curriculum provides in-depth instruction, coaching, and consultation to enhance agency services. This training model brings together the strengths of evidence-based treatment with the realities of practice to offer an enhanced approach to meeting the needs of youth in care.[1]

Together Facing the Challenge is based on eight core values:

- Relationships are Key
- Trauma Informed Practice
- Evidence Based Practice
- Educational Approach
- Intentional Promotion of Physical and Emotional Health
- Respect all aspects of the individual
- Transition to Adulthood
- Professional Growth

1 Together Facing the Challenge – An Evidence-Based Model for Foster Care (duke.edu)

The TFTC implementation process leading to certification is an organized educational experience that is clearly defined, time based, and hands on:

- Interested Agency contacts and inquires about the program
- Interested Agency completes & submits TFTC Readiness Survey
- TFTC Team evaluates Readiness
- TFTC conducts site visit
- Agency Program identifies TFTC Implementation Team
- Agency Program completes 3 Day Train-the-Trainer curriculum: the model provides 19 hours of training leading to Train-the Trainer certification
- Agency program receives at least 12 months of consultation from the TFTC team during the first year of implementation
- There are three stages to TFTC consultation:
    - Stage 1: Group Engagement; Training Foster Parents (Months 1-3)
    - Stage 2: Active Support; Coaching process (Months 4-9)
    - Stage 3: Transition, Preparing for Agency Certification (Months 10-12)

Essential Components[2]

The essential components of Together Facing the Challenge (TFTC) include:

- Provides comprehensive training for both agency staff and treatment foster care parents in classes of 15-30 participants
- Builds a therapeutic relationship – recognizes the significance of the therapeutic relationship by exhibiting both verbal and non-verbal behaviors that include:
- Encouragement
- Showing a genuine interest
- Identifying common ground
- Having a positive attitude
- Being patient, understanding, consistent, and following through
- Explores trauma-informed care – identifies situations in which a child's traumatic past can impact their ability to form positive relationships; coaches direct care providers on alternative strategies for parenting traumatized youth
- Develops proactive parenting strategies to reinforce prosocial positive behaviors

2 www.cebc4cw.org/program/together-facing-the-challenge/detailed

- Teaches cooperation – is able to balance use of implementing corrective discipline strategies and techniques within the context of a supportive and therapeutic environment
- Addresses thoughts, feelings, and behavior – demonstrates ability to assist child in recognizing, talking about, and dealing with difficult thoughts and feelings that emerge; helps the child to understand how their thoughts and feelings can impact their behavior
- Interrupts the conflict cycle – is able to identify conflicts that take place and demonstrates ability to avoid power struggles and intervene by de-escalating the situation
- Utilizes problem solving techniques - demonstrates ability to use a problem solving model to address a specific problem by defining it clearly, generating multiple solutions, and selecting the solution that presents as the best based on outcomes
- Promotes cultural sensitivity - explores and supports youths' different aspects of identity, including race, ethnicity, and culture; and assists parents with creating culturally sensitive home environments
- Teaches relevant life skills – demonstrates ability to transform daily living activities into learning opportunities to assist youth in the development of independent living skills
- Takes care of self – is able to recognize the impact that stress has on their life, the 'warning signs' that make them aware of it, and the specific strategies they use to manage their stress level while taking time for self on a regularly scheduled basis
- TFTC program enrollment information can be found at: Application Information & Readiness Tog

Pressley Ridge Foster Parent Training Model

Background:

Pressley Ridge was founded in Pittsburg in 1832 and was the first agency serving abandoned, neglected, and orphaned children west of the Alleghenies. Today Pressley Ridge provides a range of services and supports through 70 innovative programs to over 10,000 children and families annually in Pennsylvania, Ohio, West Virginia, Maryland, Delaware, North Carolina, and Virginia. The organization is headquartered in Pittsburg, is non-profit, and has an active Board of Directors.

Pressley Ridge provides the following services:[3]

- Foster Care and Adoption Services
- Community Based/In Home Services
- Outpatient Services
- Specialized Education
- Transition Age Services
- Autism Services

3Overview - Pressley Ridge

The organization is guided by a "Re-Education"[4] philosophy that views the child as inseparable from their family and social context. "Re-Ed" is strengths based by emphasizing the child's assets, the importance of structure, and the physical and mental health well being of the child and family.

Twelve Principles of Re-Education

- Life is to be lived now, not in the past, and lived in the future only as a present challenge.
- Trust is essential, trust between child and adult is essential, the foundation on which all other principles rest, the glue that holds teaching and learning together, the beginning point for re-education.
- Competence makes a difference; children and adolescents should be helped to be good at something, and especially at schoolwork.
- Time is an ally, working on the side of growth in a period of development when life has a tremendous forward thrust.
- Self-control can be taught and children and adolescents helped to manage their behavior without the development of psychodynamic insight; and symptoms can and should be controlled by direct address, not necessarily by an uncovering therapy.
- Intelligence can be taught, the cognitive competence of children and adolescents can be considerably enhanced; they can be taught generic skills in the management of their lives as well as strategies for coping with the complex array of demands placed on them by family, school, community, or job; in other words, intelligence can be taught.
- Feelings should be nurtured, shared spontaneously, controlled when necessary, expressed when too long repressed, and explored with trusted others.
- The group is very important to young people; it can be a major source of instruction in growing up.
- Ceremony and ritual give order, stability, and confidence to troubled children and adolescents, whose lives are often in considerable disarray.
- The body is the armature of the self, the physical self around which the psychological self is constructed.
- Communities are important for children and youth, but the uses and benefits of community must be experienced to be learned.
- Know joy each day, in growing up, a child should know some joy in each day and look forward to some joyous event for the morrow.

Trauma-Informed Care at Pressley Ridge

Pressley Ridge has committed to being a trauma informed provider organization and is engaged in organization wide training through the Neurosequential Network led by Dr. Bruce Perry (Co-Author with

4 Re-Education Philosophy - Pressley Ridge

Oprah Winfrey of the book: "What Happened to You"). Pressley Ridge's commitment to Trauma Informed Care includes:[5]

- Integrates in all aspects of the organization (policies, procedures and practices) have been considered and evaluated with a basic understanding of the role that trauma plays in the lives of children, adolescents, adults and families.
- Provides the foundation for a basic understanding of the psychological, neurological, biological, and social impact that trauma and violence has on individuals.
- Incorporates proven practices into current organizational operations to deliver services that acknowledge the role that trauma plays in the lives of most of the individuals entering our systems.
- Addresses the needs of individuals who have been traumatized and are delivered in a way to avoid inadvertent re-traumatization, to facilitate participation in treatment, decision-making in intervention and to take ownership of their recovery.
- Provides opportunities for staff at all levels to acknowledge and address any vicarious traumatization or compassion fatigue in themselves and others.

The essential components of Pressley Ridge's Treatment Foster Care (PR-TFC) Pre-Service Curriculum include[6:]

- Lessons for prospective treatment foster parents for children with emotional and behavioral issues about the following areas:
    - Roles and responsibilities of a treatment parent
    - Safety and supervision of children in foster care
    - Appropriate discipline of children
    - Normal child developmental stages
    - Effects of traumatic experiences on children's development
    - Psychiatric diagnoses of children in foster care
    - Separation and loss that children in foster care experience
    - Effective Parenting competencies: social rewards, active listening, behavior management techniques, motivation systems, skill teaching
    - Managing conflicts in parent-child relationships
    - Managing crisis situations
- Competency-based curriculum:

5 Trauma-Informed Care - Pressley Ridge
6 www.cebc4cw.org/program/together-facing-the-challenge/detailed

- Provides 12 units with accompanying objectives to achieve desirable treatment parent competencies
    - Unit 1: Introduction to Treatment Foster Care
    - Unit 2: Professional Parenting I
    - Unit 3: Professional Parenting II
    - Unit 4: Understanding Child Development I
    - Unit 5: Understanding Child Development II
    - Unit 6: Developing Healthy Relationships
    - Unit 7: Therapeutic Communication
    - Unit 8: Understanding Behavior
    - Unit 9: Changing Behavior
    - Unit 10: Skill Teaching
    - Unit 11: Conflict Resolution
    - Unit 12: Understanding & Managing Crisis
- Comprehensive curriculum package (available in English and Spanish):
    - The Trainer Resource Manual contains everything a trainer needs to deliver the preservice training:
        - All training units are fully scripted for easy reference to what a trainer needs to say or do
        - Each unit provides an overview of the core competencies

The Pressley Ridge Treatment Parent Training Curriculum and Trainer Certification Program brochure can be found at: TFC Curriculum Brochure single pages (pressleyridge.org)

Treatment Foster Care Oregon

Background:

The Treatment Foster Care Oregon (TFCO) program was developed as an alternative to institutional, residential, and group care placement for adjudicated teenagers with histories of chronic and severe criminal behavior. The two main goals of TFCO are to create opportunities for youth to successfully live in a family setting and to simultaneously help parents (or other long-term family resource) provide effective parenting. The rationale for TFCO is that adolescent adjustment can be enhanced by the extent to which parents are able to effectively supervise their teenager, follow through with consequences when necessary, and promote positive involvement in school and other normative activities.

Community foster families are recruited, trained, and closely supervised to provide TFCO-placed adolescents with treatment and intensive supervision at home, in school, and in the community; clear and consistent limits with follow-through on consequences; positive reinforcement for appropriate behavior; a relationship with a mentoring adult; separation from delinquent peers along with access to prosocial peers; and an environment that supports daily school attendance and homework completion.

TFCO utilizes a behavior modification program based on a three-level point system by which the youth are provided with structured daily feedback. As youth accumulate points, they are given more freedom from adult supervision. Youth are provided weekly meetings with an individual therapist who provides support and assists in teaching skills needed to relate successfully to adults and peers. Family therapy sessions help parents prepare for the youth's return home and help them become more effective at supervising, encouraging, supporting, and following through with consequences. Case managers closely supervise and support the youths and their foster families through daily phone calls.

Throughout the six- to nine-month placement in foster homes, there is an emphasis on teaching interpersonal skills and on participation in positive social activities including sports, hobbies, and other forms of recreation. Aftercare services remain in place for as long as the parents want, but typically last about one year.

The initial evaluation certified by Blueprints[7] involved three articles (Chamberlain, 1997; Chamberlain et al., 1996; and Eddy et al., 2004) in which 79 boys, who were mandated into out-of-home care by the juvenile court, were randomly assigned to treatment (n = 37) or control (n = 42) between 1991 and 1995. The boys were from 12 to 17 years old, had an average of thirteen previous arrests and 4.6 prior felonies, and half had committed at least one crime against a person. After one year, TFCO boys, relative to controls, were incarcerated 60% fewer days, had fewer arrests, reported less self-reported drug use, and were less likely to run away from their program. TFCO boys also experienced less tobacco and marijuana use, and other drug use at 18 months. After two years, TFCO boys had fewer violent offense referrals and self-reported violent offenses than controls.

A second Blueprints-certified study (Leve et al., 2005 and Chamberlain et al., 2007) involved girls who were mandated to community-based, out-of-home care because of problems with chronic delinquency. Girls were 13-17 years of age at baseline, and were only recruited if they had at least one criminal referral in the prior 12 months, were not currently pregnant, and were placed in out-of-home care within 12 months following referral. Girls were randomly assigned to TFCO (n=37) or group care (n=44). TFCO girls, relative to controls, experienced fewer days in locked settings, fewer criminal referrals, lower caregiver-reported delinquency, and more time on homework at 12 months post-baseline. The reductions on days spent in locked settings and criminal referrals remained at 24-months post-baseline, along with reductions in self-reported delinquency.

The third Blueprints-certified evaluation (Kerr et al., 2009) included two consecutively run randomized controlled trials involving the girls from the second study plus an additional 85 girls selected based upon the same eligibility criteria. In total, the trials included 166 girls with 81 randomized to treatment and

7 Treatment Foster Care Oregon – Blueprints for Healthy Youth Development (blueprintsprograms.org) Note: TFCO is a Certified Model Program from the Blueprints for Healthy Youth Development Institute located at the University of Colorado Boulder

85 to control. Results indicated that the odds of girls in group care (control) becoming pregnant were 2.44 times that of girls in TFCO. Reporting on the same sample, Rhoades et al. (2014) found that girls randomly assigned to TFCO when they were 13-17 years old reported significant decreases in drug use over a 2-year period in young adulthood (7-9 years after the study began), while those assigned to group care did not report significant decreases in drug use during this time.

TFCO has been adapted to meet the needs of other populations, including adolescents with severe emotional and behavioral problems referred by mental health and child welfare systems, youth with developmental disabilities who also have a history of sexual acting out, and preschoolers. Evaluations conducted with these populations have not been thoroughly tested.

TFCO is a cost-effective alternative to group or residential treatment, incarceration, and hospitalization for adolescents who have problems with chronic antisocial behavior, emotional disturbance, and delinquency. The Washington State Institute for Public Policy estimates a return of $1.85 for every dollar invested. Read the Program Fact Sheet

TFCO Program Certification

Use of the model name 'Treatment Foster Care Oregon'™ and its abbreviation, 'TFCO' ™ is restricted to programs that are certified or are receiving clinical supervision from TFC Consultants, Inc. A number of research studies have shown that maintaining program fidelity is extremely important in achieving positive outcomes for youth and families in evidence-based programs. In devising a process for ongoing fidelity monitoring, we have strived to achieve the following:

- Containment of costs to the applicant program
- Consistency and objectivity in measurement and application of adherence standards
- Precise targeting of technical assistance to areas in need of attention with respect to meeting adherence standards

To develop TFCO program certification standards, the program developers have created a program certification protocol that provides standardized measurement of all important TFCO model components and sets consistent standards that must be met for programs to be considered certified. As part of the process, detailed feedback is provided to applicant programs regarding program strengths and areas in need of improvement.

The certification application process involves a thorough evaluation of several components of your TFCO program, including coding and evaluating treatment parent and clinical staff meetings, and a fee is charged for this process. The application fee is non-refundable, regardless of whether or not certification standards are met and certification is obtained, therefore it is important to consider whether your program has a good chance to meet certification standards. To this end, please carefully review the certification criteria and the standards that must be met for certification before applying for certification.

TFC Consultants, Inc. is available to provide technical assistance to help identify areas in need of improvement prior to application for certification, or to address adherence issues as they emerge in the certification process. This certification model, in tandem with the availability of consultation and

technical assistance tailored to the specific needs of each applicant, is intended to provide a cost-effective, individualized mechanism for ongoing assurance of model fidelity and outcomes. Once a program is certified, the certification is valid for two years, and re-certifications are valid for three years. Program certification provides assurance to funders and referring agencies regarding the quality of your program and its level of model adherence.

Please contact us for application materials and information regarding the standards for certification.

TFCO Program Implementation[8]

TFC Consultants, Inc. specializes in providing complete implementation services for TFCO sites. In order to realize positive treatment outcomes similar to those attained in the evaluation studies, implementation efforts focus on promoting program fidelity. To facilitate adherence to the treatment model, TFC Consultants, Inc., works with communities to identify issues that are likely to affect their ability to successfully implement the TFCO model.

First Year Schedule of Implementation Activities

Adjustments to this schedule are occasionally made to accommodate specific circumstances.

1. TFC Consultants, Inc., visits your site. The focus of this visit is to bring all of the stakeholders to a common understanding about the model and implementation procedures. Program success depends on the participation in and commitment to the model of all relevant agencies and officials, so it is important to include all of the stakeholders at this initial step. The model is presented to administrators, program staff, any foster parents who may have already been identified for participation, and representatives from relevant outside entities, such as the local juvenile justice community, mental health community, and/or foster care certification agency. Finally, an implementation plan and timelines are developed for training program staff; recruiting, training, and certifying foster parents; and placements in the foster homes.
2. Your agency staff attends a four-day training session at the model site in Eugene, Oregon (five days for Program Supervisors). Clinical training sessions are scheduled three times a year for replacement staff and new implementation teams (training calendar).
3. TFCO-P and TFCO-C training sessions are scheduled as needed.
4. Consultation is provided regarding foster parent recruitment with your agency staff, as needed.
5. The first group of foster parents are trained at your site during a two-day training.
6. FOCUS Parent Daily Report (PDR) procedures are initiated and training is provided for staff.
7. Ongoing weekly telephone consultation is conducted with your program supervisors regarding treatment plans, progress, issues, and problems for each placement.
8. Periodic reports are prepared for your program director or administrator on implementation progress, staff performance, model adherence and other relevant issues. As part of the

8 https://www.tfcoregon.com/implementation/

quarterly review, videotapes of your site's weekly foster parent and clinical meetings are coded for adherence to TFCO principles and procedures.

9. Additional in-person training, problem solving, and consultation can be provided when needed. Up to six days of on-site consultation is provided.

In most cases, new sites can be fully operational within a year from start-up of the implementation. Adequate staffing is an important factor in starting up the TFCO model and in the program's continued success. To operate a program with approximately 10 beds (the typical start-up size), the following staff is needed:

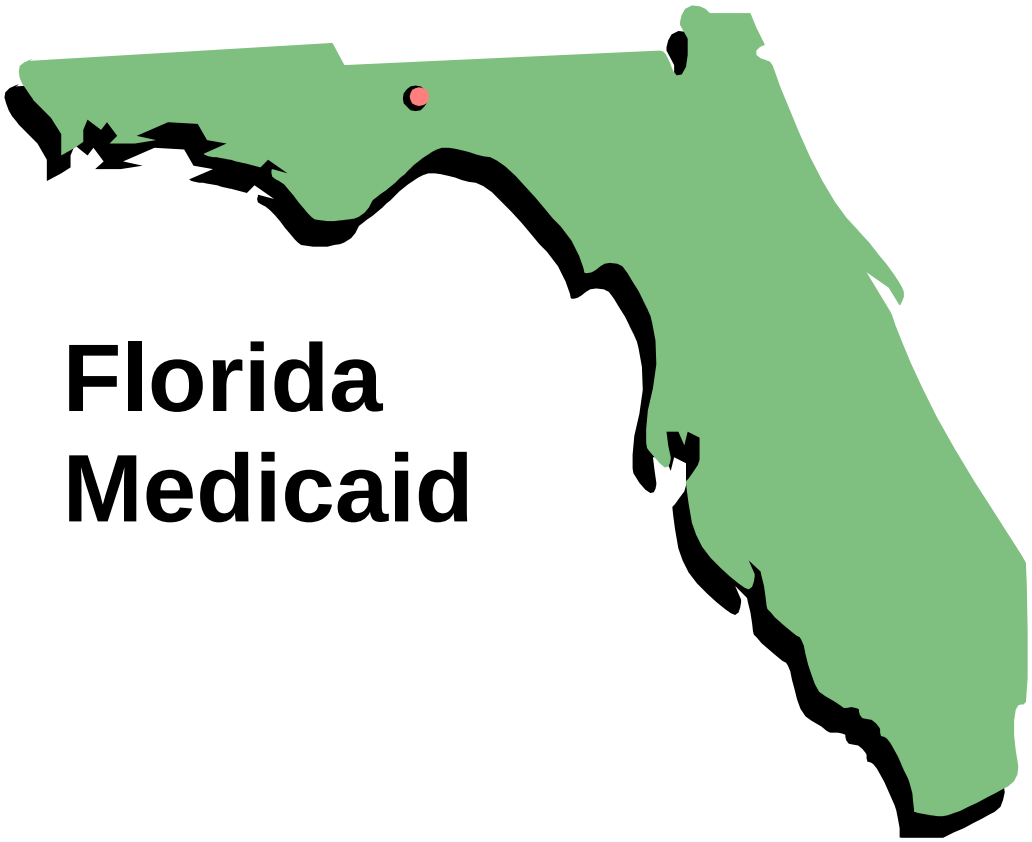
- Team Leader – 1.0 FTE
- Individual Therapist – 0.50 FTE
- Family Therapist – 1.0 FTE
- Skills Trainer(s) – 20-25 hours a week per 10-bed program.
- Foster Parent Recruiter, Trainer, and PDR Caller – 0.75 FTE
- One foster family for each placement.
- Consulting psychiatry.

Texas High Needs Classifications

Characteristics Comprising Key Indicators				
Emotional	**Learning**	**Medical**	**Physical Needs**	**Special Needs***
	ADD/ADHD			
	Autism			
	Developmental Delay			
	Developmental Disability			Developmental Disability
				Down Syndrome
Animal Cruelty				
Assaultive Behavior				
Reactive Attachment Disorder				Reactive Attachment Disorder
Bipolar				Bipolar
Depression				Depression
Eating Disorder				
Emotionally Disturbed – DSM				Emotionally Disturbed – DSM
		Enuresis/encopresis		Enuresis/encopresis
		Failure to Thrive		Failure to Thrive
Fire Setting Hx				
Gang Activity/Affiliation				
		Medically Complex		Medically Complex
		Hearing impaired		Hearing impaired
		HIV positive/AIDS		HIV positive/AIDS
	Learning Disabled			
		Medically Fragile		Medically Fragile
	Intellectual and Developmental Disability			Intellectual and Developmental Disability
			Mobility Impaired	Mobility Impaired
Oppositional Defiant Disorder				Oppositional Defiant Disorder
			Physically Disabled	Physically Disabled
Post-Traumatic Stress Syndrome				Post-Traumatic Stress Syndrome
Psychotic Disorder				Psychotic Disorder
Runaway				
Self-Abuse				
Sexually Acting Out				
		Sexually Transmitted Disease		

Characteristics Comprising Key Indicators				
	Speech Disabled			
			Spinal Bifida	
		Terminal Illness		Terminal Illness
		Traumatic Brain Injury		
Other Behavior Problem		Visual Impairment	Visual Impairment	

Note: A child is “special needs” if they are part of a sibling group, are white and over age 6, are non-white and over age 2, and have any of the characteristics shown.



Florida Medicaid

SPECIALIZED THERAPEUTIC SERVICES COVERAGE AND LIMITATIONS HANDBOOK

Agency for Health Care Administration
March 2014

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

SPECIALIZED THERAPEUTIC SERVICES
COVERAGE AND LIMITATIONS HANDBOOK
UPDATE LOG

How to Use the Update Log

Introduction

The update log provides a history of the handbook updates. Each Florida Medicaid handbook contains an update log.

Obtaining the Handbook Update

When a handbook is updated, the Medicaid provider will be notified. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Medicaid providers who are unable to obtain an updated handbook from the Web site may request a paper copy from the Medicaid fiscal agent's Provider Services Contact Center at 1-800-289-7799.

Explanation of the Update Log

Providers can use the update log below to determine if updates to the handbook have been received.

Update describes the change that was made.

Effective Date is the date that the update is effective.

UPDATE	EFFECTIVE DATE
New Handbook	March 2014

SPECIALIZED THERAPEUTIC SERVICES
COVERAGE AND LIMITATIONS HANDBOOK
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INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter outlines the three types of Florida Medicaid policy handbooks that all enrolled providers must comply with in order to obtain reimbursement. This chapter also describes the format used for the handbooks and instructs the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

- Provider General Handbook describes the Florida Medicaid program.
- Coverage and limitations handbooks explain covered services, their limits, who is eligible to receive them, and any corresponding fee schedules. Fee schedules can be incorporated within the handbook or separately.
- Reimbursement handbooks describe how to complete and file claims for reimbursement from Medicaid.

The current Florida Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Federal and State Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act
- Title 42 of the Code of Federal Regulations
- Chapter 409, Florida Statutes
- Rule Division 59G, Florida Administrative Code

In This Chapter

This chapter contains:

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Handbook Use

Purpose	The purpose of the Medicaid handbooks is to educate the Medicaid provider about the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients. The handbooks provide descriptions and instructions on how and when to complete forms, letters, or other documentation.
Provider	Term used to describe any entity, facility, person, or group who is enrolled in the Medicaid program and provides services to Medicaid recipients and bills Medicaid for services.
Recipient	Term used to describe an individual enrolled in Florida Medicaid.
Provider General Handbook	Information that applies to all providers regarding the Florida Medicaid program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook.
Coverage and Limitations Handbook	Each coverage and limitations handbook is named for the service it describes. A provider who renders more than one type of Medicaid service will have more than one coverage and limitations handbook with which they must comply.
Reimbursement Handbook	Most reimbursement handbooks are named for the type of claim form submitted.

Characteristics of the Handbook

Format	The format of the handbook represents a reader-friendly way of displaying material.
Label	Labels are located in the left margin of each information block. They identify the content of the block in order to help scanning and locating information quickly.
Information Block	Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines. Each block is identified or named with a label.
Chapter Topics	Each chapter contains a list of topics on the first page, which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.
Note	Note is used to refer the reader to other important documents or policies contained outside of this handbook.
Page Numbers	Pages are numbered consecutively within each chapter throughout the handbook. The chapter number appears as the first digit before the page number at the bottom of each page.
White Space	The "white space" found throughout a handbook enhances readability and allows space for writing notes.

Handbook Updates

Update Log	The first page of each handbook will contain the update log. Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received. Each update will be designated by an "Update" and "Effective Date."
How Changes are Updated	The Medicaid handbooks will be updated as needed. Updates are classified as either a: • Replacement handbook – Major revisions resulting in a rewrite of the existing handbook, without any underlines and strikethroughs throughout the rulemaking process. • Revised handbook – Minor revisions resulting in modification of the existing handbook identified during the rulemaking process by underlines and strikethroughs.
Handbook Effective Date	The effective date of a handbook is the month and year that will appear on the final published handbook. The provider can check this date to ensure that the material being used is the most current and up to date.
Identifying New Information	New information or information moved from one place to another within the handbook will be identified by an underline on draft versions of the handbook during the development and proposed stages of the rulemaking process (e.g., <u>new information</u>).
Identifying Deleted Information	Deleted information will be identified by a line through the middle of the selected text on draft versions of the handbook during the development and proposed stages of the rulemaking process (e.g., ~~deleted information~~).
Final Published Handbook	The adopted and published version of the handbook will not have underlines (indicating insertions) and text with strikethroughs (indicating deletions).

CHAPTER 1
QUALIFICATIONS, ENROLLMENT, AND REQUIREMENTS

Overview

Introduction

This chapter describes Florida Medicaid's specialized therapeutic services, the specific authority regulating these services, staff qualifications, and provider enrollment and requirements.

Legal Authority

Specialized therapeutic services are authorized by section 409.906, Florida Statutes (F.S.), and in Rule 59G-4.295, Florida Administrative Code (F.A.C.).

In This Chapter

This chapter contains:

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Purpose and Definitions

Medicaid Provider Handbooks

This handbook is intended for use by specialized therapeutic services providers that render services to eligible Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains information about specific procedures for submitting claims for payment, and the Florida Medicaid Provider General Handbook, which describes the Florida Medicaid program.

Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. All of the Florida Medicaid provider handbooks are incorporated by reference in Rule Division 59G, F.A.C.

Aftercare Planning

The process of planning for a recipient's transition from the current level of care. This process begins during the assessment process when the recipient's needs and possible barriers to care are identified.

Specialized therapeutic foster care and therapeutic group care services require the development of a formal aftercare plan.

Purpose and Definitions, continued

Bachelor's Level Infant Mental Health Practitioner	A bachelor's level practitioner who provides services to recipients under the age of six years.
Emotional Disturbance	A person under the age of 21 years who is diagnosed with a mental, emotional, or behavioral disorder of sufficient duration to meet one of the diagnostic categories specified in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, but who does not exhibit behaviors that substantially interfere with or limit the role or ability to function in the family, school, or community. The emotional disturbance must not be considered to be a temporary response to a stressful situation.
Discharge Criteria	Measurable criteria established at the onset of treatment that identify a recipient's readiness to transition to a new level of care or out of care. Discharge criteria must be included on the recipient's individualized treatment plan and are separate and apart from the recipient's treatment plan goals and objectives.
Group Therapy Services	Group therapy services include the provision of cognitive behavioral, supportive therapy interventions to individuals or families, and consultation with family or other responsible persons for sharing of clinical information. Also included is educating, counseling, or advising family or other responsible persons on how to assist the recipient. Group therapy services include the provision of cognitive behavioral, supportive therapy, or counseling interventions to recipients or their families. In addition to counseling, group therapy services to recipient families or other responsible persons include education, the sharing of clinical information, and guidance on how to assist recipients.
Hub Site	The telecommunication distance site in Florida at which the consulting physician, dentist or therapist is delivering telemedicine services.
Individual and Family Therapy Services	Individual and family therapy services include the provision of insight-oriented, cognitive behavioral or supportive therapy interventions to an individual recipient or family. Individual and family therapy may involve the recipient, the recipient's family (without the recipient present), or a combination of therapy with the recipient and the recipient's family. The focus or primary beneficiary of individual and family therapy services must always be the recipient.

Purpose and Definitions, continued

Institution for Mental Disease	A hospital or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care to persons with behavioral diseases in accordance with 42 CFR 435.1010.
Multidisciplinary Team (MDT)	The role of the MDT is to assess whether the recipient is appropriate for specialized therapeutic foster care (STFC). A MDT consists of a representative from the Department of Children and Families (DCF), or its designee, the local Medicaid area office, or the Department of Juvenile Justice (when applicable). Other MDT members should include the recipient, the recipient's case manager, a representative from the recipient's school, the recipient's biological or adoptive parents or relatives, the foster care parents or emergency shelter staff, assigned counselors or case managers, and the recipient's medical health care provider.
Other Responsible Persons	A relative, legal guardian, caretaker, or other individuals and natural supports who are known to the recipient and family and are active in providing care to the recipient. For services provided in the school, this may also include a child's classroom teacher or guidance counselor. Provision of services where the family or other responsible persons are involved must clearly be directed to meeting the identified treatment needs of the recipient. Services provided to family members or other responsible persons independent of meeting the identified needs of the recipient are not reimbursable by Medicaid.
Primary Clinician	The Medicaid-enrolled, clinical staff who provide services under a specialized therapeutic foster care or therapeutic group care provider group.
Psychiatric Advanced Registered Nurse Practitioner (ARNP)	A licensed ARNP who works in collaboration with a physician according to protocol to provide diagnostic and interventional patient care.
Rehabilitative Services	Rehabilitative services utilize direct care interventions to assist the recipient in the development of the skills necessary for independent living and for symptom management.

Serious Emotional Disturbance	A person under the age of 21 years who is all of the following: • Diagnosed as having a mental, emotional, or behavioral disorder that meets one of the diagnostic categories specified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. • Exhibits behaviors that substantially interfere with or limit the role or ability to function in the family, school, or community, which behaviors are not considered to be a temporary response to a stressful situation.
Shelter Status	The legal status that begins when a recipient under the age of 18 years is taken into the protective custody of DCF and ceases when one of the following occurs: • Court grants custody to a parent • After disposition of the petition for dependency • Court orders the child to be released to a parent or placed in the temporary custody of a relative, a nonrelative, or DCF
Specialized Therapeutic Foster Parent Pre-Service Training	Specialized therapeutic foster parent pre-service training must be approved by the DCF or their designee, or by a managed care plan for their network providers. The specialized therapeutic foster parent pre-service training must address at least the following areas: • Program orientation, including the responsibilities of the treatment parent and provider agency • Normal childhood development • Emotional disturbances in children and common behavioral problems exhibited • Behavior management, theory and skills • Discipline, limit-setting, logical consequences, problem-solving, and relationship building skills • Communication skills • Permanency planning • Stress management • Crisis intervention and emergency procedures • Self-defense and passive physical restraint • Working with biological or adoptive families • Placement adjustment skills • Confidentiality • Cultural competency • Behaviors and emotional issues of children who have been sexually abused

Purpose and Definitions, continued

Spoke Site	The provider office location in Florida where an approved service is being furnished through telemedicine.
Telemedicine	The practice of health care delivery using telecommunication equipment by the treating provider (at the spoke site) for the provision of approved covered services by the consulting provider (at the hub site) for the purpose of evaluation, diagnosis, or treatment.
Therapeutic Home Assignments	Therapeutic home assignments are overnight stays the recipient spends with the biological, adoptive, or extended family, or in a potential placement in order to practice the generalized skills learned in treatment at the recipient's home or other natural settings. Therapeutic home assignments must be prior authorized by the primary clinician and they must be recorded in the recipient's clinical record. Therapeutic home assignments may include time spent away overnight with friends, school, or club activities. Therapeutic home assignments are planned in conjunction with the recipient's treatment goals and objectives. A primary clinician or a specialized therapeutic foster parent must be accessible and must maintain a level of communication during therapeutic home assignments.
Treating Practitioner	A Medicaid-enrolled professional who authorizes services within the purview of the treating practitioner's credentials and state law on behalf of the Medicaid group provider (provider type 05).
Treatment Plan	The treatment plan is an individualized, structured, and goal-oriented schedule of services with measurable objectives that promotes the maximum reduction of the recipient's disability and restoration to the best possible functional level. Individualized recipient treatment plans must directly address the primary diagnosis(es) that is(are) consistent with the assessment. The provider must document efforts to coordinate services for behavioral health diagnoses outside their expertise that, if treated, would assist meeting the recipient's goals.

Treatment Plan, continued

Specialized therapeutic foster care and therapeutic group care services must be prescribed on a treatment plan authorized by one of the group provider's treating practitioners.

The treatment plan must be jointly developed by the recipient and the treatment team. The treatment plan must be recipient-centered and consistent with the recipient's identified strengths, abilities, needs, and preferences.

The recipient's parent or guardian should be included in the development of the recipient's individualized treatment plan, if the recipient is under the age of 18 years. Treatment planning for a recipient under the age of 18 years that does not include the recipient's parent, guardian, or legal custodian in a situation of exception requires a documented explanation.

The treatment plan must contain all of the following:

- Recipient's diagnosis code(s) consistent with assessment(s).
- Goals that are individualized, strength-based, and appropriate to the recipient's diagnosis, age, culture, strengths, abilities, preferences, and needs, as expressed by the recipient.
- Measurable objectives with target completion dates that are identified for each goal.
- List of the services to be provided (treatment plan development, treatment plan review, and evaluation or assessment services provided to establish a diagnosis and to gather information for the development of the treatment plan need not be listed).
- Amount, frequency, and duration of each service for the six-month duration of the treatment plan (e.g., four units of therapeutic behavioral on-site services two days per week for six months). It is not permissible to use the terms "as needed," "p.r.n.," or to state that the recipient will receive a service "x to y times per week."
- Dated signature of the recipient.
- Dated signature of the recipient's parent, guardian, or legal custodian (if the recipient is under the age of 18 years).
- Signatures of the treatment team members who participated in development of the plan.
- A signed and dated statement by the treating practitioner that services are medically necessary and appropriate to the recipient's diagnosis and needs.
- Discharge criteria.

Treatment Plan Review	The treatment plan review is a process conducted to ensure that treatment goals, objectives, and services continue to be appropriate to the recipient's needs and to assess the recipient's progress and continued need for services. The treatment plan review requires the participation of the recipient and the treatment team identified in the recipient's individualized treatment plan as responsible for addressing the treatment needs of the recipient. The treatment plan review must contain all of the following components: • Recipient's current diagnosis code(s) and justification for any changes in diagnosis. • Recipient's progress toward meeting individualized goals and objectives. • Recipient's progress toward meeting individualized discharge criteria. • Updates to aftercare plan. • Findings. • Recommendations. • Dated signature of the recipient. • Dated signature of the recipient's parent, guardian, or legal custodian (if the recipient is under the age of 18 years). • Signatures of the treatment team members who participated in review of the plan. • A signed and dated statement by the treating practitioner that services are medically necessary and appropriate to the recipient's diagnosis and needs. If the treatment plan review process indicates that the goals and objectives have not been met, documentation must reflect the treatment team's re-assessment of services and justification if no changes are made. The written documentation must be included in the recipient's clinical record upon completion of the treatment plan review activities.
Treatment Team	Key staff involved in planning and providing specialized therapeutic services to the recipient.

Staff Qualifications

General	Specialized therapeutic services staff must provide services within the scope of their professional licensure or certification, training, protocols, and competence. Providers must maintain staff records with background screening results, state mandated I-9 results, staff qualifications, verification of work experience, reference checks, and evidence of ongoing training. These records must additionally reflect adherence to human resources policies and procedures established by the provider.
Advanced Registered Nurse Practitioner (ARNP)	A licensed ARNP who works in collaboration with a physician according to protocol to provide diagnostic and interventional patient care. An ARNP must be authorized to provide these services in accordance with Chapter 464, F.S., and protocols filed with the Florida Board of Nursing.
Bachelor's Level Infant Mental Health Practitioner	A bachelor's level infant mental health practitioner must complete 20 hours of documented training in the following areas, prior to work with this age population: • Early childhood development • Behavior observation • Developmental screening • Parent and child interventions and interactions • Functional assessment • Developmentally appropriate practices for serving infants • Young children and their families • Psychosocial assessment and diagnosis of young children • Crisis intervention training Bachelor's level practitioners who have had the above training through conferences, workshops, continuing education credits, or academic training are not required to repeat the training. Bachelor's level infant mental health practitioners must be supervised by a master's level practitioner with two years of full-time experience with recipients, under the age of six years, or by a licensed practitioner of the healing arts.

Staff Qualifications, continued

Bachelor's Level Practitioner

A bachelor's level practitioner must meet all of the following criteria:

- A bachelor's degree from an accredited university or college with a major in counseling, social work, psychology, nursing, rehabilitation, special education, health education, or a related human services field.
- Training in the treatment of behavioral health disorders, human growth and development, evaluations, assessments, treatment planning, basic counseling and behavior management interventions, case management, clinical record documentation, psychopharmacology, abuse regulations, and recipient rights.
- Work under the supervision of a master's level practitioner.

Certified Addictions Professional (CAP)

A CAP must be certified by the Florida Certification Board (FCB) in accordance with Chapter 397, F.S.

A bachelor's level CAP must have a bachelor's degree and be certified in accordance with Chapter 397, F.S. by the FCB.

A master's level CAP must have a master's degree and be certified in accordance with Chapter 397, F.S. by the FCB.

Comprehensive Behavioral Health Assessor

Comprehensive behavioral health assessors include the following licensed providers:

- Psychiatric advanced registered nurse practitioner
- Clinical social worker
- Mental health counselor
- Marriage and family therapist
- Psychiatric clinical nurse specialist
- Psychologist
- Psychiatric physician's assistant
- Psychiatrist

These licensed practitioners must have a minimum of two years of direct, full-time experience working with children and families who are victims of physical abuse, sexual abuse, or neglect; emotionally disturbed; or delinquent.

Comprehensive behavioral health assessors can be master's level practitioners working under a licensed practitioner of the healing arts, who have all of the following:

- Master's degree in the field of counseling, social work, psychology, rehabilitation, special education, or a human services field.
- Minimum of five years of full-time experience working directly with children and families who are victims of physical abuse, sexual abuse, neglect; or youth who are emotionally disturbed and who have been determined to be delinquent by the Department of Juvenile Justice.

Comprehensive Behavioral Health Assessor, continued

- Minimum of two years of experience working with foster parents.
- Minimum of 30 hours of documented training, dedicated to relevant child and family treatment issues, within the last two years.

Master's level practitioners must complete child and adolescent needs and strengths (CANS) recertification and a minimum of 30 hours of training, relevant to child and family issues, every two years.

To be in compliance with the policy of DCF related to assessment of children in the legal custody of DCF, comprehensive behavioral health assessments completed by a nonlicensed person must be reviewed and co-signed by a licensed professional to verify the assessment is accurate and complete.

Licensed Practitioner of the Healing Arts (LPHA)

LPHAs include:

- Clinical social workers licensed in accordance with Chapter 491, F.S.
- Mental health counselors licensed in accordance with Chapter 491, F.S.
- Marriage and family therapists licensed in accordance with Chapter 491, F.S.
- Psychologists licensed in accordance with Chapter 490, F.S.
- Clinical nurse specialists (CNS) with a subspecialty in child/adolescent psychiatric and mental health or psychiatric and mental health licensed in accordance with Chapter 496, F.S.
- Psychiatric advanced registered nurse practitioners licensed in accordance with Chapter 464, F.S.
- Psychiatric physician assistants licensed in accordance with Chapters 458 and 459, F.S.

Master's Level Practitioner

A master's level practitioner must have a master's degree from an accredited university or college with a major in the field of counseling, social work, psychology, nursing, rehabilitation, special education, health education, or a related human services field with one of the following:

- Two years of professional experience in providing services to persons with behavioral health disorders
- Current supervision under an LPHA as described in this section

Master's level practitioners hired after July 1, 2014 with degrees other than social work, psychology, marriage and family therapy, or mental health counseling must have completed graduate level coursework in at least four of the following thirteen content areas: human growth and development; diagnosis and treatment of psychopathology; human sexuality; counseling theories and techniques; group theories and practice; dynamics of marriage and family systems; individual evaluation and assessment; career and lifestyle assessment; research and program evaluation; personality theories; social and cultural foundations; counseling in community settings; and substance use disorders.

Staff Qualifications, continued

Primary Clinician	Primary clinicians include the following LPHAs: • Clinical social worker • Mental health counselor • Marriage and family therapist • Psychiatric nurse • Psychiatric CNS • Psychiatric physician assistant • Psychiatrist • Psychologist These licensed primary clinicians must have a minimum of two years of direct experience working with children and families who are victims of physical abuse, sexual abuse, or neglect; emotionally disturbed; or delinquent. Master's level practitioners working under the supervision of an LPHA can also be primary clinicians. Master's level, primary clinicians must be Medicaid-enrolled clinical staff who provide services under a specialized therapeutic foster care or therapeutic group care provider group. Master's level primary clinicians must have all of the following: • A master's degree in the field of counseling, social work, psychology, rehabilitation, special education, or a human services field. • A minimum of two years of full-time experience working directly with children and families who are victims of physical abuse, neglect; or, youth who are emotionally disturbed who have been adjudicated. • A minimum of 30 hours of documented training, 15 of which must be dedicated to relevant child and family treatment issues, within the last two years.
Psychiatric Advanced Registered Nurse Practitioner (ARNP)	A psychiatric ARNP must have education or training in psychiatry and be authorized to provide these services in accordance with Chapter 464, F.S., and protocols filed with the Florida Board of Nursing.

Staff Qualifications, continued

Psychiatric Clinical Nurse Specialist (CNS)	A CNS must have a subspecialty in child/adolescent psychiatric and mental health or psychiatric and mental health and is licensed in accordance with Chapter 464, F.S., and must meet all of the following criteria: • Hold a current and active license as a registered nurse in Florida • Hold a master's degree or higher in nursing as a CNS • Provide proof of current certification in a specialty area as a CNS from one of the four certifying bodies: American Nursing Credentialing Center, American Association of Critical-Care Nurses, Oncology Nursing Certification Corporation, and National Board of Certification of Hospice and Palliative Nurses; or meet the requirements of Chapter 464, F.S. and has provided the required affidavit • Hold a certificate issued by the Florida Board of Nursing as a CNS A registered nurse currently enrolled as an LPHA must be licensed as a CNS with a subspecialty of child/adolescent psychiatric and mental health or psychiatric and mental health by January 1, 2016.
Psychiatric Physician Assistant (PPA)	A PPA must be a licensed prescribing physician assistant as defined in Chapter 458 or 459, F.S., with a Psychiatric Certificate of Added Qualification. The PPA's supervising physician must be a provider type 25 or 26 that is linked to the community behavioral health group provider type 05.
Specialized Therapeutic Foster Parents	Specialized therapeutic foster parents must be licensed in accordance with Chapter 65C-14, F.A.C. and must have completed an additional 30 hours of pre-service training specific to specialized therapeutic foster care. The specialized therapeutic foster parent(s) serves as the primary agent in the delivery of therapeutic services to the recipient. Specialized therapeutic foster parents are trained in interventions designed to meet the individual needs of the recipient. Specialized therapeutic foster parents must be available 24 hours per day to respond to crises or to the need for special therapeutic interventions. Specialized therapeutic foster parents must receive ongoing in-service training from clinical staff to support, enhance, and improve their treatment skills and strengthen their abilities to work with specific children. In-service training should be provided as often as needed, but not less than: • Level I: 8 clock hours every six months • Level II: 12 clock hours every six months

Treating Practitioner	Treating practitioners include: • Physician • Psychiatrist • Psychiatric ARNP • PPA • LPHA • Master's level CAP (for the authorization of substance use treatment only)

Enrollment

Introduction	The qualifications listed in this section apply to the following providers: • Comprehensive behavioral health assessment (provider type 07, specialty code 66) • Specialized therapeutic foster care services (provider type 07,specialty code 67) • Therapeutic group care services (provider type 05) • Treating physicians (provider types 25 and 26) • Treating practitioners (provider type 07) Note: Enrollment forms may be obtained from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com, select Public Information for Providers, then Provider Support, and then Enrollment, or by calling Provider Enrollment at 1-800-289-7799 and selecting Option 4.
Comprehensive Behavioral Health Assessment Provider	Comprehensive behavioral health assessment group provider agencies and individual practitioners must complete a Comprehensive Behavioral Health Assessment Agency and Practitioner Self-Certification, found in the appendices. Group provider agencies and the individual practitioners must submit this self-certification to the Medicaid fiscal agent with the enrollment application. Comprehensive behavioral health assessment group provider agencies are not required to be linked to a treating physician. Prior to enrollment, an individual practitioner not currently enrolled in Florida Medicaid, must complete child and adolescent needs and strengths (CANS) assessment training, provided by a certified trainer or an approved online training course, and must obtain CANS certification. Individual practitioners who meet the eligibility criteria to provide comprehensive behavioral health assessments must be linked to a certified comprehensive behavioral health assessment group provider agency before rendering this service.

Comprehensive Behavioral Health Assessment Provider Self-Certification

An agency enrolling in Medicaid as a comprehensive behavioral health assessment group provider must have policies and procedures that address the following:

- Maintaining written records for every recipient
- Maintaining confidentiality and security of clinical records
- Credentialing, recredentialing, and reappointing practitioners
- Establishing a program evaluation system to review the processes and outcomes on at least an annual basis

An individual must be certified as meeting the requirements of a comprehensive behavioral health assessor, as defined in this handbook, before enrolling in Medicaid as an individual comprehensive behavioral health assessment provider.

Specialized Therapeutic Foster Care Provider

Providers must be linked to a treating psychiatrist (provider type 25 or 26). Specialized therapeutic foster care providers must complete the Specialized Therapeutic Foster Care Provider Agency Self-Certification, found in the appendices. This self-certification also requires the signature of DCF or its designee. Providers must submit the completed self-certification to the Medicaid fiscal agent with their enrollment application.

Specialized Therapeutic Foster Care Provider Self-Certification

The following conditions must be met before the provider can enroll in Medicaid as a specialized therapeutic foster care services provider:

- The provider's primary clinicians, psychologists, psychiatrists, and foster parents delivering specialized therapeutic foster care services must meet the specific education and training requirements.
- The provider employs or contracts with primary clinicians and foster care parents who provide the services. (The primary clinicians and foster care parents are not individually enrolled in Medicaid.)
- The provider has an approved pre-service and in-service training plan for staff providing specialized therapeutic foster care services.
- The foster home is properly licensed in accordance with Chapter 409.175, F.S. and Chapter 65C-13 or 65C-14, F.A.C, by the circuit Child Welfare and Community-Based Care program office.
- The foster parents have received basic training required of all licensed foster parents and meet all other licensing requirements.
- The provider has a financial agreement with the foster parents that reimburses the foster parents for their therapeutic intervention services.
- The provider has policies and procedures that promote good therapeutic practice, ensure that therapeutic foster parents are the primary therapeutic agent, provide for appropriate treatment plans and documentation, and protect the rights of recipients and their families.

Specialized Therapeutic Foster Care Provider Self-Certification, continued

- The provider has a program evaluation system to review the process and outcomes on at least an annual basis.
- The provider has policies and procedures that are consistent with section 1003.57(3)(b), F.S. to address the school notification requirements.

Therapeutic Group Care Provider

To be eligible to enroll as a Medicaid therapeutic group care provider agency, providers must meet all of the following:

- Be enrolled as a community behavioral health services group provider (provider type 05).
- Be properly licensed in accordance with Chapter 394, F.S., and Chapter 65E-9, F.A.C., by the Agency for Health Care Administration (AHCA).
- Achieve compliance on the Community Behavioral Health Services Provider Pre-Enrollment Certification Review.

Eligible group providers must submit an enrollment application to the Medicaid fiscal agent and must submit the Provider Agency Acknowledgement for Therapeutic Group Care Services form, found in the appendices, which has been completed by the provider's executive director, to the Agency as directed on the form. AHCA will then send the provider and the local Medicaid area office a letter that acknowledges receipt of the form and confirms initial certification. Based on licensure and the provider's assurance, Medicaid will grant temporary certification for billing therapeutic group care services.

Therapeutic Group Care Provider Self-Certification

A provider must demonstrate the administrative and clinical capacity to operate as a therapeutic group care provider by meeting the service requirements listed in this section.

The service requirements cover the following areas, which are described in detail in the following sections:

- Required provider capabilities of therapeutic group care services
- Services to be provided
- Quality assurance program requirements
- Required policies and procedures

Therapeutic Group Care Provider Certification Process

An AHCA representative and DCF, or its designee, will initially certify the therapeutic group care providers within approximately six months. If the program site is in compliance, the provider will receive a Provider Agency Certification form signed by the Medicaid representative.

If the program is found to be noncompliant, the provider must complete a corrective action plan within 30 days to continue billing for services. If the program remains noncompliant with the certification criteria during a follow-up review, the temporary certification will be withdrawn within six months from the date that the corrective action plan was approved.

Therapeutic Group Care Services Required Provider Capabilities

The provider of therapeutic group care must be able to provide:

- A home-like, therapeutic group care setting serving no more than 12 recipients.
- A therapeutic environment with an identified treatment orientation described and supported in the literature and that is understood by all staff and by the recipients.
- Psychiatric services and clinical assessment, treatment planning, and therapy services by qualified staff, per the requirements in this handbook.
- Consistent implementation of programmatic policy by administrative, clinical, and direct care staff within the therapeutic group care program.
- A range of age-appropriate indoor and outdoor recreational and leisure activities, including activities for nights and weekends, based on group and individual interests and developmental needs.
- Access to, and coordination with, an accredited educational program for each recipient that complies with the State Board of Education, Rule 6A-6.0361, F.A.C.
- Access to and coordination with primary care providers.
- Behavioral programming that is individually designed and implemented and includes structured interventions and contingencies to support the development of adaptive, pro-social, interpersonal behavior.
- Psychiatric crisis management with demonstrated 24-hour response capability and access to acute care setting and behavioral health emergency management services.
- The provider must meet the staffing requirements specified in Rule 65E-9.006, F.A.C.

Therapeutic Group Care Providers Quality Assurance Program Requirements

The provider must have a quality assurance program that evaluates the effectiveness and outcomes of the behavioral health services it provides. The quality assurance policies and procedures must address:

- Monitoring of behavioral health treatment planning and implementation.
- Treatment plan review and assessment of progress at least monthly.
- Ongoing review of treatment staff performance.
- Review of medication administration and monitoring.
- The coordination of care with primary care providers.
- Implementing and documenting pre-service and ongoing staff training that improves and supports the delivery of high level therapeutic service.
- Maintaining procedures for gathering data and reporting on outcomes related to assessment of clinical status, behavioral functioning, and the recipient's academic performance in school.
- Quality and effectiveness of treatment services with recipients and their families.
- Quality and effectiveness of aftercare planning.
- Quality and degree of involvement of recipients in extracurricular activities in the community.

Therapeutic Group Care Required Policies and Procedures

The provider must have policies and procedures that promote good therapeutic practice, provide for appropriate treatment plans and documentation, and protect the rights of children and families. Policies and procedures must be in place that address the following:

- Thorough screening, evaluation, and diagnosis of symptoms, risks, functional status, and co-morbidity.
- Therapeutic crisis intervention and procedures to transfer the recipient to a more restrictive level of care, such as a hospital, crisis stabilization unit, or an inpatient psychiatric program, if clinically appropriate.
- Treatment teams that are responsible for organizing the delivery of therapeutic services.
- Individualized treatment plans that are integrated into the activities of daily living associated with therapeutic group care treatment.
- Inclusion of the recipient's family or guardian in the clinical treatment process.
- A monthly summary note, required to document the overall progress of the recipient in therapy and in the therapeutic milieu, report on contacts with the recipient's family, community, school, and activity program, and include input from the recipient's case manager relating to medical management of recipients who require psychotropic medical intervention.
- Medication administration, training, monitoring and storage.
- Prohibition of the use of mechanical restraints and seclusion.
- The use of time out.

Enrollment, continued

Therapeutic Group Care Required Policies and Procedures, continued	• Clinical aftercare planning that is coordinated with the permanency plan and supports development of independent living skills, when developmentally appropriate. • An internal review process for determining the recipient's continued eligibility and need for therapeutic group care services, on at least a monthly basis. • The clinical management of specific types of emotional and behavioral problems encountered by recipients served in the facility. • A clinical supervision protocol that assures timely monitoring of services and modification of treatment as needed through at least weekly, documented supervision of non-licensed therapists. • Staff orientation and training requirements that comply with Chapter 65E-9, F.A.C. • School notification requirements as outlined in 1003.57(3)(b), F.S.
Treating Practitioner	A treating practitioner must be independently enrolled in the Florida Medicaid program per provider type.
Treating Physician	A treating physician must enroll as a provider type 25 or 26 and must also be linked to the community behavioral health group (provider type 05).
Psychiatric Advanced Registered Nurse Practitioner (ARNP)	A psychiatric ARNP must enroll as a provider type 07 and must also be linked to a group provider type 05. To enroll as a provider type 07, psychiatric ARNPs must submit a signed Practitioner Collaborative Agreement form with a physician (provider type 25 or 26) that is linked to the community behavioral health group (provider type 05).
Psychiatric Physician Assistant (PPA)	A PPA must enroll as a provider type 07 and must also be linked to a community behavioral health group (provider type 05). To enroll as provider type 07, a PPA must submit a signed Practitioner Collaborative Agreement form with a physician (provider type 25 or 26) that is linked to the community behavioral health group (provider type 05).
Licensed Practitioner of the Healing Arts (LPHA)	A treating LPHA must enroll as a provider type 07 and must be linked to a group provider type 05 for services rendered in the capacity of a treating practitioner in order to be qualified.
Certified Addictions Professional (CAP)	A CAP with a master's degree must enroll as provider type 07 and must also be linked to a community behavioral health group (provider type 05) in order to authorize services for treatment for substance use disorders.

Enrollment, continued

Multiple Service Locations within the Same Medicaid-Designated Area	Specialized therapeutic services agency providers who render services at more than one service address within the same Medicaid-designated area are required to submit an Application for New Location Code to identify each separate physical address where services are provided. The Application for New Location Code is an attachment to the Florida Medicaid Provider Enrollment Application. Providers must use the code assigned to the location when billing for services provided at that location. Additional service sites are subject to an on-site review by the local Medicaid area office or its designee.
Multiple Service Locations in Different Medicaid-Designated Areas	Specialized therapeutic services agency providers who render services at more than one service address in different Medicaid-designated areas are required to submit a separate Florida Medicaid Provider Enrollment Application for each Medicaid-designated area. Providers must use the code assigned to the location when billing for services provided at that location. Additional service sites are subject to an on-site review by the local Medicaid area office or its designee.
Subcontracting	Florida Medicaid allows a provider to contract with an individual practitioner, but not with another agency for service delivery. As of July 1, 2014, providers are required to retain all contracts with subcontracted staff for no less than five years from the termination date of the contract. Providers must maintain subcontractor records with background screening results, staff qualifications, and verification of work experience. These records must additionally reflect adherence to human resources policies and procedures established by the provider related to subcontracting.

Requirements

Providers Contracted with Medicaid Health Plans	The service-specific Medicaid coverage and limitations handbooks provide the minimum requirements for all providers. This includes providers who contract with Florida Medicaid health plans (e.g., provider service networks and health maintenance organizations). Providers shall comply with all of the requirements outlined in this handbook, unless otherwise specified in their contract with the health plan. The provision of services to recipients enrolled in a Medicaid health plan shall not be subject to more stringent criteria or limits than specified in this handbook.

CHAPTER 2
COVERED, LIMITED, AND EXCLUDED SERVICES

Overview

Introduction

This chapter provides service coverage, limitations, and exclusions information. It also describes who can provide and receive series, as well as any applicable service requirements.

In This Chapter

This chapter contains:

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General Coverage Information

Medical Necessity

Medicaid reimburses services that are determined medically necessary and do not duplicate another provider's service.

Rule 59G-1.010 (166), Florida Administrative Code (F.A.C.) defines "medically necessary" or "medical necessity" as follows:

"[T]he medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs.
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider."

"(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services, does not, in itself, make such care, goods or services medically necessary or a covered service."

Exceptions to the Limits (Special Services) Process	As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). Services for recipients under the age of 21 years in excess of limitations described within this handbook or the associated fee schedule may be approved, if medically necessary, through the process described in the Florida Medicaid Provider General Handbook.
Description	Specialized therapeutic services include comprehensive behavioral health assessments, specialized therapeutic foster care, and therapeutic group home services provided to recipients under the age of 21 years with mental health, substance use, and co-occurring mental health and substance use disorders. The intent of specialized therapeutic services is the maximum reduction of the recipient's disability and restoration to the best possible functional level. Services must be diagnostically relevant and medically necessary. Specialized therapeutic foster care and therapeutic group home services must be included in an individualized treatment plan that has been approved by a treating practitioner. Services are treatment events that correspond with Medicaid procedure codes. Services are not the same as interventions. Unless otherwise specified, the date(s) of service on each claim must correspond to the date(s) the service was rendered.
General Requirement	Providers must request reimbursement only for services that are provided by individuals employed by, under contract with, or who are compensated monetarily by the provider.

General Coverage Information, continued

Assessment Requirement

Prior to the development of a treatment plan the provider must complete and present the recipient with an assessment of the recipient's mental health status, substance use concerns, functional capacity, strengths, and service needs or must have an assessment on file that has been conducted in the last six months. The purpose of the assessment is to gather information to be used in the formulation of a diagnosis and development of a plan of care for the recipient that includes the discharge criteria.

A comprehensive behavioral health assessment completed within the past year in accordance with this handbook can satisfy the current assessment requirement.

Recipient Clinical Record

Providers must maintain a clinical record for each recipient treated that contains all of the following:

- Consent for treatment that is signed by the recipient or the recipient's legal guardian. An explanation must be provided for signatures omitted in situations of exception.
- An evaluation or assessment that, at a minimum, contains the components of a brief behavioral health status examination conducted by a physician, psychiatrist, a licensed practitioner of the healing arts (LPHA), or master's level certified addictions professional for diagnostic and treatment planning purposes. For new admissions, the evaluation or assessment by an LPHA for treatment planning purposes must have been completed within the past six months.
- Copies of relevant assessments, reports and tests.
- Service notes (progress toward treatment plans and goals).
- Documentation of service eligibility, if applicable.
- Current treatment plans (within the last six months), reviews, and addenda.
- Copies of all certification forms (e.g., comprehensive behavioral health assessment).
- The practitioner's orders and results of diagnostic and laboratory tests.
- Documentation of medication assessment, prescription, and management.

For therapeutic group care services, the recipient's clinical record must comply with Chapter 65E-9, F.A.C.

Note: For information about electronic records, see the Florida Medicaid Provider General Handbook.

General Coverage Information, continued

General Service Documentation Requirements

Providers must maintain documentation to support each service for which Medicaid reimbursement is requested; clearly distinguish and reference each separate service billed; and be authenticated with the dated signature of the individual who rendered the service. The date of a claim should be the same as the date the service was rendered.

Service documentation must contain all of the following:

- Recipient's name
- Date the service was rendered
- Start and end times
- Identification of the setting in which the service was rendered
- Identification of the specific problem, behavior, or skill deficit for which the service is being provided
- Identification of the service rendered.
- Updates regarding the recipient's progress toward meeting treatment related goals and objectives addressed during the provision of a service
- Dated signature of the individual who rendered the service
- Printed or stamped name identifying the signature of the individual who rendered the service and the credentials (e.g., licensed clinical social worker) or functional title (e.g., treating practitioner)

For therapeutic group care services, the recipient's documentation must comply with Chapter 65E-9, F.A.C.

Note: For information about electronic signatures, see the Florida Medicaid Provider General Handbook.

Compliance and Quality of Care Reviews

Provider's compliance with service eligibility determination procedures, service authorization policy, staffing requirements, and service documentation requirements can be reviewed periodically by AHCA or its designee. Providers that violate these requirements are subject to recoupments, fines, or termination in accordance with Chapter 409.913, F.S.

Aftercare Planning

The recipient and the treating staff should collaborate to develop the recipient's individualized formal aftercare plan. A formal aftercare plan should include community resources, activities, services, and supports that will be utilized to help the recipient sustain gains achieved during treatment.

Discharge Criteria

The recipient and the treating staff should collaborate to develop the individualized, measurable discharge criteria. The recipient's progress toward meeting the discharge criteria should be addressed throughout the course of treatment as part of the treatment plan review.

Comprehensive Behavioral Health Assessments

Introduction

A comprehensive behavioral health assessment is an in-depth and detailed assessment of the recipient's emotional, social, behavioral, and developmental functioning. For those settings in which the recipient routinely participates, a comprehensive behavioral health assessment must include direct observation of the recipient in the following settings:

- Home
- School or child care
- Work site
- Community

Comprehensive behavioral health assessment components requiring face-to-face contact cannot be provided using telemedicine.

Who Can Receive

To receive a comprehensive behavioral health assessment, a recipient must be under the age of 21 years and meet all of the following criteria:

- Be a victim of abuse or neglect
- Have been determined by the Department of Children and Families (DCF) or their designee to require out-of-home care or be placed in shelter status

Or the recipient must meet all of the following criteria:

- Have committed acts of juvenile delinquency
- Be suffering from an emotional disturbance or a serious emotional disturbance
- Be at risk for placement in a residential setting

Components for Recipients Under the Age of Six Years

A comprehensive behavioral health assessment for recipients under the age of six years, must be written in narrative form and provide detailed information on the components below. The use of a checklist or fill in the blank format in lieu of a narrative is prohibited.

The assessment must include, at a minimum, the following information related to the recipient and the recipient's family:

- General identifying information (name, birth date, Medicaid identification number, sex, address, siblings, school, referral source, and diagnosis).
- Reason for referral.
- Personal and family history.
- Placement history, including adjustment to a new care giver and home.
- Sources of information (e.g., counselor, hospital, law enforcement).
- Results of interviews and interventions conducted by the assessor;
- Cognitive functioning, screening for emotional-social development, problem solving, communication, response of the child and family to the assessment, and ability to collaborate with the assessor.
- Previous and current medications including psychotropic.
- Last physical examination, including pre-natal, pregnancy and delivery history, and any known medical problems (e.g., prenatal exposure, accidents, injuries, hospitalizations) which may affect the recipient's mental health status.
- History of mental health treatment of the recipient's parents and siblings. The mother's history, including a depression screen, is important in developing this section.
- History of substance use and alcohol or chemical dependency of the recipient's family.
- Legal involvement and status of the recipient and the recipient's family.
- Resources including income, entitlements, health care benefits, subsidized housing, social services, etc.
- Emotional status, including a hands-on, interactive assessment of the recipient regarding sensory and regulatory functioning, attention, engagement, constitutional characteristics, and organization and integration of behavior.
- Educational analysis, including daycare issues concerning behavioral and developmental concerns.
- Functional analysis, including presenting strengths and problems of both the recipient and the recipient's family.
- Cultural analysis, including discovery of the family's unique values, ideas, customs and skills that have been passed on to family members and that require consideration in planning and working with the recipient's family. This component includes assessment of the family's own operational style, including habits, characteristics, preferences, roles, and methods of communicating with each other.

Components for Recipients Under the Age of Six Years, continued

- Situational analysis including direct observation of the parent or caregiver's interaction with the recipient in the home, school or child care setting, work site, and community, whenever the recipient routinely participates in these settings.
- Present level of functioning, including social adjustment and daily living skills.
- Activities catalog, including assessment of activities in which the recipient has interest or enjoys.
- Ecological analysis, including relationship of parents (guardians), parent-child relationship, sibling relationships, relationships with friends and family. A relational assessment should be provided to assess any attachment issues the recipient exhibits.
- Assessment of the desired services and goals from the recipient and the recipient's parent or guardian's viewpoint.
- An ICD diagnosis. If the recipient does not have a presenting ICD diagnosis, the provider must use the examination and observation diagnosis code.
- For recipients under the age of 4 years, Medicaid recommends use of the Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood (DC: 0-3) for assistance in determining the infant or child's ICD diagnosis.
- Completion of a standardized assessment, such as the Child & Adolescent Needs and Strengths An Information Integration Tool for Early Development CANS-0 to 3 Manual (CANS 0-3) and the Florida's Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment 0-5 Manual (CANS 0-5).

The assessment includes the following:

- Problem presentation and symptoms
- Risk behaviors
- Functioning
- Family and caregiver needs and strengths
- Recipient's strengths
- Summary of findings and recommendations

Comprehensive Behavioral Health Assessments, continued

Components for Recipients Ages 6 Years through 20 Years

A comprehensive behavioral health assessment for recipients ages 6 years through 20 years, must include, at a minimum, the information listed below related to the recipient and the recipient's family. The use of a checklist or fill in the blank format in lieu of a narrative is prohibited.

- General identifying information (name, birth date, Medicaid identification number, sex, address, siblings, school, referral source, and diagnosis).
- Reason for referral.
- Personal and family history.
- Placement history, including adjustment and level of understanding about out-of-home placement.
- Sources of information (e.g., counselor, hospital, law enforcement).
- Interviews and interventions.
- Cognitive functioning (attention, memory, information, and attitudes), perceptual disturbances, thought content, speech and affect, and an estimation of the ability and willingness to participate in treatment.
- Previous and current medications, including psychotropic.
- Last physical examination and any known medical problems, including any early medical information which may affect the recipient's mental health status, such as prenatal exposure, accidents, injuries, hospitalizations, etc.
- History of mental health treatment of the recipient and the recipient's family.
- History of current or past substance use of the recipient and the recipient's family.
- Legal involvement and status of the recipient and the recipient's family.
- Resources including income, entitlements, health care benefits, subsidized housing, social services, etc.
- Emotional status, including psychiatric or psychological condition.
- Educational analysis, including school-based adjustment, performance history, and current status.
- Functional analysis, including presenting strengths and problems of both the recipient and the recipient's family.
- Cultural analysis, including discovery of the family's unique values, ideas, customs and skills that have been passed on to family members and that require consideration in working and planning with the family. This component includes assessment of the family's own operational style, including habits, characteristics, preferences, roles, and methods of communicating with each other.
- Situational analysis, including direct observation of the recipient at home, school or child care setting, work site, and community whenever the recipient routinely participates in these settings.
- Present level of functioning, including social adjustment and daily living skills.
- Reaction or pattern of reaction to any previous out-of-home placements.
- Activities catalog, including assessment of activities in which the recipient has interest or enjoys.

Comprehensive Behavioral Health Assessments, continued

Components for Recipients Ages 6 Years through 20 Years, continued

- Ecological analysis, including relationship of parents (guardians), parent-child relationship, sibling relationships, relationships with friends and family.
- Vocational aptitude and interest evaluation, previous employment and the acquired vocational skills, activities, and interests, if ages 14 years and older.
- Assessment of the desired services and goals from the recipient and the recipient's family's viewpoint.
- An ICD diagnosis. If the recipient does not have a presenting ICD diagnosis, the provider must use the examination and observation diagnosis code.
- For recipients ages 6 years through 20 years, completion of a standardized assessment tool, such as the Child & Adolescent Needs & Strengths An Information Integration Tool for Children and Adolescents with Mental Health Challenges CANS-MH Manual (CANS-MH) or the Child and Adolescent Needs and Strengths-(CANS) Comprehensive Multisystem Assessment Manual (CANS-Comprehensive).

The assessment includes the following:

- Problem presentation and symptoms
- Risk behavior
- Functioning
- Family and caregiver needs and strengths
- Recipient's strengths
- Summary of findings and recommendations.

Authorization for Services

DCF or their designee, or the recipient's managed care plan must authorize the comprehensive behavioral health assessment services utilizing the Authorization for Comprehensive Behavioral Health Assessment form, found in the appendices. The provider must keep the authorization form on file in the recipient's clinical record.

Who Must Provide

Comprehensive behavioral health assessments must be personally rendered by a comprehensive behavioral health assessor.

Comprehensive Behavioral Health Assessments, continued

Documentation

A comprehensive behavioral health assessment must be written in narrative form and provide detailed information on the aforementioned components (pp. 2-6 and 2-8 for recipients under the age of six years and recipients ages 6 years through 20 years, respectively). The use of a checklist or fill in the blank format in lieu of a narrative is prohibited.

Each activity related to development of the comprehensive behavioral health assessment must be thoroughly documented to reflect time spent on information collection, interpretation, assessment, report writing, and other related activities.

A review of evaluations and tests previously completed by the provider or others and are deemed to be appropriate and current can be used in addition to a CANS in the development of a comprehensive behavioral health assessment.

Covered Services

Comprehensive behavioral health assessment goals are to:

- Provide assessment of areas where no other information exists.
- Update pertinent information not considered to be current.
- Integrate and interpret all existing and new assessment information.
- Provide functional information, including strengths and needs, to the referral source, the recipient, and their family that will aid in the development of long- and short-term, culturally sensitive intervention strategies to enable the recipient to live and receive education in the most inclusive environment.
- Provide specific information and recommendations to accomplish family preservation, re-unification, or re-entry and permanency planning.
- Provide data to promote the most appropriate out-of-home placement, when necessary.
- Provide information for development of an effective, individualized, strength based, culturally sensitive, comprehensive services plan and an individualized treatment plan.

Specialized Therapeutic Foster Care Services

Introduction

Specialized therapeutic foster care services are intensive treatment services provided to recipients under the age of 21 years with emotional disturbances who reside in a state licensed foster home. Specialized therapeutic foster care services are appropriate for long-term treatment and short-term crisis intervention.

The goal of specialized therapeutic foster care is to enable a recipient to manage and to work toward resolution of emotional, behavioral, or psychiatric problems in a highly supportive, individualized, and flexible home setting.

Specialized therapeutic foster care services incorporate clinical treatment services, which are behavioral, psychological, and psychosocial in orientation. Services must include clinical interventions by the specialized therapeutic foster parent(s), a primary clinician, and a psychiatrist. A specialized therapeutic foster parent must be available 24 hours per day to respond to crises or to provide special therapeutic interventions.

There are two levels of specialized therapeutic foster care, which are differentiated by the supervision and training of the foster parents and intensity of programming required. Specialized therapeutic foster care levels are intended to support, promote competency, and enhance participation in normal, age-appropriate activities of recipients who present moderate to serious emotional or behavior management problems. Programming and interventions are tailored to the age and diagnosis of the recipients.

Specialized therapeutic foster care services are offered at Level I or Level II, with crisis intervention available at both levels.

Authorization for Specialized Therapeutic Foster Care Services

The multidisciplinary team must authorize specialized therapeutic foster care services. If the multidisciplinary team determines that the recipient requires specialized therapeutic foster care services, the Authorization for Therapeutic Foster Care form, found in the appendices, is completed.

The multidisciplinary team must re-authorize specialized therapeutic foster care services no less than every six months. A new Authorization for Specialized Therapeutic Foster Care form must be completed for each authorization period.

The Authorization for Specialized Therapeutic Foster Care form must be forwarded to the provider agency to be placed in the recipient’s clinical record.

Level I

Level I specialized therapeutic foster care is characterized by close supervision of the recipient within a specialized therapeutic foster home. Services to the recipient must include clinical interventions by the specialized therapeutic foster parent(s), a primary clinician, and a psychiatrist.

Specialized Therapeutic Foster Care Services, continued

Who Can Receive

Level I specialized therapeutic foster care is for recipients with a history of abuse or neglect, or delinquent behavior, and who have an emotional disturbance or serious emotional disturbance. The recipient must qualify for foster care and must meet at least one of the following criteria:

- Requires admission to a psychiatric hospital, a crisis stabilization unit, or a residential treatment center without specialized therapeutic foster care.
- Within the last two years, been admitted to one of these treatment settings.

Level II

Level II specialized therapeutic foster care is characterized by the need for more frequent contact between the specialized therapeutic foster parents, the recipient, primary clinician, and the psychiatrist as a result of the recipient exhibiting the maladaptive behaviors listed below.

Level II specialized therapeutic foster care is intended to provide a high degree of structure, support, supervision, and clinical intervention.

Who Can Receive

A recipient requiring Level II specialized therapeutic foster care must meet the following criteria:

- Meet the criteria of Level I specialized therapeutic foster care.
- Be exhibiting more severe maladaptive behaviors such as:
  - Destruction of property
  - Physical aggression toward people or animals
  - Self-inflicted injuries
  - Suicidal ideations or gestures
  - An inability to perform activities of daily and community living due to psychiatric symptoms

The recipient must require the availability of highly trained specialized therapeutic foster parents as evidenced by at least one of the behaviors or deficits listed above.

Crisis Intervention Services

Specialized therapeutic foster care services may be used for a maximum of 30 days for crisis intervention for a recipient for whom services must occur immediately in order to stabilize a behavioral, emotional, or psychiatric crisis. Any exception to this length of stay must be approved in writing by the multidisciplinary team.

A comprehensive behavioral health assessment must be initiated within 10 working days of crisis intervention services for any recipient who has not had a comprehensive behavioral health assessment in the past year.

Specialized Therapeutic Foster Care Services, continued

Who Can Receive

The recipient must be in foster care or delinquent and must be determined by the multidisciplinary team to meet Level I or Level II criteria. An Authorization for Crisis Intervention form, found in the appendices, must be completed and a copy placed in the recipient's clinical record by the provider.

For recipients who are enrolled in managed care, the plan must authorize approval for crisis intervention services.

Responsibilities of the Primary Clinician

Clinical staff are responsible for:

- Directly supervising and supporting the specialized therapeutic foster parents throughout the recipient's length of stay.
- Evaluating and assessing recipients who are receiving services.
- Providing in-service training to the therapeutic foster care parent(s), targeting skills needed to achieve treatment plan goals and objectives.
- Supervising the performance of the specialized therapeutic foster care parent(s).
- Working with the community-based care lead agency or the Department of Juvenile Justice counselor to coordinate other treatment initiatives, including school performance, permanency, and reunification planning.
- Preparing and training the recipient's biological or legal parents to resume care of the recipient when reunification is the goal.
- Working with the recipient's targeted case manager, if one has been assigned.
- Conducting home visits at least once weekly for recipients in Level I and at least twice weekly for recipients in Level II or crisis intervention services.
- Conducting regularly scheduled face-to-face meetings with the specialized therapeutic foster parents in order to monitor the recipient's progress and discuss treatment strategies and services.
- Conducting monthly visits to other community settings to observe the recipient's behavioral, psychological, and psychosocial progress and to coordinate treatment intervention.

Caseload of Primary Clinicians

The maximum caseload for full-time (40-hour employment week) primary clinicians can be less than, but must not exceed:

- Level I—eight recipients receiving specialized therapeutic foster care.
- Level II—six recipients receiving specialized therapeutic foster care.
- Crisis intervention—six recipients receiving specialized therapeutic foster care.
- Combined Level I, Level II, and crisis intervention—six recipients receiving specialized therapeutic foster care.

The caseload of primary clinicians employed or under contract for 20 hours a week should not exceed the following:

- Level I—four recipients receiving specialized therapeutic foster care.
- Level II—three recipients receiving specialized therapeutic foster care.
- Crisis intervention—three recipients receiving specialized therapeutic foster care.
- Combined Level I and Level II—three recipients receiving specialized therapeutic foster care.

Treatment Plan and Treatment Plan Review Requirements

A treatment plan must be developed by the primary clinician within the following number days of admission:

- Level I—30 days
- Level II—14 days
- Crisis intervention—14 days

A psychiatrist assigned to the program must interview the recipient and conduct a formal treatment plan review when significant changes occur or as follows from the date of authorization of the recipient's initial treatment plan:

- Level I—on a quarterly basis
- Level II—on a monthly basis
- Crisis intervention—on a monthly basis

Treatment Plan and Treatment Plan Review Signature Exceptions

If the recipient's age or clinical condition precludes participation in the development and signing of the treatment plan, an explanation must be provided on the treatment plan.

There are exceptions to the requirement for a signature by the recipient's parent, guardian, or legal custodian. Documentation and justification of the exception must be provided in the recipient's clinical record. The following exceptions are:

- As allowed by section 397.601(4)(a),(b), F.S., recipients under the age of 18 years seeking substance abuse services from a licensed service provider. Recipients ages 13 years and older, experiencing an emotional crisis in accordance with section 394.4784(1),(2), F.S.
- Recipients in the custody of the Department of Juvenile Justice who have been court ordered into treatment or require emergency treatment such that delay in providing treatment would endanger the mental or physical well-being of the recipient. The signature of the parent, guardian, or legal custodian must be obtained as soon as possible after emergency treatment is administered.

For recipients in the care and custody of the DCF (foster care or shelter status), the child's DCF or Community Based Care (CBC) caseworker must sign the treatment plan if it is not possible to obtain the parent's signature. The caseworker and foster parent should be encouraged to participate in the treatment planning. In cases in which the DCF is working toward reunification, the parent should be involved and must sign the treatment plan.

Service Specific Documentation Requirements

Documentation must include a minimum of a weekly summary progress note, completed and signed by the primary clinician, which addresses each service provided.

The summary progress note shall be co-signed by the specialized therapeutic foster parent(s).

Therapeutic Group Care Services

Introduction

Therapeutic group care services are community-based, psychiatric residential treatment services designed for recipients under the age of 21 years with moderate to severe emotional disturbances. They are provided in a licensed residential group home setting serving no more than 12 recipients under the age of 21 years.

Therapeutic group care services are intended to support, promote, and enhance competency and participation in normal age-appropriate activities of recipients who present moderate to severe psychiatric, emotional, or behavior management problems related to a psychiatric diagnosis. Programming and interventions are highly individualized and tailored to the age and diagnosis of the recipient. Therapeutic group care is intended to provide a high degree of structure, support, supervision, and clinical intervention in a home-like setting.

Therapeutic group care services are a component within Florida Medicaid's behavioral health system of care for recipients under the age of 21 years. They are appropriate for recipients under the age of 21 years who are ready to transition from a more restrictive residential treatment program or for those who require more intensive community-based treatment to avoid placement in a more restrictive residential treatment setting.

The recipient's primary diagnosis and level of functioning are the reasons for treatment and the focus of the interventions and services provided. Generally, these services include psychiatric and therapy services, therapeutic supervision, and the teaching of problem solving skills, behavior strategies, normalization activities, and other treatment modalities, as authorized in the treatment plan.

Therapeutic Group Care Services, continued

Covered Services

The following services must be provided in accordance with Chapter 65E-9, F.A.C:

- Thorough psychiatric, psychological, substance abuse and bio-psychosocial assessments, including assessment of the recipient's strengths and needs, including the strengths and needs of involved family members and other natural supports.
- Assignment of each recipient to a primary clinician who is responsible for the overall coordination and monitoring of the recipient's treatment.
- Provision of individualized, face-to-face therapeutic contact for each recipient with the primary clinician twice weekly, with more frequent contacts per week as indicated by the recipient's needs.
- Individual and group therapy by the primary clinician, as prescribed in the treatment plan.
- Family therapy with the primary clinician, or contact with the recipient's guardian, at least weekly, based on the recipient's treatment needs and permanency plan. Documentation of the circumstances must be provided in the recipient's record whenever this contact has not occurred.
- Provision of substance abuse prevention, assessment, and treatment services whenever indicated.
- Provision of social and rehabilitative services when indicated and prescribed in the recipient's individualized treatment plan.
- Supportive and psycho-educational services that promote increased capacity for independent living for older recipients.
- Behavioral programming that is individually designed and implemented and includes structured interventions and contingencies to support the development of adaptive, pro-social interpersonal behavior.
- Coordination of care that includes linkages with the schools, primary medical care, and community services for recipients.

Caseload of Primary Clinicians

The primary clinician's maximum caseload must not exceed 12 recipients. This caseload requirement is based on a 40-hour work week.

Who Can Receive

The multidisciplinary team, using the Authorization for Therapeutic Group Care Services, found in the appendices, must confirm that the recipient is appropriate for therapeutic group care placement by a licensed clinical psychologist, per section 490, F.S., or a board certified psychiatrist in compliance with section 394.4781 or 39.407, F.S., and has an emotional disturbance or serious emotional disturbance.

Therapeutic Group Care Services, continued

Re-authorization of Therapeutic Group Care Services	The designated multidisciplinary team must re-authorize therapeutic group care services no less than every six months. A new Authorization for Therapeutic Group Care Services, found in the appendices, must be completed and signed by the appropriate representative.
Treatment Plan and Treatment Plan Review Requirements	The treatment plan must be completed within 14 days of admission and a psychiatrist must interview the recipient and conduct a formal treatment plan review monthly or when significant changes occur. If the treatment plan contains an individualized behavior management component, the behavior analyst must review and sign the component. The behavior management plan must be consistent with treatment outcomes and objectives. If a parent or guardian, team member or school personnel are not at a treatment plan meeting, the record must reflect that a staff person contacted them for their input. The psychiatrist must interview each recipient monthly to assess progress toward meeting treatment goals, or more often if medically necessary.
Service Specific Documentation Requirements	In addition to a daily summary, a progress note must be completed following each service contact with a recipient.

Excluded Services

General

Medicaid does not reimburse for specialize therapeutic services for treatment of a cognitive deficit severe enough to prohibit the service from being of benefit to the recipient.

Specialized Therapeutic Services Exclusions

The following are services and supports not reimbursed under specialized therapeutic services:

- Services provided to a recipient on the day of admission into the Statewide Inpatient Psychiatric Program (SIPP). However, community behavioral health services are reimbursable on the day of discharge.
- Case management services.
- Partial hospitalization.
- Services rendered to individuals residing in an institution for mental diseases.
- Services rendered to institutionalized individuals, as defined in 42 CFR 435.1009.
- Room and board expenditures.
- Basic childcare programs for developmental delays, preschool, or enrichment programs.
- Education services.
- Travel time.
- Activities performed to maintain and review records for facility utilization, continuous quality improvement, recipient eligibility status processing, and staff training purposes.
- Activities (other than record reviews, services with family member or other interested persons that benefit the recipient, or services performed using telemedicine) that are not performed face-to-face with the recipient, except those defined below.
- Services rendered by a recipient's relative.
- Services rendered by unpaid interns or volunteers.
- Services paid for by another funding source.
- Escorting or transporting a recipient to and from a service site.

CHAPTER 3
REIMBURSEMENT AND FEE SCHEDULE

Overview

Introduction

This chapter describes reimbursement and fee schedule information for specialized therapeutic services.

In This Chapter

This chapter contains:

TOPIC	PAGE
Overview	3-1
Reimbursement Information	3-1
How to Read the Fee Schedule	3-6

Reimbursement Information

Procedure Codes

The procedure codes and fee schedule listed in the appendices are Healthcare Common Procedure Coding System (HCPCS) Level II, which is a part of a nationally standardized code set. Level II of the HCPCS is a standardized coding system used primarily to identify products, supplies, and services not included in the CPT codes. HCPCS Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter (A-V) followed by four numeric digits. Please refer to the current HCPCS Level II Expert code book for complete descriptions of the standard codes. The HCPCS Level II Expert© code book is copyrighted by Ingenix, Inc. All rights reserved.

Provider Agency Staff Linked to a Community Behavioral Health Group

The following provider agency staff must be reimbursed through the community behavioral health group (provider type 05) Medicaid number:

- Treating physician
- Psychiatric advanced registered nurse practitioner
- Psychiatric physician assistant
- Licensed practitioner of the healing arts

Telemedicine

Services must be delivered from a facility that is enrolled in Medicaid as a community behavioral health services provider for Medicaid to reimburse for services delivered through telemedicine.

Units of Service

A unit of service is the number of times a procedure is performed. The definition of unit varies by service.

For services defined in 15-minute increments, the total units of service for the day must be entered on the claim form. If multiple units are provided on the same day, the actual time spent must be totaled. If the minutes total ends in a 7 or less, round down to the nearest 15-minute increment. If the minutes total ends in 8 or more, round up to the nearest 15-minute increment. For example, 37 minutes is billed as two units of service while, 38 minutes is billed as three units of services. The provider may not round up each service episode to the nearest 15-minute increment before summing the total.

Note: For more information on entering units of service on the claim, see the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

Community Behavioral Health Services that can be Reimbursed in Conjunction with Specialized Therapeutic Foster Care Services

Medicaid can reimburse the following services in addition to specialized therapeutic foster care services only when provided as part of a public school program or summer activities program. These services cannot be reimbursed when provided in the recipient's foster home.

Service	Procedure Code	Modifier (if required)
Therapeutic behavioral on-site services—therapy	H2019	HO
Therapeutic behavioral on-site services—behavior management	H2019	HM
Therapeutic behavioral on-site services—therapeutic support services	H2019	HN
Behavioral health day services—mental health	H2012	
Behavioral health day services—substance abuse	H2012	HF

Medicaid can reimburse medical or psychiatric services only when the treatment plan requires services by a psychiatrist more than once per month.

Reimbursement Information, continued

Specialized Therapeutic Foster Care Service Reimbursement for Therapeutic Home Assignments	Medicaid can reimburse up to 10 therapeutic home assignments, per calendar quarter (three months). During the last three months prior to a planned discharge to a recipient's biological family or other permanent placement, Medicaid will reimburse for a graduated number of therapeutic visits. Three months prior to discharge, Medicaid will reimburse up to a total of five therapeutic visits in the month to the discharge placement setting. Two months prior to discharge, Medicaid will reimburse for up to a total of eight therapeutic visits in the month to the discharge placement setting. In the final month prior to discharge, Medicaid will reimburse for up to a total of 12 therapeutic visits to the discharge placement setting. The schedule for graduated therapeutic visits with the biological family or other permanent placement setting must be prior approved by the multidisciplinary team and included in the recipient's clinical record. The specialized therapeutic foster parents will maintain contact with the recipient and the receiving placement as determined by the recipient's treatment team. No other child may be placed in the bed of a recipient who is away on therapeutic home assignment.
Specialized Therapeutic Foster Care Service Reimbursement for Hospital and Crisis Stabilization Unit Placements	Medicaid can reimburse for specialized therapeutic foster care services during a hospitalization or other crisis placement of no more than 14 days duration per hospitalization. Specialized therapeutic foster care services will be reimbursed during not more than a total of four hospitalizations or crisis stabilization unit placements per specialized therapeutic foster home placement. Specialized therapeutic foster parents must be accessible and must maintain a level of communication during such placements as determined by the clinical staff person. If a recipient experiences more than one crisis placement within a six-month period, the recipient's multidisciplinary team must convene and reassess the recipient's plan to ensure that the plan is meeting the recipient's needs.

Reimbursement Information, continued

Specialized Therapeutic Foster Care Service Reimbursement for Trips

Specialized therapeutic foster care services can take place during trips when special arrangements have been pre-approved in writing by the multidisciplinary team. Arrangements must be made in advance for contact with the recipient's primary clinician during trips. Every effort must be made prior to any trips to schedule the clinician's home visits. If this is not possible, the clinician must make telephone contact during the trip. The cost of the phone calls is the responsibility of the provider agency. Documentation of any special arrangement must be maintained in the recipient's clinical record.

Specialized Therapeutic Foster Care Unauthorized Absences

Medicaid can reimburse for up to three days during times when a placement is being maintained for a recipient who has an unauthorized absence (i.e., runs away) from specialized therapeutic foster care.

Community Behavioral Health and Target Case Management Services that May Be Reimbursed in Conjunction with Therapeutic Group Care Services

Recipients receiving therapeutic group care services in community-based group homes of fewer than 16 beds retain their Medicaid eligibility for other medical and dental benefits under the Medicaid program.

Targeted case management reimbursement is limited to eight hours of billable services per month for recipients placed in therapeutic group care services.

Service	Procedure Code	Modifier (if required)
Comprehensive behavioral health assessment*	H0031	HA
Medication administration	T1015	
Review of records	H2000	
Brief behavioral health status examination**	H2010	HO
Brief individual psychotherapy—mental health	H2010	HE
Brief individual psychotherapy—substance abuse	H2010	HF
Psychological testing	H2019	
Psychiatric evaluation by a medical doctor or doctor of osteopathic medicine	H2000	HP
Psychiatric evaluation by a psychiatric ARNP or psychiatric PA	H2000	HO

* If not previously provided and if indicated during an admission to therapeutic group care services.

** If needed more than once a month, as documented in the clinical record.

Community Behavioral Health and Target Case Management Services that May Be Reimbursed in Conjunction with Therapeutic Group Care Services, continued

Medicaid can reimburse the following services in addition to therapeutic group care services only when provided as part of a Medicaid approved school program or summer activities program. These services cannot be reimbursed when provided in the recipient's group home.

Service	Procedure Code	Modifier (if required)
Therapeutic behavioral on-site services—master's degree level	H2019	HO
Therapeutic behavioral on-site services—behavior management	H2019	HN
Therapeutic behavioral on-site services—therapeutic support	H2019	HM
Behavioral health day services—mental health	H2012	
Behavioral health day services—substance abuse	H2012	HF
Psychosocial rehabilitative services	H2017	

Reimbursement for Therapeutic Home Assignments

Medicaid will reimburse the therapeutic group care provider for up to 10 therapeutic home assignments per calendar quarter, increasing up to 21 days during the last quarter prior to discharge as described below.

During the last three months prior to a planned discharge to a recipient's biological family or other placement, Medicaid will reimburse the therapeutic group care provider for a graduated number of therapeutic home assignments. Three months prior to discharge, Medicaid will reimburse up to a total of five therapeutic home assignments to the discharge placement setting. During the second to the last month and the last month of a recipient's stay, Medicaid will reimburse for up to a total of eight therapeutic home assignments per month to the recipient's discharge placement setting.

The schedule for graduated therapeutic home assignments with the biological family or other placement setting must be prior approved by the recipient's treatment team and included in the recipient's clinical record. The therapeutic group care staff will maintain contact with the recipient and the receiving placement as determined by the recipient's treatment team. No other recipient may be placed in the bed of a recipient who is away on therapeutic home assignments.

How to Read the Fee Schedule

Introduction	Procedure codes allowed for specialized therapeutic services are listed in the Procedures Codes and Fee Schedule in the appendices. The Procedures Codes and Fee Schedule includes the following information: • Description of covered service • Covered procedure code • Modifiers • Maximum fee per code • Reimbursement and service limitations
Description of Service	Describes the service to be reimbursed.
Procedure Code	The code in the Procedure Codes and Fee Schedule, found in the appendices, that corresponds to specialized therapeutic services.
Modifier	For certain types of services, a two-digit modifier must be entered on the claim form. Modifiers more fully describe the procedure performed so that accurate payment may be determined.
Maximum Fee	Maximum amount that Medicaid will reimburse for the procedure code, per unit of service.
Reimbursement and Service Limitations	Reimbursement and service limitations that pertain to the specific procedure code. Service limits are per recipient, per state fiscal year (July 1 through June 30). Medicaid will not reimburse for the same procedure code twice in one day.

APPENDIX A

PROCEDURE CODES AND FEE SCHEDULE

PROCEDURE CODES AND FEE SCHEDULE					
These procedure codes are to be used for dates of service April 1, 2014 and after.					
Description of Service	**Procedure Code**	**Modifier 1**	**Modifier 2**	**Maximum Fee**	**Reimbursement and Service Limitations**
Comprehensive Behavioral Health Assessment	H0031	HA		$12.12 per quarter hour	The comprehensive behavioral health assessment may be reimbursed only once per state fiscal year (July 1 through June 30) per recipient. Reimbursement is limited to a total of 20 hours per recipient per fiscal year. The assessment is reimbursed on the date that the report is completed. The date of referral may be used as the date of service if the recipient entered the Statewide Inpatient Psychiatric Program or if the recipient loses Medicaid eligibility prior to completion of the assessment.
Specialized Therapeutic Foster Care, Level I	S5145			$87.30 per day	Medicaid will not reimburse a provider for days when a recipient is in a Juvenile Justice detention center. The community behavioral health services psychosocial rehabilitation and clubhouse will not be reimbursed as a separate service by Medicaid for recipients receiving specialized therapeutic foster care services.
Specialized Therapeutic Foster Care, Level II	S5145	HE		$135.80 per day	
Specialized Therapeutic Foster Care, Crisis Intervention	S5145	HK		$135.80 per day	

Description of Service	Procedure Code	Modifier 1	Modifier 2	Maximum Fee	Reimbursement and Service Limitations
Therapeutic Group Care Services	H0019			$180.00 per day	Medicaid will not reimburse for therapeutic group care services when a recipient is in a Department of Juvenile Justice detention center placement. A provider may not be reimbursed for therapeutic group home services or any other community behavioral health service if the provider has been paid for the provision of the same service or type of service by another purchasing entity.

APPENDIX B

AUTHORIZATION FOR
COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT

AUTHORIZATION FOR
COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT

This is to certify that:

Recipient's Name _____ Date _____

Medicaid Number _____

has been screened and determined to be in need of a comprehensive behavioral health assessment as outlined in the Florida Medicaid Specialized Therapeutic Services Coverage and Limitations Handbook. The comprehensive behavioral health assessment will be provided by:

_____ (provider)

_____ _____
Community Based Care Representative Date

OR

_____ _____
Managed Care Plan Representative (or designee) Date

OR

_____ _____
Department of Juvenile Justice Representative (or designee) Date

AUTHORIZATION FOR COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT FOR CHILD IN SHELTER

This is to certify that:

Recipient's Name _____ Date of Referral _____

Medicaid Number _____ Shelter Name _____

Shelter Address _____

has been screened and determined to be in need of a comprehensive behavioral health assessment as outlined in the Florida Medicaid Specialized Therapeutic Services Coverage and Limitations Handbook. The comprehensive behavioral health assessment will be provided by:

_____ (provider)

_____ _____
Department of Children and Families (or designee) Date

To be placed in recipient's clinical record.

AHCA Form 5000-3511, Revised March 2014 (incorporated by reference in Rule 59G-4.295, F.A.C.)

APPENDIX C

COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT AGENCY AND PRACTITIONER SELF-CERTIFICATION

COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT AGENCY AND PRACTITIONER SELF-CERTIFICATION

This is to certify that:

Name: _____

Address: _____

_____

_____

Phone Number: ( ) _____

Agency Medicaid Number: _____ (if enrolled)

Practitioner Medicaid Number: _____ (if enrolled)

meets the qualifications to be a provider of comprehensive behavioral health assessment by providing documentation to the Medicaid area office staff who have verified that the agency or practitioner has met the qualifications as outlined in the Florida Medicaid Specialized Therapeutic Services Coverage and Limitations Handbook.

Begin date: _____ End date: _____

_____ _____

Provider Agency Representative Date

To complete the initial Medicaid provider enrollment process, submit this form with your Florida Medicaid Provider Enrollment Application to the address listed below.

Florida Medicaid Provider Enrollment
P.O. Box 7070
Tallahassee, Florida 32314-7070

AHCA Form 5000-3512, Revised March 2014 (incorporated by reference in Rule 59G-4.295, F.A.C.)

APPENDIX D

SPECIALIZED THERAPEUTIC FOSTER CARE PROVIDER AGENCY SELF-CERTIFICATION

SPECIALIZED THERAPEUTIC FOSTER CARE
PROVIDER AGENCY SELF-CERTIFICATION

This is to certify that:

Agency Name: _____

Address: _____

_____

Phone Number: (__)_____ Agency Medicaid No.: _____ (if enrolled)

meets the criteria for certification as a provider of specialized therapeutic foster care as outlined in the Florida Medicaid Specialized Therapeutic Services Coverage and Limitations Handbook.

_____ _____
Provider Agency Representative Date

Submit this form with your Florida Medicaid Provider Enrollment Application to the address listed below.

Florida Medicaid Provider Enrollment
P.O. Box 7070
Tallahassee, Florida 32314-7070

AHCA Form 5000-3513, Revised March 2014 (incorporated by reference in Rule 59G-4.295, F.A.C.)

APPENDIX E

AUTHORIZATION FOR
SPECIALIZED THERAPEUTIC FOSTER CARE

AUTHORIZATION FOR
SPECIALIZED THERAPEUTIC FOSTER CARE

This is to certify that:

Recipient's Name: _____ Date: _____

Medicaid Number: _____

has been screened and recommended by a multidisciplinary team for specialized therapeutic foster care and has been determined to require the following level of service:

_____ Level I Specialized Therapeutic Foster Care

_____ Level II Specialized Therapeutic Foster Care

These services are to be provided by: _____ (provider agency), as authorized by:

The recipient is eligible for Specialized Therapeutic Foster Care as follows:

____ The recipient meets eligibility criteria for service.

____ Multidisciplinary team has determined the child is in need of the service.

_____ _____
Medicaid Area Office Representative (or designee) Date

Services will be reviewed and reauthorized by the multidisciplinary team prior to: _____
Date

Refer to policy in the Florida Medicaid Specialized Therapeutic Services Coverage and Limitations Handbook for instructions on what must be completed for the specific service.

To be placed in recipient's clinical record. Medicaid reimbursement covers only dates of service authorized on this form.

AHCA Form 5000-3514, Revised March 2014 (incorporated by reference in Rule 59G-4.295, F.A.C.)

APPENDIX F

AUTHORIZATION FOR CRISIS INTERVENTION

AUTHORIZATION FOR CRISIS INTERVENTION

This is to certify that:

Recipient's Name _____ Date _____

Medicaid Number _____

has been screened and recommended for Crisis Intervention by the multidisciplinary team.

This service will be provided by: _____ (provider agency) as authorized by:

The recipient is eligible for Specialized Therapeutic Foster Care as follows:

____ The recipient meets eligibility criteria for service.

____ Multidisciplinary team has determined the child is in need of the service.

_____ _____
Medicaid Area Office Representative (or designee) Date

Services will be authorized by the multidisciplinary team from: _____
Date

Services must be reviewed and reauthorized by the multidisciplinary team prior to _____
Date

Refer to policy in the Florida Medicaid Specialized Therapeutic Services Coverage and Limitations Handbook for instructions on what must be completed for the specific service.

To be placed in recipient's clinical record. Medicaid reimbursement will cover certified dates, only.

AHCA Form 5000-3515, Revised March 2014 (incorporated by reference in Rule 59G-4.295, F.A.C.)

APPENDIX G

PROVIDER AGENCY ACKNOWLEDGEMENT FOR THERAPEUTIC GROUP CARE SERVICES

PROVIDER AGENCY ACKNOWLEDGEMENT FOR THERAPEUTIC GROUP CARE SERVICES

Provider Agency Name: _____ Medicaid No.: _____

Provider Agency Address: _____

City: _____ Zip Code: _____ Phone No.: ( ) _____

County: _____ Circuit: _____ Area: _____

Name and Address of Site: _____

_____

_____ Zip Code: _____

I certify that the above named site has met the criteria for therapeutic group care services certification and is in compliance with Medicaid policies and procedures as put forth in the Florida Medicaid Specialized Therapeutic Services Coverage and Limitations Handbook and with the specific standards for therapeutic group care services. I further certify that statements made in this document are accurate and correct to the best of my knowledge.

Executive Director's Signature: _____ Date: _____

Executive Director's Name (please print): _____

Send original form to AHCA, Medicaid Services, Long Term Care and Behavioral Health Unit, 2727 Mahan Drive, MS 20, Tallahassee, FL 32308.

Provider should maintain a copy.

AHCA Form 5000-3519, Revised March 2014 (incorporated by reference in Rule 59G-4.295, F.A.C.)

APPENDIX H

AUTHORIZATION FOR THERAPEUTIC GROUP CARE SERVICES

AUTHORIZATION FOR
THERAPEUTIC GROUP CARE SERVICES

This is to certify that:

Recipient's Name: _____ Date: _____

Medicaid Number: _____ Date of Birth: _____

has been determined by a multidisciplinary team as appropriate for therapeutic group care placement by a licensed clinical psychologist, per section 490, F.S., or a board certified psychiatrist in compliance with section 394.4781 or 39.407, F.S., and has an emotional disturbance or serious emotional disturbance.

These services are to be provided by: _____

_____ _____
Medicaid Area Office Representative (or designee) Date

Services will be reviewed and reauthorized by the multidisciplinary team prior to this date: _____

This form must be placed in recipient's clinical record. Medicaid will reimburse services only for the dates of service authorized on this form.

AHCA Form 5000-3521, Revised March 2014 (incorporated by reference in Rule 59G-4.295, F.A.C.)