TITLE	POLICY NUMBER	
Criteria for High Needs Foster Care	DCS 19-01	
RESPONSIBLE AREA	EFFECTIVE DATE	REVISION
Placement Administration	May 5, 2021	3

I. POLICY STATEMENT

In accordance with 42 U.S.C. § 675(5), the Department of Child Safety (DCS) is committed to the least restrictive and most supportive environment for youth whose needs cannot be met safely and effectively at home. Some youth may benefit from High Needs Foster Care (HNFC) even if their clinical presentations do not meet the requirements for Medicaid funding. To ensure quality, the Department shall conduct regular reviews of HNFC, including but not limited to the efficacy of treatment services, bed capacity, lengths of stay, licensing requirements, training standards, alignment with Arizona's 12 principles, and other factors.

II. APPLICABILITY

HNFC is intended to provide youth with the care they need. This policy applies to providing HNFC when a youth has not met the clinical threshold for Medicaid-funded therapeutic foster care.

III. AUTHORITY

ACCCHS Policy 320-W	Therapeutic Foster Care for Children
A.A.C. R21-6-331 (E) 3	Requirements for Certification to Provide Specialized Services
A.R.S. § 8-514	Placement in foster homes
DCS Program Policy Chapter 4, Section 5	Selecting an Out-of-Home Care Provider

DCS Program Policy Chapter 4, Section 6 Placing Children in Out-of-Home Care

IV. DEFINITIONS

Assessment: An analysis of a youth's need for behavioral health services to determine which services a health care institution shall provide to the patient as specified in A.A.C. R9-10-101.

Caregiver: An adult who is providing for the physical, emotional, and social needs of a child who is under the care, custody and control of the Department. Examples of caregivers can include birth parent(s), foster parent(s), adoptive parent(s), kin or relative(s), group home staff. Caregivers may be licensed or unlicensed.

Child and Family Team (CFT): A defined group of individuals that includes, at a minimum, the child and their family, a behavioral health representative, and any individuals important in the child's life that are identified and invited to participate by the child and family.

DCS Comprehensive Health Plan System of Care (CHP SOC) Team: Formerly known as Behavioral Health Clinical Coordinators, the team provides navigation, accountability, support, and technical assistance to DCS Specialists and the CFT process.

Department or DCS: The Arizona Department of Child Safety.

Health Plan: An organization or entity that provides health care services to members either directly or through subcontracts with providers, in conformance with contractual requirements and State and Federal law, rule, regulations, and policies.

High Needs Foster Care (HNFC): A family-based placement option in which care is provided by a licensed foster parent who has received specialized training within a support system of clinical and consultative services to children with serious behavioral or emotional needs. This term is often used synonymously with Therapeutic Foster Care.

High Needs Foster Care (TFC) Coordinator: A DCS employee located within Placement Administration who manages the assignment of living arrangements for children who require HNFC.

Medicaid: A Federal/State program authorized by Title XIX of the Social Security Act, as amended.

Medically necessary: A covered service provided by a physician or other licensed practitioner of the healing arts within the scope of practice under State law to prevent disease, disability or other adverse conditions or their progression, or to prolong life (A.A.C. R9- 22-101).

Notice of Adverse Determination: The denial or limited authorization of a service request, or the reduction, suspension, or termination of a previously authorized service.

Placement/Living Arrangement: A domicile that may include a parent's home, foster home, significant person's home, adoptive home, child care agency, institution, hospital, or medical facility.

Qualified Residential Treatment Program (QRTP): An accredited, non-foster family setting for which DCS can seek federal reimbursement under Title IV-E. It must be licensed as a child care institution in accordance with section 471(a) (10) of the Social Security Act. It must meet certain criteria such as having a trauma-informed treatment model and facilitating participation of family members in the child's treatment program.

Therapeutic Foster Care (TFC): Often used synonymously with High Needs Foster Care (see definition above), this is the term applied to Medicaid-funded care, whereas High Needs Foster Care, for the purposes of this policy, applies to DCS-funded care.

Therapeutic Foster Care (TFC) Agency Provider: The provider contracted by DCS and credentialed by a managed care organization to oversee professional TFC Family Providers who provide TFC services to children.

Therapeutic Foster Care (TFC) Family Providers: Specially trained adults in a family unit licensed by DCS and endorsed to provide TFC services to children. They are also known as TFC parents or caregivers.

Therapeutic Foster Care Licensing Specialist: An employee of a TFC Agency Provider who oversees licensed individuals who provide TFC services to children. Job duties include preparing home studies, overseeing applications, making placements, and monitoring homes for compliance.

V. POLICY

A. Placement in High Needs Foster Care

DCS shall place youth in the most appropriate, least restrictive setting consistent with their best interests, the permanency plan, placement policy procedures and the recommendations of the Child and Family Team (CFT). For youth who meet HNFC criteria, such placement shall occur before placement in a congregate care setting is considered.

HNFC shall, to the extent appropriate and in accordance with the youth's wishes, facilitate family participation in the youth's permanency plan by contacting family members (including siblings, known biological family, and fictive kin) and integrating them into the plan.

B. Criteria for High Needs Foster Care

DCS (through the Placement Administration) may place a youth in HNFC in the following circumstances while utilizing the procedures outlined in Section VI:

1. prior to any determination of medical necessity for purposes of Medicaid reimbursement when therapeutic foster care is best-suited to meet the youth's needs;

2. when a Notice of Adverse Determination (NOA) has been received from the Medicaid health plan in response to a request for Medicaid to fund the TFC, and the TFC home remains the best-suited living arrangement to meet the youth's needs/high needs.

DCS may also place a youth in HNFC pursuant to a court order.

Furthermore, if it is in the youth's best interest and consistent with the placement policies/procedures and/or permanency plan, a youth may remain in a HNFC home without a determination of medical necessity by the Medicaid health plan.

C. Continuous Review Process

The HNFC Coordinator shall conduct a review of each youth in HNFC every 90 days to ensure progress and determine when and if a youth is ready to step down to a lower level of care. The review shall address the following questions:

1. Is the youth connected to, and regularly attending, behavioral health services?

    a. Is the youth engaged in the services?

    b. Are there alternative services that could benefit the youth?

    c. Is there an active CFT meeting on a regular monthly cadence?

2. How is the youth progressing educationally?

    a. Does the youth require an IEP or other educational assistance not currently in place?

    b. Is the youth participating in any extracurricular activities?

3. Has there been a decrease in negative behaviors and/or incident reports?

4. Has there been an increase in pro-social skills?

5. What is the youth's connection to family or kin?

    a. Is there a regular visitation schedule with parents, siblings, or kin?

    b. How is the youth before and after visits?

6. What is the current case plan, and is it likely to change in the next 90 days?

7. What is the transition plan? If the case plan is reunification, what is the time frame to return to parent?

8. Are there any factors upcoming in the near future that may affect the youth's stability (e.g., ICPC placement, visitation with a sibling or parent the youth has not seen in an extended period of time, goodbye visit with a parent, etc.)?

D. Quality Oversight of Youth Receiving High Needs Foster Care Services

Agency Providers shall provide education, coaching and other necessary training to HNFC Family Providers to ensure that they are able to adequately meet the needs of the youth placed into their care, and support the youth's transition to permanency.

The Office of Licensing and Regulation (OLR) shall ensure TFC certification standards and supports for HNFC Family Providers.

Procurement and Contracts shall conduct fidelity monitoring of TFC Agency Providers.

HNFC Coordinators and, if applicable, a CHP SOC Coordinator who is assigned to or already working with the youth, shall participate in continuous reviews of youth in HNFC. The HNFC Coordinator will document the review and forward that documentation to the assigned DCS Specialist.

E. Payment Structure

The payment structure for HNFC and TFC is outlined in the Child Placement Rates and Special Allowances Approval Matrix (CSO-1109A) and referenced in the *Foster Care Rates, Allowances, and Payments* (Chapter 4; Section 10) policy.

VI. PROCEDURES

A. Criteria for High Needs Foster Care

If a Placement Coordinator at the Placement Administration, a DCS Specialist, or a CHP SOC Coordinator believes that a youth may benefit from HNFC, they shall discuss the matter with the CFT. If the CFT decides that the clinical threshold for Medicaid-funded TFC is not met (e.g., the CFT does not believe that an official request should be submitted to the health plan, or the health plan has issued an NOA), then the following criteria shall be considered for DCS to fund HNFC:

1. a youth who requires the services provided by HNFC due to the severity of the abuse or neglect;

2. a youth whose injuries require emergency services or hospitalization, including but not limited to:

a. fractures;

b. head or facial injuries;

c. burns (immersion, cigarette, or other unexplained burns);

d. extensive bruising;

e. sexual abuse.

3. a youth who has witnessed the death of a parent, sibling, or guardian due to domestic violence;

4. a youth who has disrupted from a TFC Family Provider in the last year (including risk of disrupting from current caregiver), and whose behavior is not reasonably expected to improve while continuing to reside in a traditional foster home, group home, or shelter placement. The reasons for the disruption include but are not limited to:

a. continuous running away behavior;

b. physical or verbal aggression;

c. harm to animals;

d. prior history of frequent hospitalizations, and a recent clinical assessment finding that the youth does not need a higher level of care such as inpatient stabilization, BHIF, or BHRF;

e. prior history of being a danger to themselves or others, and a recent clinical assessment finding that the youth does not need a higher level of care such as inpatient stabilization, BHIF, or BHRF;

f. prior history of suicidal or homicidal ideation/behaviors, and a recent clinical assessment finding that the youth does not need a higher level of care such as inpatient stabilization, BHIF, or BHRF;

g. arrests/detention.

5. a concern expressed, during a congregate care review, that the youth has evidenced an increase in behavioral or emotional dysregulation jeopardizing the stability of the placement despite consistent behavioral health services. Additionally, the existence of the following criteria should be considered:

    a. whether the need for HNFC was addressed at the 90-day congregate care review;

    b. whether a higher level of care was denied by Mercy Care within the last 90 days;

    c. efforts to secure a family-like setting have been unsuccessful due to the youth's behavior and/or emotional needs;

    d. the CFT believes that services to maintain the child's stability with the current caregiver are in place but the youth is not showing improvement.

If no criteria are met, the youth shall remain in the current placement and the Placement Coordinator shall seek a QRTP/cohort group home, or assesses the case for a special rate at a foster home.

If any of the above-listed criteria are met, the Placement Coordinator sends a request to the Placement Administrator to seek placement in HNFC.

B. Placement Administrator Review of High Needs Foster Care Appropriateness

The Placement Administrator, or designee, reviews:

1. the services offered by the behavioral health provider;

2. the CFT's recommendation for placement/treatment, if applicable;

3. previous placements and time in placement;

4. the youth's concerns/needs that preclude placement in a standard foster home;

5. incident reports;

6. the transitional/case plan;

7. whether it is in child's best interest to be placed in a family-like setting.

If the Placement Administrator, or designee, determines that a HNFC recommendation is *not* required for the youth to stabilize, the case will be referred back to the Placement Coordinator, who will seek a QRTP/cohort group home or assess the case for a special rate at a foster home. If the Placement Administrator, or designee, determines that HNFC placement is warranted, a referral will be sent to the HNFC Coordinator.

C. HNFC Coordinator Duties

The HNFC Coordinator receives a referral from the Placement Administrator, or designee, to locate a HNFC home and shall:

1. gather information from resources including DCS database, caregiver, hospital, behavioral health case manager, CFT, DCS Specialist, etc.;

2. determine the status of any out-of-home packet, depending on the urgency of the placement;

3. staff the case with the DCS Supervisor, DCS Specialist, and, if necessary, the CHP SOC (Comprehensive Health Plan System of Care) Team;

4. if applicable, connect with the High Needs Case Manager to acquire additional information;

5. contact the TFC Licensing Specialist and/or agency to locate a HNFC Family Provider;

6. once a HNFC Family Provider is identified, contact the TFC Licensing Worker or agency Match Specialist to determine if the youth and the caregiver are a good match (this process will continue until a good match has been identified;

7. conduct a professional staffing with the TFC Licensing Worker, HNFC Family Provider, CFT, behavioral health providers, and DCS Specialist

and Supervisor to discuss the youth's strengths, needs, services, goals, etc.;

8. conduct a staffing with the Placement Administrator regarding the HNFC setting that has been identified;

9. coordinate a "meet and greet" and transitional visits if the TFC Licensing Worker and caregiver decide to proceed; if applicable, request the CFT convene to discuss whether a formal request for Medicaid TFC funding should be submitted to Mercy Care DCS CHP;

10. if applicable, convenes a CFT to ensure that the formal prior authorization request for TFC is submitted to the health plan if the youth meets medical necessity per the AHCCCS Policy 320 W;

11. complete the placement service approval;

12. update the placement service approval when TFC funding is approved;

13. complete the tracking log;

14. attend ongoing CFTs to ensure appropriate service provisions are implemented and provide HNFC support;

15. continue to monitor every 90 days throughout duration of youth's HNFC placement to assist with stepping down once the team has determined that HNFC level of care is no longer needed.

D. Transition from High Needs Foster Care: Exit and Permanency Options

1. When a child is ready to be discharged from HNFC, the DCS Specialist will send a referral and supporting information via email to the appropriate centralized Placement Unit. The referral will be sent as soon as a discharge date has been determined.

2. If the youth is hospitalized and the previous caregiver is not willing or able to be the youth's caregiver upon discharge, the DCS Specialist will send a referral and supporting information to the appropriate centralized Placement Unit on the day the youth is admitted to the hospital.

3. The “supporting information” referenced in this section includes:

    a. location and caregiving agency;

    b. identified mental or behavioral health needs and related services;

    c. psychiatric evaluation (if applicable);

    d. psychological evaluation (if applicable);

    e. identified medical needs and related services;

    f. Individual Education Plan (if applicable);

    g. criminal charges (if applicable);

    h. terms of probation or parole (if applicable);

    i. special considerations or restrictions (such as maintaining proximity to parents, siblings, or supportive people; enrollment in the same school; or continuity of specialized care with specialty behavioral health or medical providers that may be unavailable elsewhere).

4. The following factors shall be considered in discharge planning:

    a. improvement of the youth’s functional capacity resulting in a need for less restrictive care;

    b. the youth has demonstrated the ability to participate in needed monitoring and follow-up services, or a caregiver is available to provide monitoring in a less restrictive level of care;

    c. the availability of appropriate services, providers, and supports to meet the youth’s needs at a less restrictive level of care;

    d. a current clinical assessment of the youth’s symptoms, behaviors, and treatment needs has been reviewed by the CFT and has established that continued care in a HNFC is setting no longer adequate to provide for the safety and treatment. The CFT will

then discuss if a higher level of care is necessary.

In the event that the youth has to move to a higher level of care, the HNFC Family Provider and TFC Agency Provider, in collaboration with the CFT, shall work to make this transition as seamless as possible.

VII. FORMS INDEX

N/A