MEDI-CAL MANUAL
For Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries

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If you have questions regarding obtaining ICC, IHBS or TFC services for an eligible child or youth, please contact your County Mental Health Plan (MHP). A list of County MHP’s toll free numbers can be located at

http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx

or contact the Mental Health Services Division, at the Department of Health Care Services at (916) 322-7445.

You may also email your questions to DHCS at: KatieA@dhcs.ca.gov
CHAPTER 1: PURPOSE AND BACKGROUND

PURPOSE

The purpose of this manual is to provide mental health plans (MHPs) and Medi-Cal providers with information regarding Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and SMHS service activities provided through the Therapeutic Foster Care service model (referred to as “TFC” hereinafter). These services and service model are available when medically necessary to correct or ameliorate defects and mental illnesses or conditions through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. This benefit is available to beneficiaries under the age of 21 who are eligible for full scope Medi-Cal. (42 U.S.C. § 1396a (a) (43) and 42 U.S.C. § 1396d (r)).

This manual sets forth the standards and guidelines for the delivery and billing of ICC, IHBS and TFC. It also serves as a supplement to other federal and State documents related to the delivery of SMHS in the State of California including, but not limited to:

- Federal Medicaid laws and regulations
- California Code of Regulations (CCR), Title 9, Division 1, Chapter 11
- California Medicaid State Plan
- California Department of Health Care Services, (DHCS) contract with the MHPs
- DHCS/CDSS Core Practice Model Guide

- DHCS Mental Health Substance Use Disorder Services (MHSUDS) Information Notices, as well as former Department of Mental Health Policy Letters and Department of Mental Health Information Notices

This manual also describes the Core Practice Model (CPM) principles that MHPs should utilize when providing ICC, IHBS, and TFC. The CPM is defined in Appendix B and in Chapter 3, and further articulated in more detail in a companion document called the Core Practice Model Guide that should be relied on for further guidance on the expectations of the model and the required elements for fidelity practice to the model.

This manual will be maintained by DHCS and reviewed and updated as needed. The most recent version of this manual can be found on the DHCS Katie A. webpage. Any questions concerning the standards and guidelines set forth in this manual should be directed to: KatieA@dhcs.ca.gov.

Please note that MHPs and providers should continue to provide other existing SMHS to children and youth, when medically necessary. ICC, IHBS and TFC provided to Medi-Cal beneficiaries should be identified using the procedure codes listed in this manual and provided based on medical necessity.
KATIE A. V. BONTÁ SETTLEMENT

As a result of the Settlement Agreement in Katie A. v. Bontá, the State of California agreed to take a series of actions that transformed the way California children and youth who are in foster care, or who are at imminent risk of foster care placement, receive access to mental health services. The settlement specifically changed the way a defined group of children and youth with the most intensive needs, referred to as “Katie A. subclass members”, are assessed for mental health services. Pursuant to the settlement, subclass members were required to be provided an array of services, and specifically medically necessary ICC, IHBS and TFC, consistent with the CPM. The Settlement Agreement had the following objectives:

a) Facilitate the provision of an array of services delivered in a coordinated, comprehensive, community-based fashion that combines service access, planning, delivery, and transition into a coherent and all-inclusive approach;

b) Support the development and delivery of a service structure and a fiscal system that supports a core practices and services model, as described in (a);

c) Support an effective and sustainable solution that will involve standards and methods to achieve quality-based oversight, along with training and education that support the practice and fiscal models;

d) Address the need for certain class members with more intensive needs (hereinafter referred to as “Subclass members”) to receive medically necessary mental health services in the child’s or youth’s own home, a family setting, or the most homelike setting appropriate to the child’s or youth’s needs, in order to facilitate reunification, and to meet the child’s or youth’s needs for safety, permanence, and well-being;

e) Utilize the CPM principles and components, including: a strong engagement with and participation of the child or youth and the family; focus on the identification of child/youth and family needs and strengths when assessing and planning services; teaming across formal and informal support systems; and use of Child and Family Teams (CFTs) to identify strengths and needs, make plans and track progress, and provide intensive home-based services;

f) Assist, support and encourage each eligible child/youth to achieve and maintain the highest possible level of health, well-being, and self-sufficiency;

g) Reduce timelines to permanency and lengths of stay within the child welfare system; and

h) Reduce reliance on congregate care.

While the Katie A. Settlement only

1 As defined in the Settlement Agreement.
concerned children and youth in foster care or at imminent risk of placement in foster care, membership in the Katie A. class or subclass is no longer a requirement for receiving medically necessary ICC, IHBS, and TFC. Therefore, a child or youth need not have an open child welfare services case to be considered for receipt of ICC, IHBS, or TFC.²

² See MHSUDS Information Notice 16-004.
CHAPTER 2: TARGET POPULATION

ICC AND IHBS

ICC and IHBS are provided through the EPSDT benefit to all children and youth who:

- Are under the age of 21;
- Are eligible for the full scope of Medi-Cal services; and
- Meet medical necessity criteria for these SMHS, as set forth in CCR, Title 9, Section 1830.205 or Section 1830.210.

Membership in the Katie A. subclass is not a prerequisite to receiving ICC and IHBS. (DHCS MHSUDS Information Notice No: 16-004.). ICC and IHBS must be provided to all children and youth who meet medical necessity criteria for those services. The MHP must make individualized determinations of need for ICC and IHBS based on each child’s or youth’s strengths and needs. As discussed below, these services are appropriate for children and youth with more intensive needs or who are in or at risk of placement in residential or hospital settings, but could be effectively served in the home and community.

Counties have an affirmative responsibility to identify, screen, and assess children and youth who may be in need of ICC and IHBS. The following criteria should be considered as indicators of need for ICC and IHBS, and are intended to be used to identify children and youth who should be assessed for whether ICC and/or IHBS are medically necessary. Thus, ICC and IHBS are very likely to be medically necessary for children and youth who meet the following criteria. These criteria are not requirements or conditions, but are provided as guidance in order to assist counties in identifying children and youth who are in need of ICC and IHBS.

ICC and IHBS are very likely to be medically necessary for children and youth who:

a) Are receiving, or being considered for Wraparound;

b) Are receiving, or being considered for a specialized care rate due to behavioral health needs;

c) Are receiving, or being considered for, other intensive SMHS, including but not limited to, therapeutic behavioral services, or crisis stabilization/intervention;

d) Are currently in, or being considered for A. subclass members over many years. It is expected that Katie A. subclass members will continue to receive ICC, and IHBS when medically necessary.
high level care institutional settings such as group homes or Short-Term Residential Therapeutic Programs (STRTPs).

e) Have been discharged within 90 days from, or currently reside in or are being considered for placement in a psychiatric hospital or 24-hour mental health treatment facility (e.g. psychiatric inpatient hospital, psychiatric health facility (PHF), community treatment facility, etc.);

f) Have experienced two or more mental health hospitalizations in the last 12 months;

g) Have experienced two or more placement changes within 24 months due to behavioral health needs;

h) Have been treated with two or more antipsychotic medications at the same time over a three-month period (Healthcare Effectiveness Data Information Set [HEDIS] Specification for Antipsychotics in Children and Adolescents [APC]);

i) If the child is zero through five years old and has more than one psychotropic medication, the child is six through 11 years old and has more than two psychotropic medications, or the child is 12 through 17 years old and has more than three psychotropic medications;

j) If the child is zero through five years old and has more than one mental health diagnosis, the child is six through 11 years old and has more than two mental health diagnoses, or the child is 12 through 17 years old and has more than three mental health diagnoses;

k) Have two or more emergency room visits in the last 6 months due to primary mental health condition or need, including, but not limited to, involuntary treatment under California Welfare and Institutions (W &I) Code section 5585.50;

l) Have been detained pursuant to W &I sections 601 and 602 primarily due to mental health needs4; or

m) Have received SMHS within the last year, and have been reported homeless within the prior six months.

ICC is intended to link beneficiaries to services provided by other child-serving systems; to facilitate teaming; and to coordinate mental health care. If a beneficiary is involved with two or more child-serving systems, MHPs should utilize ICC to facilitate cross-system communication and planning. For example, children and youth receiving SMHS who

4 This criterion does not alter the suspension of Medi-Cal eligibility for juveniles under age 21 who were Medi-Cal beneficiaries at the time they became “inmates of a public institution,” which is a term defined in state and federal law. However, youth who are physically in juvenile hall not due to criminal activity and who are awaiting placement or are there temporarily under a specific plan for care or protection are not considered to be “inmates of a public institution,” and are eligible for Medi-Cal, provided all other eligibility criteria have been met. For more information, please refer to DHCS ACWDL 12-22 and DHCS ACWDL 10-06.
also are involved with the child welfare system, special education, probation, drug and alcohol, and other health and human services agencies or legal systems should have improved outcomes from receiving ICC. These examples are illustrative, yet are not an exhaustive list of child-serving agencies that may be involved in a child or youth’s care and result in a need for ICC.

TFC Services Model

SMHS service activities delivered through the TFC service model are provided under the EPSDT benefit to all children and youth who:

- Are under the age of 21,
- Are eligible for the full scope of Medi-Cal services; and
- Meet medical necessity criteria for these specialty mental health services (SMHS) as set forth in CCR, Title 9, Section 1830.205 or Section 1830.210.

Membership in the Katie A. subclass is not a prerequisite to receiving TFC. Service activities must be delivered through the TFC service model to all children and youth who meet medical necessity criteria for utilizing this service delivery model. The MHP must make individualized determinations of need for TFC based on each child’s or youth’s strengths and needs. As discussed below, these services are appropriate for children and youth with more intensive needs or who are in or at risk of placement in residential or hospital settings, but who could be effectively served in the home and community.

Counties have an affirmative responsibility to identify, screen, and assess children and youth who may be in need of TFC.

The following are the circumstances in which TFC may be an appropriate service model to address the child’s or youth’s mental health needs. These circumstances should be considered as indicators of need for TFC and are intended to be used to identify children and youth who should be assessed to determine if TFC is medically necessary. These indicators of need are not requirements or conditions, but are provided as guidance in order to assist counties in identifying children and youth who are in need of TFC.

1. The child or youth is at risk of losing his or her placement and/or being removed from his or her home as a result of the caregiver’s inability to meet the child’s or youth’s mental health needs; and, either:

   (a) There is recent history of services and treatment (for example, ICC and IHBS) that have proven insufficient to meet the child’s or youth’s mental health needs, and the child or youth is immediately at risk of residential, inpatient, or institutional care; or

   (b) In cases when the child or youth is transitioning from a residential, inpatient, or institutional setting to a community setting, and ICC, IHBS, and other intensive SMHS will not be sufficient to prevent deterioration, stabilize the child or youth, or support effective rehabilitation.
CHAPTER 3: PRINCIPLES OF THE CORE PRACTICE MODEL (CPM)

The Core Practice Model (CPM) is a set of practices and principles that promotes a set of values shared by all who seek to support children, youth, and families involved in child-serving agencies including, but not limited to, the child welfare system, special education, probation, drug and alcohol and other health and human services agencies, or legal systems with which the child or youth is involved.

To effectively provide ICC, IHBS, and TFC, the MHP should utilize the principles of the CPM. Specifically, the services must be provided in conjunction with a Child and Family Team (CFT).

The implementation of a CPM should be used to guide the delivery of integrated and coordinated services.

The framework of the CPM is a shared set of practice principles to be used when providing SMHS to children and youth. In brief, the CPM provides a prescribed set of family-centered practice values and principles that drive a definable planning and service delivery process. The CPM values and principles are summarized as follows:

- Children and youth are first and foremost protected from abuse and neglect and maintained safely in their own homes.
- Services allow the child or youth to achieve stability and permanence in his/her home and community-based living situations.
- Services are needs-driven, strengths-based, and family-focused from the first conversation with or about the family.
- Services are individualized and tailored to the strengths and needs of each child or youth and his/her family.
- Services are delivered with multi-agency collaboration that is grounded in a strong, shared preference for community-based services and resources, and reflected in alignment of all service plans.
- Family voice, choice, and preference are assured throughout the process and can be seen in the development of formal plans and intervention strategies where the child or youth and family have participated in the design.
- Services incorporate a blend of formal and informal resources designed to assist families with successful transitions beyond system services that ensure long-term success.
• Services are respectful of and informed by the culture of the child or youth and his/her family.

• Services and supports are provided in the child’s or youth’s and family’s local community and in the least restrictive and most normative settings.

As previously noted, the CPM is defined in Appendix B and further articulated in more detail in a companion document called the Core Practice Model Guide.
CHAPTER 4: THE CHILD AND FAMILY TEAM

The CPM incorporates the practice of teaming for all children or youth who are Medi-Cal beneficiaries and their families. The Child and Family Team (CFT) is central to the CPM. The CFT is comprised of the child or youth and family, and all of the ancillary individuals\(^5\) who are working with them to address the child’s or youth’s needs and strengths. The CPM focuses on issues such as successful treatment of the child’s or youth’s mental health needs and achieving goals in other child-serving systems in which the child or youth is involved. For children and youth in the child welfare or probation systems, one goal is to transition the child or youth out of those systems to achieve safety and permanency. The team process begins with identifying the child’s or youth’s and the family’s strengths and underlying needs. As these strengths and needs are identified, the original team expands to include other members, as necessary and appropriate, including natural supports that help the family maintain sustainability after professionals have transitioned off the team.

What is transformative about the CFT is the recognition that a team approach, utilizing the CPM, is very successful assisting certain children achieve safety, permanency, and/or improve well-being.

Mental health staff and service providers, in coordination with any ancillary individuals from child-serving agencies involved in the child’s or youth’s treatment, must utilize a CFT when providing ICC, IHBS, and TFC. Each individual team member has his or her unique role and responsibilities, but he or she is always working as part of the team.

The CFT is a team that shares a vision with the family and is working to advance that vision, while a CFT meeting is how the members communicate. No single individual, agency, or service provider works independently. Working as part of a team positively impacts decision-making.

ELEMENTS OF SUCCESSFUL TEAMING

Teaming has been a traditional practice in social work, child welfare, mental health, and...
and other child-serving systems such as education and developmental regional centers. This process of integrating the varying perspectives of individuals with diverse levels of educational, professional and personal life experiences guards against individual bias through cultural competence, while promoting better-informed decision-making and transmission of learning. In California over the past two decades, teaming efforts in child welfare services have merged professional multidisciplinary teams with family and youth involvement, and have effectively advanced and transformed systems of care. Several teaming models commonly used in child welfare, such as Team Decision Making (TDM) and Family Group Decision Making (FGDM), emphasize the importance of family presence and participation. The teaming process is most successful when:

- Team membership includes the child or youth and family, foster family, extended family, a coordinator, informal support persons (such as friends, coaches, faith-based connections), formal supports (such as mental health, child welfare and educational professionals), and representatives from other agencies providing services to the child or youth and family. These formal support persons may include, but are not limited to: regional center case managers, probation officers, substance use disorder specialists, education staff, and health care professionals.
- Team composition is guided by the child’s/youth’s needs and the family’s input and preferences.
- Team meeting schedules and locations are guided by the child’s/youth’s needs and the family’s preferences.
- All team members participate in the development and implementation of the care plan, and are responsible for supporting the child or youth in attaining the goals set forth in the client plan.
- The process is standardized and facilitated to ensure the following are included:
  - A clearly defined purpose, goal, and agenda for each meeting;
  - An agreed-upon decision-making process;
  - Identification of family strengths and needs;
  - A brainstorming and option-generating process; and
  - Specific action steps to be carried out by team members according to a timeline.

The CFT for beneficiaries receiving ICC, IHBS, and/or TFC is comprised of individuals committed to working with and supporting

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6 When the child or youth is in the child welfare or probation systems, the coordinator will often be the placing agency worker.
the child or youth and family to meet the child’s or youth’s needs, and to assist the child or youth to achieve his or her goals. In addition to the child or youth and his or her family, the CFT includes the various agency and provider staff involved in service delivery to the family, as well as people who are natural (non-paid) support persons, including relatives, friends, or other community resources.

For children in the child welfare and/or probation systems, the placing agency is responsible for convening the CFT. For children and youth outside the child welfare and/or probation systems receiving SMHS that require a CFT, the MHP is responsible for convening the CFT.

If the child/youth and family already have an established team through another agency such as mental health, or program such as Wraparound, the placing agency will support the existing team process to expand and evolve so that the needs and services indicated under the child welfare or probation case are included. Cross system planning and coordination will ensure that there is only one team process for any single child/youth and his/her family in care.7

The principle role of the CFT is as follows:

- Identification of important persons to participate on the CFT;
- Identification of the needs and strengths of the child or youth and his/her family, those of other CFT members, and other potential resources to support child’s or youth’s and family’s success;
- Articulation of the goals of the child or youth and family, as well as those of the system partners, so that the efforts of the team in planning and service delivery are in alignment with a shared goal of child or youth safety, permanence, and well-being;
- Development of a shared plan(s) to address risks and meet the needs of the child or youth and his/her family in a way that builds on strengths and natural supports, in addition to the use of formal system resources;
- Routine evaluation and refinement of plan intervention strategies to assure that progress is made toward the established goals, and changes are made if approaches are not successful to allow modifications, at any time, as an effort to continue working toward success; and
- Planning for the transition of formal services, as goals are met and symptoms and behaviors are improved, and result in improved developmental functioning and well-being.

7 See All County Letter 16-84 or MHSUDS Information Notice 16-049 on Requirements and Guidelines for Creating and Providing a Child and Family Team.
This manual is not intended to address overall concerns with confidentiality and sharing of information laws and regulations. To obtain more information on these issues, please consult county policies and contracts. In addition, the CPM Guide further describes the information sharing processes.
CHAPTER 5: ICC, IHBS AND TFC SERVICES

This section of the Manual is intended to provide an overview of ICC, IHBS and TFC. Appendix C provides a chart with additional detail about ICC, IHBS, and TFC, including who can provide these services, where these services can be delivered, and how to claim for these services.

PLANNING FOR ICC, IHBS AND TFC

Planning within the CPM is a dynamic and interactive process that addresses the goals and objectives necessary to assure that children and youth are safe, live in permanent, loving families, and achieve well-being. This process is built on an expectation that the planning process and resulting plans reflect the child’s or youth’s and family’s own goals and preferences, and that they have access to necessary services and resources that meet their needs.

The ICC coordinator is responsible for working within the CFT to ensure that plans from any of the system partners (including the mental health client plan, and plans from child welfare, special education, juvenile probation, etc.) are integrated to comprehensively address the identified goals and objectives, and that the activities of all parties involved with service to the child or youth and/or family are coordinated to support and ensure successful and enduring change.

INTENSIVE CARE COORDINATION (ICC)

GENERAL DESCRIPTION

ICC is similar to the activities routinely provided as Targeted Case Management (TCM). However, ICC services must be delivered using a CFT as described in the previous chapter to develop and guide the planning and service delivery process.

The difference between ICC and the more traditional TCM service functions is that ICC must be delivered using a CFT, and is intended for children and youth with more intensive needs and/or whose treatment requires cross-agency collaboration.

Although more than one mental health provider/practitioner may participate in the CFT, there must be an identified ICC coordinator who ensures participation by the child or youth, family or caregiver, and significant others, so that the child’s or youth’s assessment and plan addresses the child’s or youth’s needs and strengths in the context of the values and philosophy of the CPM.
SERVICE SETTINGS

ICC may be provided to children and youth living and receiving services in the community (including in a TFC home), as well as to children and youth who are currently in the hospital, group home, Short Term Residential Therapeutic Program (STRTP), or other congregate or institutional placement. When ICC is provided in a hospital, psychiatric health facility, community treatment facility, or psychiatric nursing facility, it solely will be used for the purpose of coordinating placement of the child or youth on discharge from those facilities, and may be provided during the 30 calendar days immediately prior to the day of discharge, for a maximum of three, nonconsecutive periods of 30 calendar days or less per continuous stay in the facility, as part of discharge planning.

CLAIMING AND REIMBURSEMENT

Refer to the California Code of Regulations (CCR), Title 9, Division 1, Chapter 11 for applicable claiming rules.

To clearly distinguish ICC from general TCM, ICC uses a different procedure code (T1017 HK) and service function code (07).

ICC will be reimbursed at the same rates as Targeted Case Management Services.

In addition, the guidance for the provision of ICC in inpatient settings is subject to the same direction provided in the State Medicaid Directors Letter (SMDL) dated July 25, 2000 for TCM that states:

“For members of the target group who are transitioning to a community setting targeted case management services will be made available for up to 30 calendar days for a maximum of three non-consecutive periods of 30 calendar days or less per hospitalization or inpatient stay prior to the discharge of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions."

ICC SERVICE COMPONENTS/ACTIVITIES/DOCUMENTATION

Engagement of the child or youth and his/her family is foundational to building trust and mutually beneficial relationships between the family and service providers. Engagement is a process that must be nurtured and developed throughout service delivery, and is critical in allowing CFT members to work to reach agreement about services.

Activities may include interventions such as:

• Developing and maintaining a constructive and collaborative relationship among a child or youth, his/her family or caregiver(s), other Medi-Cal SMHS providers, and other involved child-serving systems to create a CFT;
• Care planning and monitoring to ensure that the plan is aligned and coordinated across the mental health and child serving systems to allow the child or youth to be served in his/her community in the least restrictive setting possible;

• Ensuring services are provided that equip the parent/caregiver to meet the child’s or youth’s mental health treatment and care coordination needs, described in the child’s or youth’s plan;

• Ensuring that medically necessary mental health services included in the child’s or youth’s plan are effectively and comprehensively assessed, coordinated, delivered, transitioned and/or reassessed as necessary in a way that is consistent with the full intent of the CPM;

• Providing active coordination of services and resources, as required to meet the goals of the plan; and

• Providing active participation in the CFT planning and monitoring process to assure that the plan addresses, or is refined to meet, the mental health needs of the child or youth. Examples include:
  o Scenario #1: Clinician attends a CFT meeting and learns from the child’s or youth’s parent and the TBS coach that the client recently suffered a panic attack while in school. Based on this shared information, the clinician suggests the plan include practicing relaxation techniques with client to reduce levels of anxiety.
  o Scenario #2: During the CFT, Parent Partner/Advocate learned from the parent that the child’s or youth’s school counselor had said the client continues to display isolative behaviors during recess. Based on this information, the CFT coordinator or therapist works with the child’s or youth’s IHBS provider to encourage the child or youth to initiate social interaction with peers during recess and strengthen the client’s pro-social behaviors while playing, such as taking turns, waiting his/her turn, and listening, rather than interrupting.

SERVICE COMPONENTS/ACTIVITIES
ICC service components/activities include: assessing; service planning and implementation; monitoring and adapting; and transition. These components/activities and corresponding examples are described as follows:

ASSESSING
• Assessing client’s and family’s needs and strengths
• Assessing the adequacy and availability of resources
• Reviewing information from family and other sources
• Evaluating effectiveness of previous interventions and activities

Example 1: CFT members, including the TBS worker, teacher, coach, parents, older sister, Parent Partner and Youth Partner, discussed the circumstances and situations
where John’s physically aggressive behavior takes place at school, identifying potential environmental triggers, including adults physically leaning too close to help when he is struggling with school tasks. It is noted that John is much calmer when support comes in the form of reminders about steps he can take that have been pre-planned, and the adult is at least four feet away during the conversation.

Example 2: John’s parents talked about the different circumstances that were going on when he became so anxious he could not handle remaining in the location, including someone touching him or lots of noise and activity from the younger children in the house. The ICC coordinator and Parent Partner assisted John’s parents and John to identify what circumstances were going on when he seemed calmer and more in control: morning seems better than later in the day; fewer people seem better; talking is better than touching when giving feedback.

**Service Planning and Implementation**

- Developing a plan with specific goals, activities and objectives
- Ensuring the active participation of the client and individuals involved, and clarifying the roles of the individuals involved
- Identifying the interventions/course of action targeted at the client’s and family’s assessed needs

Example 1: The ICC coordinator, behavior specialist, John, John’s parents, the child welfare worker, and the teacher’s aide discussed potential strengths that could form the basis of positive intervention strategies that John can use to manage his anxiety when he is feeling stressed and frustrated by his school work:

- John can tell that he is getting frustrated before he lashes out; he is able to communicate his frustration to his teacher with an agreed upon signal.
- John can read and could use a list of reminders of what to do when he’s frustrated.
- The teacher’s aide in the classroom recognizes that, when John’s leg jiggles fast, he is getting agitated. When the teacher’s aide reminds John to breathe slowly, John does it and settles down.

All present agreed that the behavior specialist will work with the teacher’s aide to develop a list of coping strategies that John can use when he is becoming agitated. The teacher’s aide will track the number of times that he notices John is agitated and how many of those times John is able to use his strategies to calm down. The CFT members will evaluate at the next CFT meeting.

**Monitoring and Adapting**

- Monitoring to ensure that identified services and activities are progressing appropriately
• Changing and redirecting actions targeted at the client’s and family’s assessed needs, not less than every 90 days

Example 1: Discussed Susie’s level of participation and progress at the Boys and Girls (B&G) Club for the past month; what she likes about going there; and what is not going as well. Susie reports that she likes the art activities, but that she does not want to go back because two girls are bullying her and calling her names. The ICC coordinator suggested strategies to increase support at the B&G Club to observe and coach Susie to respond to the girls and/or to talk to an adult. Susie agreed, so the client plan was refined and will be reviewed in two weeks. Assignment made to behavior specialist to support Susie on Tuesday and Thursday for the next month.

TRANSITION

• Developing a transition plan for the client and family to foster long-term stability, including the effective use of natural supports and community resources.

Example 1: CFT participants, including the ICC coordinator, IHBS provider, Susie’s parents, Susie, and Susie’s teacher, reviewed the client’s and family’s gains and progress, along with their personal strengths and external resources, in order to better assist the client’s transition away from formal supports. The CFT members identified the presence and effectiveness of their natural supports, which include Susie’s church youth group, soccer team, and B&G Club leadership group, and address ways of maximizing community resources and activities in order to ensure long-term stability for Susie and her family.

DOCUMENTATION OF SERVICE COMPONENTS AND ACTIVITIES

Active Listening during a CFT Meeting

Example 1: Clinician attends a CFT meeting and learns from the school counselor that Sam recently grabbed the arm of another student because he was not passing the ball to the client in P.E. class. Based on this shared information, clinician will work to develop and strengthen Sam’s active problem-solving skills in order to help him consider alternative solutions to anger-provoking situations.

Multiple staff during a CFT Meeting

Example 2: During the CFT meeting, the client’s IHBS worker learns from the ICC coordinator that Sam continues to display isolative behaviors during recess because his peers do not like how he acts (e.g., does not wait his turn, interrupts, plays too rough) and refuse to let him play with them. The IHBS worker and ICC coordinator review with the family different interventions to apply. Based on this information and discussion, the IHBS worker will focus interventions to strengthen Sam’s pro-social behaviors while playing with peers by teaching, modeling, and reinforcing behaviors such as listening rather than interrupting, waiting his turn,
playing more gently and appropriately, and initiating social interaction with peers. The IHBS worker and ICC coordinator each claim (to ICC) for the actual amount of time they each participated during the CFT meeting, including active listening time. Each staff may claim up to the length of the meeting plus documentation and travel time. Any participation time claimed, which may include active listening time, must be supported by documentation showing what information was shared and how it can/will be used in planning for client care or services to the client (i.e., how the information discussed will impact the Client Plan).

Example 3: During the CFT meeting, the team discusses the effectiveness of various interventions intended to diminish Noah’s isolative behaviors during recess at school. Noah’s IHBS worker coaches Noah to talk about how he has been practicing to wait his turn, and otherwise actively listens and learns how things have been going for Noah from the perspective of his teacher and his mom. The ICC coordinator shared that information when she spoke to the recess monitor, and the recess monitor reported that Noah goes off by himself when his peers do not like how he acted (e.g., does not wait his turn, interrupts, plays too rough) and refuse to let the client play with them. Mrs. T is upset because she feels that the school staff does not follow through with the support that they promised for Noah. The Parent Partner agrees to meet with her the following day and to help Mrs. T plan exactly what she would like the school staff to do, and how she will make that request. The IHBS worker and ICC coordinator review with the family the different interventions to apply and how they will keep track of Noah’s progress. Based on this information and discussion, the IHBS worker will focus interventions to strengthen client’s pro-social behaviors while playing with peers by: teaching, modeling and reinforcing behaviors such as listening, rather than interrupting; waiting his turn; playing more gently and appropriately; and initiating social interaction with peers.

POINTS ON CLAIMING FOR MULTIPLE STAFF

- Refer to the California Code of Regulations (CCR), Title 9, Division 1, Chapter 11 for applicable claiming rules.

- Each staff may claim to ICC for time at the CFT meeting clearly linked to the mental health client plan goals and/or the information gleaned during the meeting that contributed to the formulation of the mental health client plan or revisions.

- Medi-Cal reimbursement must be based on staff time, including the length of the meeting, plus any documentation and travel time (e.g., a single staff member who participates in the CFT meeting cannot claim for more time than was provided).

- Progress notes must include evidence of incorporation of CPM elements described in the CPM Guide. Please see Appendix D for examples of progress notes.
INTENSIVE HOME BASED SERVICES (IHBS)

GENERAL DESCRIPTION

IHBS are intensive, individualized, strength-based, and needs-driven intervention activities that support the engagement and participation of the child or youth and his/her significant support persons, and help the child or youth develop skills and achieve the goals and objectives of the plan. IHBS is not a traditional therapeutic service.

The difference between IHBS and more traditional outpatient Specialty Mental Health Services (SMHS) is that the service is expected to be of significant intensity to address the mental health needs of the child or youth, consistent with the plan and the CPM, and will be predominantly delivered outside an office setting, and in the home, school, or community.

Consistent with Medi-Cal SMHS regulatory requirements and the CPM, IHBS includes, but is not limited to:

- Medically necessary, skill-based interventions for the remediation of behaviors or improvement of symptoms, including, but not limited to, the implementation of a positive behavioral plan and/or modeling interventions for the child’s or youth’s family and/or significant others to assist them in implementing the strategies;
- Development of functional skills to improve self-care, self-regulation, or other functional impairments by intervening to decrease or replace non-functional behavior that interferes with daily living tasks or avoid exploitation by others;
- Development of skills or replacement behaviors that allow the child or youth to fully participate in the CFT and service plans, including, but not limited to, the client plan and/or child welfare service plan;
- Improvement of self-management of symptoms, including self-administration of medications, as appropriate;
- Education of the child or youth and/or his/her family or caregiver(s) about, and how to manage, the child’s or youth’s mental health disorder or symptoms;
- Support of the development, maintenance, and use of social networks, including the use of natural and community resources;
- Support to address behaviors that interfere with the achievement of a stable and permanent family life;
• Support to address behaviors that interfere with seeking and maintaining a job;
• Support to address behaviors that interfere with a child’s or youth’s success in achieving educational objectives in an academic program in the community; and
• Support to address behaviors that interfere with transitional independent living objectives, such as seeking and maintaining housing and living independently.

SERVICE SETTINGS
IHBS may be provided in any setting where the child or youth is naturally located, including the home (biological, foster or adoptive), schools, recreational settings, child care centers, and other community settings. IHBS is available wherever and whenever needed, including weekends and evenings. IHBS is typically (but not only) provided by paraprofessionals under clinical supervision. Peers, including Parent Partners, may provide IHBS.

Example 1: IHBS worker met with Sam and his mother at their home to teach Sam behavior management skills, so he can gain better self-control when upset. Explained and modeled to both mother and Sam four different self-calming techniques to use when upset.

Example 2: IHBS worker met with and observed Sam at his school during recess. Sam became upset with a peer and started banging his head on the playground climbing structure. IHBS worker prompted Sam to walk away and use one of the self-calming techniques that he has been practicing. Sam used deep breathing techniques, and was able to calm himself down. IHBS worker praised Sam for walking away and doing the deep breathing exercises.

Example 3: IHBS worker met with Sam’s mom to assist her in ways of communicating without getting so upset. IHBS worker explained to Mom how her anger impacts Sam’s reaction and taught her different ways of expressing herself when she is upset.

In order to distinguish IHBS from other outpatient SMHS when claiming, IHBS uses a different procedure code (H2015) and modifier (HK) and service function code (57). Mental Health Services (MHS) are authorized and defined in California’s existing Medicaid State Plan for Medi-Cal SMHS.
CLAIMING AND REIMBURSEMENT

Refer to the California Code of Regulations (CCR), Title 9, Division 1, Chapter 11 for applicable claiming rules.

IHBS will be reimbursed at the same rates as MHS.

COORDINATION OF IHBS WITH OTHER MENTAL HEALTH SERVICES

Children and youth who are receiving IHBS are eligible for all of the other medically necessary specialty mental health modes of services, which meet medical necessity criteria and are consistent with their identified needs. The MHP and providers should consider the full array of services and the needs of the child or youth. Certain services may be part of the child’s or youth’s course of treatment, but may not be provided during the same hours of the day as IHBS services are being provided to the child or youth. These services include:

- Day Treatment Rehabilitative or Day Treatment Intensive
- Group Therapy
- Therapeutic Behavioral Services (TBS)
THERAPEUTIC FOSTER CARE (TFC) SERVICE MODEL

GENERAL DESCRIPTION

The Therapeutic Foster Care service model\(^8\) allows for the provision of short-term, intensive, highly coordinated, trauma-informed, and individualized SMHS service activities to children and youth, up to age 21, who have complex emotional and behavioral needs, and who are placed with trained, intensely supervised, and supported TFC parents working through and under the direction of a TFC Agency.

The TFC parent\(^9\) serves as a key participant in the therapeutic treatment process of the child or youth. The TFC parent will provide trauma-informed interventions that are medically necessary for the child or youth. The SMHS service activities provided through the TFC service model assist the child or youth to achieve client plan goals and objectives; improve functioning and well-being; and help the child or youth remain in a family-like home in a community setting, thereby avoiding residential, inpatient, or institutional care.\(^10\)

The TFC service model is intended for children and youth who require intensive and frequent mental health support in a parent’s unique role. However, the program design does not prohibit relative caregivers and “non-related” extended family members from being TFC parents if they meet the TFC parent qualifications.

The difference between service activities delivered through the TFC service model and more traditional outpatient specialty mental health services (SMHS) is that service activities provided through the TFC service model (collateral, rehabilitation, and plan development as it relates to TFC) will be delivered in the home or other community setting by a trained and qualified TFC parent.

\(^8\) Therapeutic Foster Care (TFC) services do not require membership in the Katie A. class or subclass as a perquisite to receiving medically necessary services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT). A child or youth does not need to have an open child welfare services case and does not need to be in foster care to be considered for TFC.

\(^9\) As described under the section on TFC parent qualifications, it is understood that TFC parents are not required to be part of the child’s/youth’s long-term permanency plan, due to the unique characteristics of this service model and the TFC.

\(^10\) Receipt of Medi-Cal SMHS service components provided under the TFC service model does not limit the availability of other SMHS. The TFC parent is not expected to provide other SMHS that may be medically necessary. 24/7 crisis intervention services will need to be available through the FFA or county MHP.
one-on-one environment. The TFC service model allows for the provision of certain SMHS service activities (rehabilitation, collateral and plan development) available under the EPSDT benefit as a home-based alternative to high level care in institutional settings, such as group homes and, in the future, as an alternative to placement in Short Term Residential Therapeutic Programs (STRTPs). The TFC home also may serve as a step down from an STRTP. The SMHS service activities provided through the TFC service model must not be the only SMHS that a child or youth would receive. Children and youth receiving SMHS service activities through the TFC service mode must receive ICC and other medically necessary SMHS, as set forth in the client plan. Counties are encouraged to continue to develop the resources, supports, and services needed to maintain foster children and youth in family-based home settings, while promoting permanency for all children and youth through family reunification, adoption, or legal guardianship. These efforts may include the provision of ICC, IHBS, and Wraparound services, as appropriate.

SERVICE SETTINGS

Service activities provided through the TFC service model are primarily provided in the child’s or youth’s TFC home. However, these service activities may be provided in any setting where the child or youth is naturally located, including schools, recreational settings, and other community settings. TFC is available wherever and whenever needed, including weekends and evenings. TFC is provided by the TFC parent(s) under the direction of a Licensed Mental Health Professional (LMHP). A Waivered or Registered Mental Health Professional (WRMHP) also may direct the TFC parent.11

TFC SERVICE COMPONENTS/ACTIVITIES

The TFC parent(s) serves as one of the key participants for the trauma-informed, rehabilitative treatment of the child or youth, as set forth in the client plan.

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11 Waivered/Registered Professional means—For a psychologist candidate, “waivered” means an individual who either 1) is getting the experience required for licensure or 2) was recruited for employment from outside California, has sufficient experience to gain admission to a licensing examination, and has been granted a professional licensing waiver approved by DHCS to the extent authorized under state law. For a social worker candidate, a marriage and family therapist candidate, or a professional counselor candidate, or a professional counselor candidate, “registered” means a candidate for licensure who is registered with the corresponding state licensing authority for the purpose of acquiring the experience required for licensure, in accordance with applicable statues and regulations, and “waivered” means a candidate who was recruited for employment from outside California, whose experience is sufficient to gain admission to the appropriate licensing examination, and who has been granted a professional licensing waiver approved by DHCS to the extent authorized under state law.
including ICC and IHBS, as medically necessary, and as set forth in the child’s or youth’s client plan.

The TFC parent(s) provides one or more of the following TFC service model activities:

**PLAN DEVELOPMENT**

Plan development (limited to when it is part of the CFT): The TFC parent will participate as a member in the CFT in care planning, monitoring, and review processes. The TFC parent also will observe, monitor, and alert the TFC Agency and members of the CFT about changes in the child’s or youth’s needs.

Example: The TFC parent informs the LMHP/WRMHP that the child’s disruptive behaviors in school are now resolved, but a change in the client plan is needed due to increased obstinacy and defiance by the child at the TFC home.

**REHABILITATION**

Rehabilitation: The TFC parent will implement in-home informed practices, which include trauma-informed rehabilitative treatment strategies set forth in the child’s or youth’s client plan. Examples of services to be provided include: providing skills-based interventions (including coaching and modeling); developing functional skills to improve self-care; and improving self-management in areas of anger management or self-esteem or peer relations.

Example: The TFC parent incorporates the use of modeling turn-taking skills at the TFC home and records and rewards the child’s or youth’s successful accomplishments on a star chart.

**COLLATERAL**

Collateral: The TFC parent will meet the needs of the child or youth in achieving his or her client plan goals by reaching out to significant support person(s) and providing consultation and/or training for needed medical, vocational, or other services to assist in better utilization of SMHS by the child or youth. Collateral includes one or more of the following: consultation and/or training of the significant support person(s) that would assist the child/youth in increasing resiliency, recovery, or improving utilization of services; consultation and training of the significant support person(s) to assist in better understanding of mental illness and its impact on the child/youth; and family counseling with the significant support person(s) to improve the functioning of the beneficiary. The child/youth may or may not be present for this service activity.

The TFC parent activities related to collateral include meeting the needs of the child or youth in achieving his/her TFC client plan goals by reaching out to significant support person(s), and providing consultation and training for needed medical, vocational, or other services to assist in better utilization of SMHS by the child or youth.
Example: The TFC parent works collaboratively with child’s or youth’s teacher (who was identified as a significant support person) in addressing disruptive behavior in school (i.e., interrupting peers and teacher; not following teacher’s directions; and exhibiting difficulty focusing on academic activities).

Example: The TFC parent consults with the teacher on understanding child’s or youth’s mental health needs and informs the teacher about the star chart that is used at home and how to utilize the star chart in school to reward the child or youth.

Example: The TFC parent (Joel) meets with the child’s (Suk’s) teacher (Mr. Diaz) at the school. Mr. Diaz has been identified as a Significant Support Person by Joel and the LMHP/WRMHP. Mr. Diaz is collaborating with Joel on interventions that focus on Suk’s oppositional behavior in school. Joel contacts Mr. Diaz weekly to check in on Suk’s progress in school. Suk is rewarded with “points” as positive reinforcement at school that Suk can then use at his TFC home.

TFC will be provided daily, up to 7 days a week, including weekends, at any time of day, as medically necessary.

**SERVICE LIMITATIONS AND LOCKOUTS**

TFC does not include:

1. Reimbursement for the cost of room and board, which will be paid separately to the TFC parents utilizing federal, State or local foster care funding sources; or

2. Other foster care program related services (e.g., assessing adoption placements, serving legal papers, home investigations, administering foster care subsidies), or other parenting functions such as providing food or transportation.

TFC is NOT reimbursable:

- When the child or youth is receiving Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services, or Psychiatric Nursing Facility Services, **EXCEPT** for the day of admission/discharge to/from these facilities;

- While the child or youth is detained in juvenile hall or is otherwise considered an inmate; or

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The TFC service model includes claiming for one or more of the following service activities, claimed under one per diem rate and provided by the TFC parent:

- Plan Development (as it applies to the CFT)
- Rehabilitation
- Collateral
• While the child or youth is in a Short Term Residential Therapeutic Program (STRTP) or other residential setting. EXCEPT for the day of admission/discharge to/from these facilities.

TFC SERVICE DOCUMENTATION
TFC shall be documented in accordance with Medi-Cal documentation requirements, the local Mental Health Plan’s (MHP) policies and procedures, and the contract between DHCS and the local MHP.

TFC is also subject to the following minimum documentation requirements:

• The TFC parent(s) must write and sign a daily progress note for each day of service. The progress note must meet Medi-Cal documentation standards. The TFC Agency’s Licensed Mental Health Professional (LMHP) or the Waivered or Registered Mental Health Professional (WRMHP) must review and co-sign each progress note to indicate service activities are appropriate and that documentation requirements are met.

• The TFC Agency must comply with the mental health documentation requirements prescribed by the county MHP and the contract between DHCS and the local MHP.

• The SMHS service activities provided through the TFC service model must be reflected in the child’s or youth’s client plan.

Please see Appendix E for a sample TFC progress note template. Counties are not required to use this template; rather, it is provided as a sample tool to assist with documentation needs.

TFC PARENT QUALIFICATIONS
Under the TFC service model, to qualify as a Medi-Cal TFC provider, a TFC parent must be approved as a TFC provider and approved as a resource parent by the TFC Agency. This means that TFC parent(s) must:

• Meet and comply with all basic foster care or resource parent requirements as set forth in California Code of Regulations (CCR) Title 22, Division 6, Chapter 9.5 or Welfare and Institutions (W&I) Code 16519.5; and

• Meet and comply with all requirements related to their role as a TFC parent(s).

For TFC parent(s) the minimum age is 21.

The TFC parent(s) must meet California’s Medicaid rehabilitation provider qualifications for “other qualified provider”12 (i.e., has a high school diploma or equivalent degree), and meet provider qualifications and other requirements regarding certification, oversight, etc., as

12 California State Medicaid Plan, Attachment 3.1 A Rehabilitation Mental Health Services.
established by the county MHP. The process for a resource parent to become a TFC parent will be determined by the TFC Agency in accordance with its contract with the MHP.

The TFC parent(s), including relative caregivers, must be resource family approved, and any additional processes regarding background checks and screenings will be determined by the MHP. The home study will include a comprehensive written report containing recommendations for approval, including the child/youth best served by the family and any restrictions (see TFC Service Model Parent Qualifications under Home Study Process and Inspection).

The TFC parent applicants also must meet additional requirements specific to the provision of TFC services that include:

- Forty (40) hours of initial TFC parent training must be completed prior to the parent being eligible to provide services as a TFC parent. An outline and agenda of the 40-hour training shall be provided to, and be approved by, the MHP as a part of the contract. Training shall include the following, at a minimum:
  - Introduction to therapeutic foster parenting and role in mental health treatment planning;
  - Working with children who have been abused, neglected and/or delinquent;
  - Trauma-informed care;
  - Developmental stages and age appropriate interventions;
  - Prevention of aggressive behavior and de-escalation techniques;
  - Positive behavioral reinforcement techniques;
  - Introduction to individualized mental health treatment of children;
  - Effective communication and relationship building techniques;
  - Understanding and monitoring medications;
  - Crisis management/de-escalation techniques
  - Cultural competence and culturally responsive services;
  - Client sensitivity training (including stories and content developed and delivered by peer roles (e.g. foster parents, former foster youth, bio parents, etc.);
  - Training around stress and well-being/self-care;
  - Involvement and role in Child and Family Team (CFT);
  - Progress note training/medical necessity criteria;
  - Health Insurance Portability and Accountability Act (HIPAA); and
  - Access to other medically-necessary SMHS service activities.
• Twenty-four (24) hours of annual ongoing training related to providing TFC services, which includes an emphasis on skill development and the delivery of SMHS service activities. This training can be provided in a variety of formats (videos, readings, internet training, and webinars).

• The TFC parent provides plan development, rehabilitation, and collateral services under the direction of the TFC Agency’s LMHP/WRMHP. The TFC Agency has overall responsibility for monitoring the TFC parent. The TFC Agency’s LMHP/WRMHP will meet with the TFC parent to review the treatment plan, review and co-sign progress notes, and will provide support to the TFC parent as follows:
  o Face-to-face supervision in the home, a minimum of one (1) hour per week, to review the treatment plan; review and co-sign progress notes, ensuring that each progress note meets Medi-Cal SMHS and contractual requirements; and
  o Supervise SMHS interventions of: rehabilitation; plan development (as part of the Child and Family Team); and collateral.

The annual TFC parent evaluation will incorporate input from the CFT members, as well as a self-evaluation by the TFC parents. The home visit should be strengths-based and solution-focused. It should address:

• The TFC parent’s role and performances as a key participant in the therapeutic treatment process of the child/youth, including treatment strategies; and
• Case records and documentation.

See Appendix G for details on Qualifications for TFC Parent(s).

CLAIMING AND REIMBURSEMENT

• Service activities provided through the TFC service model must be claimed at a per diem rate using Mode of Service 05 (24-hour) and Service Function Codes 95 – 98.

• Service activities provided through the TFC service model must be claimed using procedure Code S5145 with the Procedure Modifier HE.

• Service activities provided through the TFC service model must be claimed using the X12N 837 Health Care Claim: Professional (837P) transaction set.

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13 Refer to the California Code of Regulations (CCR), Title 9, Division 1, Chapter 11 for applicable claiming and reimbursement rules.
Service activities provided through the TFC service model will be reimbursed at a per diem rate. The interim per diem rate depends upon whether or not the TFC Agency is a contractor of the MHP or is county owned and operated.

- If the TFC Agency is a contractor of the MHP, the TFC Agency will be paid by the MHP a rate that is negotiated between the MHP and the TFC Agency. The MHP submits a claim to DHCS for federal reimbursement based upon the per diem rate the MHP paid the TFC Agency. After approving the claim, DHCS will reimburse the MHP the federal share of the approved amount.

- If the TFC Agency is county owned and operated, DHCS will reimburse the MHP the federal share of the MHP’s interim rate. As of March 2017, the county interim rate is set at $87.40 per day. Each county’s interim rate will be updated annually based upon its most recently filed cost report.

- The TFC Agency will be reimbursed for SMHS service activities provided through the TFC service model in accordance with the terms of the contract with the MHP.

- The per diem daily rate includes:
  - The TFC Agency’s administrative and LMHP/WRMHP staff costs, and
  - The payment to the TFC parent for the SMHS components provided through the TFC service model to the child or youth living in the TFC home.

The non-Medi-Cal rate for board and care is paid by the placing agency to the TFC Agency:

- A rate that will be received by the TFC Agency, and paid to the TFC parent for board, care, and supervision of the child or youth, will be paid by the placing agency using Federal Title IV-E or other state or local funding sources.

**TFC SERVICES AT-A-GLANCE**

For additional information on TFC services, please refer to Appendix I for information at-a-glance in the areas of:

- Service description indicators of need
- TFC Agency
- Service delivery
- Parent oversight
- TFC Parent
- Child and Family Teams
- Program integrity
- Compliance
- Reimbursement
APPENDIX A

GLOSSARY

For the purposes of this manual, the following definitions are provided:

**Assessment** – Assessment is a service activity for several SMHS services. The service activity is designed to evaluate the current status of a beneficiary’s mental, emotional, or behavioral health. Assessment includes, but is not limited to, one or more of the following: mental status determination; analysis of the beneficiary’s clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures.

**CDSS** – The California Department of Social Services (CDSS) is the state agency charged with serving, aiding, and protecting needy and vulnerable children, youth, and adults in ways that strengthen and preserve families, encourage personal responsibility, and foster independence.

**Client Plan** – Defined by Title 9 CCR §1830.205.2, means a plan for the provision of SMHS to an individual beneficiary who meets the medical necessity criteria in the California Code of Regulations (CCR), Title 9, Chapter 11, Sections 1830.205 or 1830.210.

**Child and Family Team (CFT)** – A CFT is comprised of the child or youth and family and all of the ancillary individuals who are working with them toward their successful treatment of the child’s or youth’s mental health needs and achieving goals in other systems in which he or she is involved. For example, for children and youth in the child welfare system or probation systems, one such goal is to transition the child or youth out of those systems. The team is comprised of the child welfare worker, the youth and family, service providers, and any other members, as necessary and appropriate. No single individual, agency or service provider works independently, but rather as part of the team for decision-making. Child welfare workers and mental health staff and service providers work within a team environment which engages youth and families as partners in that environment. Each individual team member has his/her unique role and responsibilities, but he/she always is working as part of the team. The CFT is defined in the Katie A. settlement agreement and is described in Chapter 4 of this manual.

**Collateral** – Defined by Title 9 CCR § 1810.206, means a service activity to a significant support person or persons in a beneficiary’s life for the purpose of providing support to the beneficiary in achieving client plan goals. Collateral includes one or more of the following: consultation and/or training of the significant support person(s) that would assist the beneficiary in increasing resiliency, recovery, or improving utilization of services; consultation and training of the significant support person(s) to assist in
better understanding of mental illness and its impact on the beneficiary; and family counseling with the significant support persons(s) to improve the functioning of the beneficiary. The beneficiary may or may not be present for this service activity.

**Core Practice Model (CPM)** – The CPM is a set of practices and principles for children and youth served by both the child welfare and the mental health system that promotes a set of values, principles, and practices. The CPM is meant to be shared by all who seek to support children/youth and families involved in the child welfare system, including, but not limited to: education, probation, drug and alcohol, and other health and human services agencies or legal systems with which the child/youth is involved. The CPM requires collaboration between child welfare and mental health staff, service providers, and community/tribal partners working with the children, youth, and families.

**DHCS** – The Department of Health Care Services (DHCS) is the state agency charged with preserving and improving the health status of all Californians. DHCS works closely with health care professionals, county governments, and health plans to provide a health care safety net for California’s low-income and persons with disabilities. The DHCS is the state agency responsible for the Medi-Cal program.

**EPSDT** – Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a Medi-Cal benefit for individuals under the age of 21 who have full-scope Medi-Cal eligibility. Medicaid law requires states to provide EPSDT services to beneficiaries under the age of 21 who are eligible for the full scope of Medicaid services, as medically necessary, to correct or ameliorate defects and physical and mental illnesses or conditions. This requirement obligates states to provide Medicaid-covered services whether included in a State’s Medicaid State Plan or not.

**Family Foster Agency (FFA)** - Defined as any organization engaged in the recruiting, certifying, and training of, and providing professional support to foster parents (including TFC parents), or in finding homes for placement of children for temporary or permanent care.

**Foster Care Placement** – Defined as 24-hour substitute care for all children and youth placed away from their parent(s) or guardian(s) and for whom the State agency has placement and care responsibility. (Section 1355.20 Code of Federal Regulations).

**Health Insurance Portability and Accountability Act (HIPAA)** - Signed into US law in 1996, HIPAA was designed to provide privacy standards to protect medical records and other health information provided to health plans, doctors, hospitals and other health care providers. Additionally, HIPAA required simplification and standardization of healthcare electronic data, prohibited group health plans from denying coverage to individuals with specific diseases and pre-existing conditions, and changed several related tax
laws associated with health insurance coverage.

**Intensive Care Coordination (ICC)** – Defined as a service activity that facilitates assessment, care planning and coordination of services, including urgent services (for children and youth who meet medical necessity criteria). See Appendix C for further description.

**Intensive Home Based Services (IHBS)** – Intensive, individualized and strength-based, needs-driven intervention activities that support the engagement and participation of the child or youth and his/her significant others, and assist the child or youth in developing skills and achieving the goals and objectives of the plan.

**Katie A. Lawsuit** – The Katie A. Lawsuit, Katie A. et al. v. Bontá et al., refers to a class action lawsuit filed in Federal District Court in 2002 concerning the availability of intensive mental health services to children and youth in California who are either in foster care or at imminent risk of coming into care. A settlement agreement was reached in the case in December 2011. The Settlement Agreement formally ended, with the jurisdiction of the federal court ceasing, in December 2014.

**Licensed Mental Health Professional (LMHP)** – LMHPs are licensed physicians, licensed psychologists, licensed clinical social workers, licensed marriage and family therapists, registered nurses, licensed vocational nurses, licensed psychiatric technicians and licensed professional clinical counselors.

**Mental Health Plan (MHP)** – Defined by Title 9 CCR § 1810.226, means an entity that enters into a contract with the Department of Health Care Services to provide directly, or arrange and pay for, specialty mental health services to beneficiaries in a county. An MHP may be a county, counties acting jointly or another governmental or non-governmental entity.

**Natural Supports** – Individuals that can further support the child or youth and the family with developing a sustainable system of supports that is not dependent on formal systems supports. Examples are extended family members, friends, community members, and others, as identified by the child or youth and family.

**Open Child Welfare Services Case** – A child or youth has an open child welfare services case if: a) child/youth is in foster care; and/or b) child/youth has a voluntary family maintenance case (pre or post, returning home, in foster or relative placement), including both court-ordered and by voluntary agreement. A child or youth who only has emergency response referrals does not have an open child welfare services case.

**Parent Partner/Advocate** – Parent Partners/ Advocates are key individuals who work with children, youth, and families within the public child welfare, juvenile probation or mental health systems. Parent Partners/Advocates are past consumers and can convey information on how systems and programs can instill the family-centered
and family-driven philosophy and principles necessary to engage children, youth, and families.

**Plan Development** – Plan Development is defined as a service activity that consists of development of client plans, approval of client plans, and/or monitoring and recording of a child’s/youth’s progress. Plan Development should reflect the CPM values and principles, emphasize individual needs, and incorporate child or youth and family voice/choice. Plans should be developed in the team process and incorporate the team’s goals to support the child or youth and family and meet medical necessity criteria.

**The plan** – A plan that comprehensively addresses and integrates the activities of all parties involved with service to the child or youth and/or family. The plan should align the goals and objectives necessary to support and ensure medically necessary services are provided to the child or youth and family.

**Rehabilitation** – Rehabilitation is a recovery or resiliency focused service activity identified to address a mental health need in the client plan. This service activity provides assistance in restoring, improving, and/or preserving a beneficiary’s functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the development age and needs of the beneficiary. Rehabilitation also includes support resources, and/or medication education. Rehabilitation may be provided to a beneficiary or a group of beneficiaries.

**Resource Family Approval (RFA)** – RFA is a new family-friendly and child-centered caregiver approval process that combines elements of the current foster parent licensing, relative approval, and approvals for adoption and guardianship processes, and replaces those processes. RFA is a process used by the TFC Agency to determine whether the family-based foster care provider meets the home environment assessment and permanency assessment standards adopted pursuant to Welfare and Institutions Code, Section 16519.5.

**Short Term Residential Therapeutic Programs (STRTPs)** - STRTPs are residential facilities operated by a public agency or private organization and licensed by CDSS pursuant to Section 1562.01 [Health and Safety Code]. STRTPs provide an integrated program of specialized and intensive care and supervision, services and supports, treatment, and short-term 24-hour care and supervision to children. STRTPs provide nonmedical services, except as otherwise permitted by law. Private organizations operating STRTPs must be organized and operated on a nonprofit basis.

**Significant Support Person** – Refers to persons, in the opinion of the beneficiary (i.e., the client) or the person providing services, who have or could have a significant role in the successful outcome of treatment, including, but not limited to: the parents or legal guardian of a beneficiary who is a minor; the legal representative of a beneficiary who is not a
minor; a person living in the same household as the beneficiary; the
beneficiary's spouse, and relatives of the beneficiary.

**Waivered/Registered Professional**—For a psychologist candidate, “waivered” means an individual who either 1) is getting the experience required for licensure or 2) was recruited for employment from outside California, has sufficient experience to gain admission to a licensing examination, and has been granted a professional licensing waiver approved by DHCS to the extent authorized under state law. For a social worker candidate, a marriage and family therapist candidate, or a professional counselor candidate, or a professional counselor candidate, “registered” means a candidate for licensure who is registered with the corresponding state licensing authority for the purpose of acquiring the experience required for licensure, in accordance with applicable statues and regulations, and “waivered” means a candidate who was recruited for employment from outside California, whose experience is sufficient to gain admission to the appropriate licensing examination, and who has been granted a professional licensing waiver approved by DHCS to the extent authorized under state law.

**Wraparound** – Wraparound is an intensive, individualized care planning and management process. The Wraparound process aims to achieve positive outcomes by providing a structured, creative, and individualized team planning process that results in plans and services that are effective and relevant to the child and family. Eligibility criteria for Wraparound include: A child/youth or non-minor dependent, as described in Welfare & Institutions Code (W&I Code), Section 11400, Subdivision (v), who is any of the following:

(a) A child/youth or non-minor dependent who has been adjudicated as either a dependent, transition dependent, or ward of the Juvenile Court pursuant to W&I Code, Sections 300, 450, 601, or 602 and who would be place in a group home licensed by CDSS at a rate classification level (RCL) of 10 or higher;

(b) A child/youth or non-minor dependent who is currently, or who would be, placed in a group home licensed by CDSS at an RCL of 10 or higher;

(c) A child/youth who is eligible for adoption assistance program when the responsible public agency has approved the provision of Wraparound services in lieu of out-of-home placement at an RCL of 10 or higher.
APPENDIX B

CORE PRACTICE MODEL

(Note: This definition is directly taken from Appendix B of the Katie A. Settlement Agreement)

The Core Practice Model (CPM), which should be utilized by all agencies or individuals that serve class members and their families, adheres to a prescribed set of family-centered values and principles that are driven by a definable process. The CPM values and principles are summarized as follows:

- Services are needs-driven, strengths-based, and family-focused, from the first conversation with or about the family.
- Services are individualized and tailored to the strengths and needs of each child or youth and his/her family.
- Services are delivered through a multi-agency, collaborative approach that is grounded in a strong community base.
- Family voice, choice, and preference are assured throughout the process.
- Services incorporate a blend of formal and informal resources designed to assist families with successful transitions that ensure long-term success.
- Services are culturally competent and respectful of the culture of the children, youth, and their families.
- Services and supports are provided in the child’s or youth’s and family’s community.
- Children and youth are, first and foremost, protected from abuse and neglect and maintained safely in their own homes.
- Children and youth have permanency and stability in their living situations.

In order to benefit from the full array of services the child or youth needs, at whatever level appropriate and necessary to meet the child’s or youth’s needs, class members will be best served through five key practice components that are organized and delivered in the context of an overall child or youth and family plan. These five components include the following:
- **Engagement**: Engaging families is the foundation to building trusting and mutually beneficial relationships between family members, team members, and service providers. Agencies involved with the child or youth and family work to reach agreement about services, safety, well-being (meeting attachment and other developmental needs, health, education, and mental health), and permanency.

- **Assessing**: Information gathering and assessing needs is the practice of gathering and evaluating information about the child or youth and family, which includes gathering and assessing strengths, as well as assessing the underlying needs. Assessing also includes determining the capability, willingness, and availability of resources for achieving safety, permanence, and well-being of children and youth.

- **Service Planning and Implementation**: Service planning is the practice of tailoring supports and services unique to each child or youth and family to address unmet needs. The plan specifies the goals, roles, strategies, resources, and timeframes for coordinated implementation of supports and services for the child or youth, family, and caregivers.

- **Monitoring and Adapting**: Monitoring and adapting is the practice of evaluating the effectiveness of the plan, assessing circumstances and resources, and reworking the plan, as needed. The team is responsible for reassessing the needs, applying knowledge gained through ongoing assessments, and adapting the plan in a timely manner.

- **Transition**: The successful transition away from formal supports can occur when informal supports are in place and providing the support and activities needed to ensure long-term stability.
## Intensive Care Coordination

### Definition

Intensive care coordination (ICC) is a targeted case management (TCM) service that facilitates assessment of, care planning for, and coordination of services, including urgent services for beneficiaries with intensive needs. An ICC coordinator serves as the single point of accountability to:

- Ensure that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, family/youth driven and culturally and linguistically relevant manner, and that services and supports are guided by the needs of the child or youth;
- Facilitate a collaborative relationship among the child or youth, his/her family and involved child-serving systems;
- Support the parent/caregiver in meeting his/her child’s or youth’s needs;
- Help establish the Child and Family Team (CFT) and provide ongoing support; and
- Organize and match care across providers and child serving systems to allow the child or youth to be served in his/her home community.

### Service Components/Activities

While the key service components of ICC are similar to TCM, ICC differs in that it is integrated into the CFT process and typically requires more active participation by the ICC provider, in order to ensure that the needs of the child or youth are appropriately and effectively met. As such, the
## Intensive Care Coordination

### Service Components/Activities

_(Continued)_

<table>
<thead>
<tr>
<th>ICC service components include the following:</th>
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<tbody>
<tr>
<td><strong>Comprehensive Assessment and Periodic Reassessment</strong></td>
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<tr>
<td>These assessment activities are different from the clinical assessment to establish medical necessity for specialty mental health services, but must align with the mental health client plan. Information gathering and assessing needs is the practice of gathering and evaluating information about the child or youth and family, which includes gathering and assessing strengths, as well as assessing the underlying needs. Assessing also includes determining the capability, willingness, and availability of resources for achieving safety, permanence, and well-being of children and youth.</td>
</tr>
<tr>
<td><strong>Development and Periodic Revision of the Client Plan</strong></td>
</tr>
<tr>
<td>Planning within the CPM is a dynamic and interactive process that addresses the goals and objectives necessary to assure that children and youth are safe, live in permanent loving families, and achieve well-being. This process is built on an expectation that the planning process and resulting plans reflect the child or youth and family’s own goals and preferences and that they have access to necessary services and resources that meet their needs.</td>
</tr>
<tr>
<td>The ICC coordinator is responsible for working within the CFT to ensure that plans from any of the system partners (child welfare, education, juvenile probation, etc.) are integrated to comprehensively address the identified goals and objectives, and that the activities of all parties involved with service to the child or youth and/or family are coordinated to support and ensure successful and enduring change.</td>
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<tr>
<td><strong>Intensive Care Coordination</strong></td>
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<tr>
<td><strong>Service Components/ Activities (Continued)</strong></td>
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<tr>
<td>Monitoring and adapting is the practice of evaluating the effectiveness of the plan, assessing circumstances and resources, and reworking the plan as needed. The CFT also is responsible for reassessing the needs; applying knowledge gained through ongoing assessments; and adapting the plan to address the changing needs of the child or youth and family in a timely manner, but not less than every 90 days. Intervention strategies should be monitored on a frequent basis, so that modifications to the plan can be made based on results, incorporating approaches that work, and refining those that do not.</td>
</tr>
<tr>
<td><strong>Transition</strong></td>
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<tr>
<td><strong>Provider Qualifications</strong></td>
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<tr>
<td>Intensive Care Coordination</td>
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<tr>
<td><strong>Service Authorization and Discharge</strong></td>
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<tr>
<td><strong>Documentation Requirements</strong></td>
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<tr>
<td><strong>Service Limitations/ Lockouts</strong></td>
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</tbody>
</table>
**Intensive Care Coordination**

| Service Limitations/ Lockouts (Continued) | FFP is only available for TCM services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program, except for case management that is included in an individualized education program or individualized family service plan consistent with section 1903(c) of the Act. (Sections 1902(a) (25) and 1905(c).

For members of the target group who are transitioning to a community setting, TCM services will be made available for up to 30 calendar days, for a maximum of three, non-consecutive periods of 30 calendar days or less per hospitalization or inpatient stay, prior to the discharge of a covered stay in a medical institution. The target group does not include individuals who are inmates of public institutions. (9 CCR § 1840.374)

ICC may be provided solely for the purpose of coordinating placement of the child or youth on discharge from the hospital, psychiatric health facility, or psychiatric nursing facility, may be provided during the 30 calendar days immediately prior to the day of discharge, for a maximum of three, nonconsecutive periods of 30 calendar days or less per continuous stay in the facility, as part of discharge planning.

| Billing Code and Billing Requirements | ICC is claimed by using the standard unit of service for claiming and the TCM procedure code T1017 with the modifier HK.

ICC will be reimbursed at the TCM rate.

All other claiming and reimbursement requirements that apply to TCM apply to ICC.

For more current information, please see the DHCS All County Information Notice regarding ICC and IHBS billing. |
## Intensive Home Based Mental Health Services

### Definition

Intensive home-based mental health services (IHBS) are mental health rehabilitation services provided to Medi-Cal beneficiaries as medically necessary. IHBS are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child's or youth's functioning, and are aimed at helping the child or youth build skills necessary for successful functioning in the home and community, and improving the child's or youth's family's ability to help the child or youth successfully function in the home and community.

### Service Components/Activities

Service activities may include, but are not limited to:

- Medically necessary, skills-based interventions for the remediation of behaviors or improvement of symptoms, including, but not limited to, the implementation of a positive behavioral plan and/or modeling interventions for the child's or youth's family and/or significant others to assist the child or youth in implementing the strategies;
- Development of functional skills to improve self-care, self-regulation, or other functional impairments, by intervening to decrease or replace non-functional behaviors that interfere with daily living tasks, or to avoid exploitation by others;
- Development of skills or replacement behaviors that allow the child or youth to fully participate in the CFT and service plans including, but not limited to, the client plan and/or child welfare service plan;
## Intensive Home Based Mental Health Services

### Service Components/Activities

*(Continued)*

- Improvement of self-management of symptoms, including self-administration of medications as appropriate;
- Education of the child or youth and/or his/her family or caregiver(s) about, and how to, manage the child’s or youth’s mental health disorder or symptoms;
- Support of the development, maintenance, and use of social networks, including the use of natural and community resources;
- Support to address behaviors that interfere with the achievement of a stable and permanent family life;
- Support to address behaviors that interfere with seeking and maintaining a job;
- Support to address behaviors that interfere with a child’s or youth’s success in achieving educational objectives in an academic program in the community;
- Support to address behaviors that interfere with transitional independent living objectives, such as seeking and maintaining housing and living independently.

### Provider Qualifications

IHBS are typically, but not always, provided by paraprofessionals under clinical supervision. Peers, including a Parent Partner/Advocate, may provide IHBS, if qualified to provide the service.

Provider qualifications for IHBS are the same as those allowed by DHCS for mental health services, and as approved by the MHP. (See Appendix F which provides a description of providers eligible to provide services.)
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<tr>
<th><strong>Intensive Home Based Mental Health Services</strong></th>
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<tbody>
<tr>
<td><strong>Provider Qualifications (Continued)</strong></td>
<td>All MHPs and providers in the SD2 provider master file currently certified to claim for procedure code H2015 will be automatically eligible to claim for IHBS. With the next re-certification, the MHP must specifically indicate those providers who are eligible to provide IHBS by using the Mode of Service 15 along with Service Function Code 57.</td>
</tr>
<tr>
<td><strong>Service Authorization and Discharge</strong></td>
<td>Service authorization should be consistent with the MHP’s process for authorizing mental health services.</td>
</tr>
<tr>
<td><strong>Documentation Requirements</strong></td>
<td>Documentation requirements should be consistent with the MHP’s policies and procedures and the contract between DHCS and the MHP.</td>
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</table>
## Intensive Home Based Mental Health Services

| Service Limitations/Lockouts | Mental health services (including IHBS) are not reimbursable when provided by day treatment intensive or day rehabilitation staff during the same time period that day treatment intensive or day rehabilitation services are being provided. Authorization is required for mental health services if these services are provided on the same day that day treatment intensive or day rehabilitation services are provided. Certain services may be part of the child’s or youth’s course of treatment, but may not be provided during the same hours of the day that IHBS services are being provided to the child or youth. These services include:  
- Day Treatment Rehabilitative or Day Treatment Intensive,  
- Group Therapy, and  
- Therapeutic Behavioral Services (TBS). |
| Billing Code and Billing Requirements | In order to distinguish IHBS from non-inpatient Specialty Mental Health Services (SMHS) when claiming, IHBS uses a different procedure code and modifier (H2015 HK) and service function code (57). IHBS will be reimbursed at the same rates as Mental Health Services (MHS). |
## Service Delivery through the Therapeutic Foster Care (TFC) Service Model

<table>
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<tr>
<th>Key Service Components</th>
<th>Description</th>
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</table>
| **TFC Service Model Overview** | The Therapeutic Foster Care (TFC) service model allows for the provision of short-term, intensive, highly coordinated, trauma-informed, and individualized Specialty Mental Health Services (SMHS) service activities to children and youth, up to age 21, who have complex emotional and behavioral needs, and who are placed with trained, intensely supervised, and supported TFC parents. The TFC parent serves as a key participant in the therapeutic treatment process of the child or youth. The TFC parent will provide trauma-informed interventions that are medically necessary for the child or youth. The SMHS service activities provided through the TFC service model assist the child or youth in achieving client plan goals and objectives, improve functioning and well-being, and help the child or youth to remain in a family-like home in a community setting, thereby avoiding residential, inpatient, or institutional care.  

The TFC service model is intended for children and youth who require intensive and frequent mental health support in a family environment. The TFC service model allows for the provision of certain SMHS service activities available under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, as a home-based alternative to high level care in institutional settings, such as group homes and, in the future, as an alternative to Short Term Residential Therapeutic Programs (STRTPs). |

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14 As described under the section on TFC parent qualifications, due to the unique characteristics of this service and their role, it is understood that TFC parents are not required to be part of the child’s/youth’s long-term permanency plan. However, the program design does not prohibit relative caregivers and “non-related extended family members from being TFC parents if they meet the TFC parent qualifications.

15 Receipt of Medi-Cal SMHS service activities provided under the TFC service model does not limit the availability of other SMHS. TFC parents are not expected to provide other SMHS that may be medically necessary.
### TFC Service Model Overview

(Continued)

The TFC home may also serve as a step down from STRTPs. SMHS activities provided through the TFC service model should not be the only SMHS that a child or youth would receive. The SMHS service activities provided through the TFC service model are part of a continuum of care for children and youth. Counties are encouraged to continue to develop the resources, supports, and services needed to maintain foster children and youth in family-based home settings, while promoting permanency for the children and youth through family reunification, adoption, or legal guardianship. These efforts may include the provision of Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Wraparound services, as appropriate.

The SMHS activities provided through the TFC service model must be delivered using a CFT to develop and guide the planning and service delivery process.

### Indicators of Need for SMHS Components through the TFC Service Model

The SMHS activities provided through the TFC service model are appropriate for children and youth with more intensive needs, or children and youth who are in or at risk of residential, inpatient, or institutional care, but who could be effectively served in the home and community.

The following are the circumstances in which SMHS service activities provided through the TFC service model may be appropriate to address the child’s or youth’s mental health needs:

1. The child or youth is at risk of losing his or her placement and/or being removed from his or her home as a result of the caregiver’s inability to meet the child’s
<table>
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<th>Key Service Components</th>
<th>Description</th>
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</table>
| Indicators of Need for SMHS Components through the TFC Service Model (Continued) | or youth’s mental health needs; and, either  
  a. There is recent history of services and treatment (for example, ICC and IHBS) that have proven insufficient to meet the child’s or youth’s mental health needs, and the child or youth is immediately at risk of residential, inpatient, or institutional care; or  
  b. In cases when the child or youth is transitioning from a residential, inpatient, or institutional setting to a community setting, ICC, IHBS and other intensive SMHS service activities will not be sufficient to prevent deterioration, stabilize the child or youth, support effective rehabilitation, or avoid the need to initiate or continue a more intensive level of care in a more restrictive setting. |
<p>| Role of TFC Service Model Agency (TFC Agency)             | The TFC service model agency (TFC Agency) is responsible for ensuring the TFC parent meets both resource family approval (RFA) program standards and meets the required qualifications as a TFC Parent. The TFC parent will work under supervision of the TFC Agency. A Licensed Mental Health Professional (LMHP) or a Waivered or Registered Mental Health Professional (WRMHP) employed by the TFC Agency will provide direction to the TFC parent, and will ensure the TFC parent is following the client plan. The TFC Agency’s LMHP/WRMHP assumes ultimate responsibility for directing the SMHS service activities provided through the TFC service model by the TFC parent. |</p>
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<th>Key Service Components</th>
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</table>
| **Role of TFC Service Model Agency (TFC Agency)** *(Continued)* | The TFC Agency will provide the management oversight of a network of TFC parents. The TFC Agency activities include:  
- Recruiting, approving (unless already approved by the county), and annually re-approving TFC parents, following both the RFA process and Medi-Cal SMHS requirements, as a TFC parent who has the ability to meet the diverse therapeutic needs of the child or youth;  
- Providing, at a minimum, a 40-hour training for the TFC parent prior to providing SMHS service activities through the TFC service model, as outlined in the TFC Parent Qualifications document;  
- Actively participating in the CFT to identify supports for the child and family, including linking with a TFC parent who can best meet the child’s or youth’s individual needs;  
- Integrating the TFC parent and appropriate staff into the existing CFT;  
- Providing competency-based training to the TFC parent, both initially and ongoing;  
- Providing ongoing supervision and intensive support to the TFC parent;  
- Monitoring the child’s or youth’s progress in meeting client plan goals related to SMHS service activities provided through the TFC service model;  
- Maintaining documentation (progress notes) related to the TFC parent and child or youth, which is included in |
## Service Delivery through the Therapeutic Foster Care (TFC) Service Model

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<th>Key Service Components</th>
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</table>
| **Role of TFC Service Model Agency (TFC Agency)** |  the child’s or youth’s client plan\(^{16}\);  
  - Providing Medi-Cal-related reports, as required, to the MHP or designee;  
  - Providing other supports to the TFC parent and child or youth (i.e. Parent Partner and/or youth mentor); and  
  As it relates to the care of the individual child or youth, the TFC Agency is responsible for the following:  
  - Collaborating and coordinating with the ICC coordinator and CFT in the development and implementation of the client plan;  
  - Assessing the child’s or youth’s progress in meeting client plan goals related to the provision of SMHS service activities provided through the TFC service model, and communicating progress through the CFT;  
  - Incorporating evidence informed practices in the training of TFC parents and the treatment of the child or youth.  
  The TFC Agency may also be responsible for providing other non-TFC medically necessary SMHS, if included in its contract with the MHP.\(^{17}\) |

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\(^{16}\) See definition of “the plan” in the Medi-Cal Manual for Intensive Care Coordination (ICC), IHBS and TFC for Medi-Cal Beneficiaries.

\(^{17}\) A TFC Agency is not required to provide all SMHS (i.e. other mental health providers could provide these services). The 24/7 crisis intervention services will need to be available through the FFA or county MHP.
### Service Delivery through the Therapeutic Foster Care (TFC) Service Model

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<th>Key Service Components</th>
<th>Description</th>
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</table>
| **Qualifications for TFC Agency** | The TFC Agency is:  
- A California Foster Family Agency (FFA) that meets licensure and accreditation requirements established by the California Department of Social Services (CDSS), and that is able to approve TFC homes, and that is able to accept for placement from county placing agencies; and  
- A Medi-Cal SMHS provider that has a contract with a MHP as a Medi-Cal provider (or an MHP that has been certified by DHCS) to provide TFC services. The TFC Agency may provide a wide array of other SMHS, if these SMHS are included in its contract with the MHP. |
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<tr>
<th>Key Service Components</th>
<th>Description</th>
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</table>
| **Role of TFC Parent as a Provider of SMHS** | The TFC parent serves as a key participant in the trauma-informed, rehabilitative treatment of the child or youth, as set forth in the client plan. The TFC parent provides one or more of the following TFC service model SMHS service activities:  
  - **Plan development (limited to when it is part of the CFT):** The TFC parent will participate as a member in the CFT in care planning, monitoring, and review processes. The TFC parent also will observe, monitor, and alert the TFC Agency and members of the CFT about changes in the child’s or youth’s needs.  
  - **Rehabilitation:** The TFC parent will implement in-home informed practices which include trauma-informed rehabilitative treatment strategies set forth in the child’s or youth’s client plan. Examples of services to be provided include: providing skills-based interventions (including coaching and modeling); developing functional skills to improve self-care; and improving self-management in areas of anger management or self-esteem or peer relations;  
  - **Collateral:** The TFC parent will meet the needs of the child or youth in achieving his or her client plan goals by reaching out to significant support person(s) and providing consultation, and/or training for needed medical, vocational, or other services to assist in better utilization of SMHS by the child or youth. |
## Service Delivery through the Therapeutic Foster Care (TFC) Service Model

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<tr>
<th>Key Service Components</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Service Authorization</strong></td>
<td>• Service authorization should be consistent with the MHP process for authorizing SMHS. The progress of Service authorization should be consistent with the MHP process for authorizing SMHS. The progress of this service should be reviewed in coordination with the CFT, at least every three (3) months.</td>
</tr>
</tbody>
</table>
| **Medi-Cal Documentation Requirements** | The SMHS service activities provided through the TFC service model should be documented in accordance with the MHP’s policies and procedures and must listed in the child’s or youth’s client plan.  
• The TFC parent must write and sign a progress note for each day of service. The progress note must meet Medicaid documentation standards. The TFC Agency’s LMHP/WRMHP must review and co-sign each progress note to indicate that service activities are appropriate and that documentation requirements are met. |
| **Service Limitations/Lockouts** | The TFC service model does not include:  
1. Reimbursement for the cost of room and board which will be paid separately to the TFC parents utilizing federal, state and/or local foster care funding sources; or  
2. Other foster care program-related services (e.g., assessing adoption placements, serving legal papers, home investigations, administering foster care subsidies), or other parenting functions such as providing food or transportation. |
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<th>Key Service Components</th>
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<tbody>
<tr>
<td><strong>Service Limitations/Lockouts (Continued)</strong></td>
<td>The SMHS service activities provided through the TFC service model are <strong>NOT</strong> reimbursable:</td>
</tr>
<tr>
<td></td>
<td>• When the child or youth is receiving Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services, or Psychiatric Nursing Facility Services, <strong>EXCEPT</strong> for the day of admission to these facilities;</td>
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<tr>
<td></td>
<td>• While the child or youth is detained in juvenile hall; or</td>
</tr>
<tr>
<td></td>
<td>• While the child or youth is in a Short Term Residential Treatment Program or other residential setting.</td>
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<tr>
<td><strong>Payment Methodology</strong></td>
<td>Rate for SMHS activities provided through the TFC service model:</td>
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<td>• SMHS activities provided through the TFC service model will be reimbursed at a daily per diem rate. This rate will depend upon whether or not the TFC Agency is a contractor of the MHP or is county owned and operated.</td>
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<tr>
<td></td>
<td>• If the TFC Agency is a contractor of the MHP, the TFC Agency will be paid by the MHP at a rate that is negotiated between the MHP and the TFC Agency.</td>
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<td></td>
<td>• If the TFC Agency is county owned and operated, DHCS will reimburse the MHP the federal share of the MHP’s interim rate. The county interim rate currently is set at $87.40 per day. Each county’s interim rate will be updated annually, based upon its most recently filed cost report.</td>
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<tr>
<td>Key Service Components</td>
<td>Description</td>
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</tr>
<tr>
<td><strong>Payment Methodology</strong></td>
<td>The TFC Agency shall be paid for SMHS activities provided through the TFC service model in accordance with terms of the contract with the MHP. The per diem daily rate includes:</td>
</tr>
<tr>
<td><em>(Continued)</em></td>
<td>• The TFC Agency’s administrative and LMHP/WRMHP staff costs; and</td>
</tr>
<tr>
<td></td>
<td>• The payment to the TFC parent for the SMHS activities provided through the TFC service model to the child or youth living in the TFC home.</td>
</tr>
<tr>
<td></td>
<td>Rate for Board and Care:</td>
</tr>
<tr>
<td></td>
<td>A rate that will be received by the TFC Agency and paid to the TFC parent for board, care, and supervision of the child or youth will be paid by the placing agency using federal IV-E or other state or local funding sources, and not by Medi-Cal.</td>
</tr>
</tbody>
</table>
### Role of Other Entities

<table>
<thead>
<tr>
<th>County Mental Health Plan</th>
<th>The MHP is responsible for:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Providing directly or arranging and paying for medically necessary SMHS service activities provided through the TFC service model to Medi-Cal beneficiaries;</td>
</tr>
<tr>
<td></td>
<td>• Providing directly or arranging and paying for other medically necessary SMHS service activities, as determined by the child’s or youth’s client mental health plan; and</td>
</tr>
<tr>
<td></td>
<td>• Certifying and monitoring the TFC Agency to ensure SMHS service activity requirements are met.</td>
</tr>
</tbody>
</table>

| County Child Welfare and Probation Agencies | County Child Welfare and Probation Agencies retain social work case management and placement responsibilities, and file necessary reports with the courts. |

<table>
<thead>
<tr>
<th>California Department of Health Care Services (DHCS)</th>
<th>The California Department of Health Care Services (DHCS) is the designated single state agency for Medicaid and responsible for:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Supporting statewide implementation of the TFC service model, including providing technical assistance and resources to counties and providers;</td>
</tr>
<tr>
<td></td>
<td>• Providing overall oversight of SMHS, including those SMHS service activities provided through the TFC service model; and</td>
</tr>
<tr>
<td></td>
<td>• Coordinating with CDSS in the oversight and implementation of the TFC service model, as needed.</td>
</tr>
</tbody>
</table>
## Role of Other Entities Continued

<table>
<thead>
<tr>
<th>California Department of Social Services (CDSS)</th>
<th>The California Department of Social Services (CDSS) is responsible for:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Developing rates for the board, care, and supervision of foster children and youth, licensing FFAs, and performing audits of agencies;</td>
</tr>
<tr>
<td></td>
<td>• Conducting oversight of programs and licensing of agencies, including investigations for licensing violations;</td>
</tr>
<tr>
<td></td>
<td>• Supporting statewide implementation of the TFC service model, including technical assistance and resources to counties; and</td>
</tr>
<tr>
<td></td>
<td>• Coordinating with DHCS in the oversight and implementation of the TFC service model, as needed.</td>
</tr>
</tbody>
</table>
Date: 01/10/17  Staff Service Duration: :40  Travel Durations: :15  Documentation: :09

Telephone Contact: ☑️ Y ☐️ N

Other Staff Duration: :40  Travel Durations: :15  Documentation: :00

Procedure Code: T1017:HK

Service: Intensive Care Coordination

Location of Service: Client's Home

Goal: John will increase replacement behaviors related to his diagnosis of Attention Deficit Hyperactivity Disorder to reduce client's kicking and punching siblings and peers, from 5x per day to 1x per week.

John reported no angry outbursts at school for the last 5 days. John has been playing basketball with peers after school. John also shared that he was invited to a classmate's birthday party on Saturday, and is looking forward to going to the party.

John's mother and grandmother reported his progress in self-regulation at home and school. With encouragement and prompting from his maternal grandmother, John is able to complete his homework and has been taking care of his hygiene. He has been taking his prescribed medications from his mother, without resistance. Mother is pleased with client's behavioral improvement.

Parent Partner informed team that Mrs. T continues to participate in school conferences and IEP meetings, which has helped Mother better understand the context of John's behavior. Parent Partner also reported fewer altercations between client and Mother, because of improved communication styles between the two. The ICC Coordinator led a discussion regarding potential of IHBS worker decreasing amount of sessions at the home, but continuing to reinforce anger management plan. John smiled at the idea of the IHBS worker coming less. When the ICC Coordinator prompted John to share why he was smiling, client stated “it makes me feel like I am getting better.” Mother was supportive of the idea, but asked if the IHBS worker could still come every week. The IHBS worker shared that she thought working on other ways to express feelings might be helpful to the John and his family.

Parent Partner acknowledged Mother’s appropriate communication skills, and discussed with Mother importance of consistency in dealing with John's outbursts. Parent Partner will assist Mother in developing a plan to support and recognize appropriate behavior and social interaction. IHBS worker will meet with John, reinforce his anger management plan, and teach alternative ways in expressing feelings.

Mrs. T. reported feeling much more confident in her own response when John is struggling and indicated that she understands the importance of her response to John in helping John to stay calm.
**Goal:** John will reduce aggressive behaviors related to his diagnosis of Attention Deficit Hyperactivity Disorder, including kicking and punching siblings, from 5x per day to 1x per week and will increase use of pro-social replacement behaviors.

IHBS worker met with Mother and Aunt to identify situations and triggers at home that contribute to client’s angry outbursts. Family reported that client has been throwing tantrums, kicking and punching his siblings. When they start playing and teasing each other, John’s behavior escalates and gets out of hand.

IHBS worker assessed home situation and assisted Mother in identifying situations that lead to John’s angry outbursts. IHBS worker and family discussed alternative ways to deal with John’s frustration, such as talking to client in a firm but calm tone of voice, and suggesting alternative options. IHBS worker also assisted Mother in gaining a better understanding of client’s behavior, as well as the need to recognize the behavior she wants to see at least once every 5 minutes, from both boys, so that they know what they should do.

Also, John agreed that he will take a short client time out when becoming angry. If he becomes violent towards self/family members, he will go to his room for a 15-minute period to calm himself. IHBS worker will continue to assist Mother in identifying when the interaction is likely to become out of control, so that she can intervene early, as well as modeling appropriate responses to client’s outbursts.
## TFC SERVICE MODEL SAMPLE PROGRESS NOTE TEMPLATE AND INSTRUCTIONS

### TFC SERVICE MODEL SAMPLE PROGRESS NOTE TEMPLATE

<table>
<thead>
<tr>
<th>Child’s/Youth’s Name and other required information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Date _____________________________________</td>
</tr>
</tbody>
</table>

1. **Presentation**  
   Observations of the child’s/youth’s behavior(s) for the day. Include the target behavior(s), as well as appropriate behaviors and interactions the child engaged in.

2. **Target behavior(s)**  
   Behaviors identified in the client plan

3. **Intervention(s) utilized?**  
   What strategies were used to address the target behavior, based on proposed interventions identified in the client plan?

4. **Child’s response to intervention(s)**  
   Was the intervention effective? How did the child/youth practice coping strategies? Did the child/youth remember coping strategies/think about the strategies before or after the behavior? Can the child/youth think of what could have gone better? Identify other coping solutions? How did the child/youth respond to strategies utilized?

| TFC Parent Signature/Date: | LMHP/WRMHP Co-Signature/Date: |
INSTRUCTIONS FOR COMPLETING TFC SERVICES PROGRESS NOTE TEMPLATE

The Licensed Mental Health Professional (LMHP) or Waivered or Registered Mental Health Professional (WRMHP) directing the TFC parent(s) in providing this service should use this document to assist the TFC parent in completing the TFC Daily Progress Note. This document contains instructions, explanations, and examples that are intended to aid the TFC parent in completing a progress note that is in compliance with Medi-Cal documentation requirements.

I. **Service Date:** TFC Parent to provide the date that the service being claimed was performed.

II. **Client Plan:** Use the client plan developed with the CFT as a reference to identify the target behavior(s) and/or planned intervention(s).

III. **Progress Note:**
   1. **Presentation**
      a. Brief narrative of how the child/youth’s day went.
      b. Include the target behavior(s), as well as appropriate behaviors and interactions the child/youth engaged in.
   2. **Target behavior(s)**
      a. Identify the target behaviors identified in the client plan that the child/youth engaged in that day.
      b. Be specific
   3. **Intervention(s) utilized**
      a. What strategies were used to prevent the target behavior, or promote the desired behavior, based on proposed interventions identified in the client plan?
      b. How did you respond when the child/youth engaged in the target behavior?
      c. How did you utilize interventions identified in the client plan?
   4. **Child’s response to the intervention**
      a. Describe how the child/youth reacted to your intervention? How did the child/youth respond to strategies utilized?
      b. How did the child/youth practice coping strategies? Did child/youth remember coping strategies/think about the strategies before or after the behavior?
      c. Can the child/youth think of what could have gone better? Identify other coping solutions?
      d. Describe whether the child’s/youth’s reaction was positive or negative. (Not all interventions will have the desired result). This helps guide future treatment planning and interventions.
      e. Include quotes from the child/youth, whenever possible.
   5. **Signature/Date of TFC Parent and Co-Signature/Date of LMHP/WRMHP**
Examples of potential target behaviors, including, but not limited to:

- Noncompliance with house rules
- Refusing to get out of bed
- Refusing to go to school
- Refusing to eat meals
- Interrupting—repeatedly cutting off foster mother as she tried to have a conversation with her friend

Examples of desirable behaviors, including, but not limited to:

- Child/youth does not throw tantrums
- Child/youth does not destroy property
- Child/youth follows instructions appropriately
- Child/youth used his/her coping skills to navigate a difficult issue

Possible ways to debrief with the child at the end of the day:

- Explore with the child/youth his/her response to the intervention(s) and if he/she found it helpful.
- Explore with the child/youth possible preferred parental approaches to target behaviors.
- Be mindful of the child’s/youth’s current mood state at the time of debriefing in order to have a successful interaction.
§1830.205. MEDICAL NECESSITY CRITERIA FOR MHP REIMBURSEMENT OF SPECIALTY MENTAL HEALTH SERVICES

(a) The following medical necessity criteria determine Medi-Cal reimbursement for specialty mental health services that are the responsibility of the MHP under this Subchapter, except as specifically provided.

(b) The beneficiary must meet criteria outlined in Subsections (1)-(3) below to be eligible for services:

(1) Have one of the following diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, Fourth Edition (1994), published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders, except Autistic Disorders
(B) Disruptive Behavior and Attention Deficit Disorders
(C) Feeding and Eating Disorders of Infancy and Early Childhood
(D) Elimination Disorders
(E) Other Disorders of Infancy, Childhood, or Adolescence
(F) Schizophrenia and other Psychotic Disorders, except Psychotic Disorders due to a General Medical Condition
(G) Mood Disorders, except Mood Disorders due to a General Medical Condition
(H) Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition
(I) Somatoform Disorders
(J) Factitious Disorders
(K) Dissociative Disorders
(L) Paraphilias
(M) Gender Identity Disorder
(N) Eating Disorders
(O) Impulse Control Disorders Not Elsewhere Classified
(P) Adjustment Disorders
(Q) Personality Disorders, excluding Antisocial Personality Disorder
(R) Medication-Induced Movement Disorders related to other included diagnoses.

(2) Have at least one of the following impairments as a result of the mental disorder(s) listed in Subsection (b)(1) above:

(A) A significant impairment in an important area of life functioning.
(B) A reasonable probability of significant deterioration in an important area of life functioning.
(C) Except as provided in Section 1830.210, a reasonable probability a child will not progress developmentally as individually appropriate. For the purpose of this Section, a child is a person under the age of 21 years.

(3) Meet each of the intervention criteria listed below:

(A) The focus of the proposed intervention is to address the condition identified in Subsection (b)(2) above.

(B) The expectation is that the proposed intervention will:

1. Significantly diminish the impairment, or
2. Prevent significant deterioration in an important area of life functioning, or
3. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.
4. For a child who meets the criteria of Section 1830.210(1), meet the criteria of Section 1830.210(b) and (c).

(C) The condition would not be responsive to physical health care based treatment.

1. When the requirements of this Section or Section 1830.210 are met, beneficiaries shall receive specialty mental health services for a diagnosis included in Subsection (b)(1) even if a diagnosis that is not included in Subsection (b)(1) is also present.
§1830.210. MEDICAL NECESSITY CRITERIA FOR MHP REIMBURSEMENT FOR SPECIALTY MENTAL HEALTH SERVICES FOR ELIGIBLE BENEFICIARIES UNDER 21 YEARS OF AGE.

(a) For beneficiaries under 21 years of age who are eligible for EPSDT supplemental specialty mental health services, and who do not meet the medical necessity requirements of Section 1830.205(b)(2)-(3), medical necessity criteria for specialty mental health services covered by this Subchapter shall be met when all of the following exist:

1. The beneficiary meets the diagnosis criteria in Section 1830.205(b)(1);
2. The beneficiary has a condition that would not be responsive to physical health care based treatment; and
3. The requirements of Title 22, Section 51340(e)(3)(A) are met with respect to the mental disorder; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3)(A) with respect to the mental disorder and the requirements of Title 22, Section 51340(f) are met.

(b) The MHP shall not approve a request for an EPSDT supplemental specialty mental health service under this Section or Section 1830.205 if the MHP determines that the service to be provided is accessible and available in an appropriate and timely manner as another specialty mental health service covered by this Subchapter and the MHP provides or arranges and pays for such a specialty mental health service.

(c) The MHP shall not approve a request for specialty mental health services under this Section in home and community based settings if the MHP determines that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater than the total cost to the Medi-Cal program in providing medically equivalent services at the beneficiary’s otherwise appropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner, and the MHP provides or arranges and pays for the institutional level of care if the institutional level of care is covered by the MHP under Section 1810.345, or arranges for the institutional level of care, if the institutional level of care is not covered by the MHP under Section 1810.345. For the purpose of this Subsection, the determination of the availability of an appropriate institutional level of care shall be made in accordance with the stipulated settlement in T.L. v. Belshe.
APPENDIX G

Therapeutic Foster Care (TFC) Service Model Parent Qualifications

TFC Parent Qualifications

Under the TFC service model, to qualify as a Medicaid TFC provider, the TFC parent must be approved as a resource parent and a TFC provider by the TFC Agency. This means that the TFC parent must:

- Meet and comply with all basic foster care or resource parent requirements as set forth in California Code of Regulations (CCR) Title 22, Division 6, Chapter 9.5 or Welfare and Institutions (W&I) Code 16519.5; and
- Meet and comply with all requirements related to their role as a TFC parent outlined below.

Resource Family Approval (RFA)

- Pursuant to Assembly Bill (AB) 403 (Statutes of 2015) all new family-based foster care providers will be required to meet Resource Family Approval (RFA) standards\(^\text{18}\) starting January 1, 2017 and existing licensed/certified foster care providers will be required to complete the process by January 1, 2020.

**TFC Parents must meet BOTH the RFA and TFC requirements as specified in Column A and B in the table on the following pages.**

\(^{18}\) For most updated information, refer to CDSS’ RFA directives.
## TFC Parent Qualifications

<table>
<thead>
<tr>
<th><strong>COLUMN A</strong> Resource Family Approval (RFA)</th>
<th><strong>COLUMN B</strong> Additional Requirements for Therapeutic Foster Care (TFC) Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Resource Parent</strong></td>
<td></td>
</tr>
<tr>
<td>Must be at least 18 years of age.</td>
<td>For TFC parents the minimum age is 21 rather than 18 years of age.</td>
</tr>
<tr>
<td>• All new caregivers, related and non-related, interested in providing care to children in child welfare or probation must go through the RFA process.</td>
<td>• The TFC parent must meet California’s Medicaid rehabilitation provider qualification for “other qualified provider” 19 (i.e., has a high school diploma or equivalent degree)” and meet provider qualifications and other requirements regarding certification, oversight, etc. as established by the Mental Health Plan (MHP).</td>
</tr>
<tr>
<td>• An approved Resource Family (RF) is approved for foster care, legal guardianship and adoption.</td>
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<tr>
<td>• An RF has been determined to have ability and willingness to provide permanency and/or ability and willingness to support permanency for a child.</td>
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<tr>
<td>• Counties, CDSS, and FFAs shall adhere to RFA standards for all families.</td>
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</tr>
<tr>
<td><strong>Application Process</strong></td>
<td></td>
</tr>
<tr>
<td>Forms:</td>
<td></td>
</tr>
<tr>
<td>• Application and Criminal Records Statement</td>
<td></td>
</tr>
<tr>
<td>• Home Environment Checklist</td>
<td></td>
</tr>
<tr>
<td>• Risk Assessment</td>
<td></td>
</tr>
<tr>
<td>• Written Report</td>
<td></td>
</tr>
<tr>
<td>Supporting Documentation:</td>
<td></td>
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<tr>
<td>• Proof of Identity</td>
<td></td>
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<tr>
<td>The process for a resource parent to become a TFC parent will be determined by the TFC Agency in accordance with its contract with the MHP.</td>
<td></td>
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</tbody>
</table>

19 See California State Medicaid Plan Attachment 3.1 A Rehabilitation Mental Health Services.
<table>
<thead>
<tr>
<th>Application Process (Continued)</th>
<th>COLUMN A Resource Family Approval (RFA)</th>
<th>COLUMN B Additional Requirements for Therapeutic Foster Care (TFC) Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Department of Motor Vehicles (DMV) report for applicants and adults who may frequently transport children or non-minor dependents</td>
<td></td>
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<tr>
<td>• Verification of good physical &amp; psychosocial assessment for applicants</td>
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<tr>
<td>• Good mental health noted in the written report</td>
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<tr>
<td>• Tuberculosis (TB) screening on all adults in home</td>
<td></td>
<td></td>
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<tr>
<td>• Employment verification</td>
<td></td>
<td></td>
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<tr>
<td>• Verification of income/expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Proof of home ownership or rental agreement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prior history of applicant’s status as Foster Family Home (FFH); Certified Family Home (CFH); approved relative or nonrelative extended family member; or employee, volunteer or licensee of a Community Care Facility (CCF)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Personal references</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Requirements:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Home Environment Assessment (Building and Grounds)</td>
<td></td>
<td></td>
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<tr>
<td>• Background Checks Assessment</td>
<td></td>
<td></td>
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<tr>
<td>• Psychosocial Assessment</td>
<td></td>
<td></td>
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<tr>
<td>• Pre-Approval Training</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## TFC Parent Qualifications

<table>
<thead>
<tr>
<th>Background Checks</th>
<th>COLUMN A Resource Family Approval (RFA)</th>
<th>COLUMN B Additional Requirements for Therapeutic Foster Care (TFC) Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Fingerprint based criminal records check on applicant and all adults in the home at adoption clearance levels</td>
<td>• Full criminal history considered in psychosocial assessment</td>
<td>Any additional processes regarding background checks and screenings will be determined by the MHP and included in the contract between the TFC Agency and the MHP.</td>
</tr>
<tr>
<td>o Department of Justice (DOJ)</td>
<td>• Megan’s Law check</td>
<td></td>
</tr>
<tr>
<td>o Federal Bureau of Investigation (FBI)</td>
<td>• DMV Report</td>
<td></td>
</tr>
<tr>
<td>o Child Abuse Central Index (CACI)</td>
<td>• Legal Administration Action Records System (LAARS) check</td>
<td></td>
</tr>
<tr>
<td>• Full criminal history considered in psychosocial assessment</td>
<td>o Licensing Information System (LIS)</td>
<td></td>
</tr>
<tr>
<td>Information provided to applicants:</td>
<td>This review process includes:</td>
<td></td>
</tr>
<tr>
<td>• Benefits associated with foster care, Adoption Assistance Program (AAP), Kin- GAP, Approved Relative Caregiver (ARC) funding, and any other assistance that may apply</td>
<td>• A comprehensive written report which includes a discussion of family strengths, challenges, risk management concerns; the family’s appropriateness for providing Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services under the TFC service model; and a recommendation for FFA approval, including the child/youth best served by the family and any restrictions.</td>
<td></td>
</tr>
<tr>
<td>COLUMN A</td>
<td>COLUMN B Additional Requirements for Therapeutic Foster Care (TFC) Services</td>
<td></td>
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<td>----------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>Home Study Process and Inspection (Continued)</strong></td>
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<td></td>
</tr>
<tr>
<td>• Access to health, mental health, and dental care through Medi-Cal, in home supportive services, and developmental or other services based on the needs of a child or non-minor dependent in the care of a Resource Family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The Reasonable and Prudent Parent Standard(^\text{20})</td>
<td></td>
<td></td>
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<tr>
<td>• The Quality Parenting Initiative Partnership Plan(^\text{21}), if applicable</td>
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<td></td>
</tr>
<tr>
<td>Comprehensive RFA Assessment includes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Home Environment Assessment Check</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Building and Grounds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Fire Clearance (if required)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Capacity determination</td>
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</tbody>
</table>

\(^{20}\) As defined in W&I Code Section 362.05 (c), “reasonable and prudent parent standard” means the standard characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child while at the same time encouraging the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in foster care under the responsibility of the state to participate in age or developmentally appropriate extracurricular, enrichment, cultural, and social activities.

\(^{21}\) “Quality Parenting Initiative Partnership Plan” means the document that describes the roles of a Resource Family and a County in mutually supporting a child or non-minor dependent in care and meets the case plan objectives.
TFC Parent Qualifications

<table>
<thead>
<tr>
<th>COLUMN A</th>
<th>COLUMN B Additional Requirements for Therapeutic Foster Care (TFC) Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home Study Process and Inspection (Continued)</strong></td>
<td><strong>Home Study Process and Inspection (Continued)</strong></td>
</tr>
</tbody>
</table>

- Psychosocial Assessment
  - Minimum 3 face-to-face interviews with each applicant (at least one jointly and one individually)
  - Minimum 1 face-to-face interview with everyone in the home (including children)
  - Interviews include at minimum:
    - Childhood upbringing and experiences.
    - Adult experiences and personal characteristics
    - A risk assessment, which shall include:
      - Past and current alcohol and other substance use and abuse history
      - Physical, emotional, sexual abuse and family domestic violence history
      - Past and current physical and mental health of the applicant
    - Current marital status and history of marriages, domestic partnerships, or significant relationships
<table>
<thead>
<tr>
<th>TFC Parent Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COLUMN A</strong></td>
</tr>
<tr>
<td><strong>Resource Family Approval (RFA)</strong></td>
</tr>
<tr>
<td><strong>Home Study Process and Inspection (Continued)</strong></td>
</tr>
<tr>
<td>A. Children living in or out of the home</td>
</tr>
<tr>
<td>B. Name</td>
</tr>
<tr>
<td>C. Gender</td>
</tr>
<tr>
<td>D. Date of birth</td>
</tr>
<tr>
<td>E. Relationship to applicant</td>
</tr>
<tr>
<td>F. General health</td>
</tr>
<tr>
<td>G. Past and current behavioral issues</td>
</tr>
<tr>
<td>H. If children are not living in the home, the reason</td>
</tr>
<tr>
<td>I. Custody arrangements and disputes</td>
</tr>
<tr>
<td>• Parenting approaches</td>
</tr>
<tr>
<td>A. Family values</td>
</tr>
<tr>
<td>B. Lifestyles, activities, and home environment</td>
</tr>
<tr>
<td>C. Parenting practices and discipline procedures</td>
</tr>
<tr>
<td>D. Ability to parent a child from different backgrounds or experiences including race, ethnicity, sexual orientation, gender identity, or a child who is gender non-conforming</td>
</tr>
<tr>
<td>• Social support system</td>
</tr>
<tr>
<td>• Employment</td>
</tr>
<tr>
<td>• Financial situation</td>
</tr>
<tr>
<td>Home Study Process and Inspection (Continued)</td>
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| Initial Training Requirements                    | A current certificate verifying completion of an age-appropriate | 40 hours of initial TFC parent training must be completed prior to the parent being eligible to provide services as a TFC parent. An outline and agenda of the 40-
# TFC Parent Qualifications

<table>
<thead>
<tr>
<th>COLUMN A</th>
<th>COLUMN B Additional Requirements for Therapeutic Foster Care (TFC) Services</th>
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<tbody>
<tr>
<td><strong>Initial Training Requirements (Continued)</strong></td>
<td>hour training shall be provided to and be approved by the MHP as a part of the contract. Training shall include the following at a minimum:</td>
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<tr>
<td><strong>Cardio-Pulmonary Resuscitation and First Aid course</strong></td>
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<td>Minimum of 12 hours of pre-approval training which shall include:</td>
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<td>- A Resource Family orientation</td>
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<td>- An overview of the child protective system</td>
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<td>- Role of the resource family, including working cooperatively with service providers and agencies to develop and implement the case plan</td>
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<td>- Child and adolescent development and the effects of child abuse and neglect on child development</td>
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<td>- Positive discipline and the importance of self-esteem</td>
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<td>- Common health issues of foster children</td>
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<td>- Accessing education and health services available to foster children or non-minor dependents in care</td>
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<td>- Personal rights of foster youth</td>
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<td>- Options for permanency</td>
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<tr>
<td>Initial Training Requirements (Continued)</td>
<td>COLUMN A Resource Family Approval (RFA)</td>
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<tr>
<td>• Permanence, well-being, and education needs of children</td>
<td>• Effective communication and relationship building techniques</td>
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<td>• Birth parent relationships and safety issues regarding contact, as applicable</td>
<td>• Understanding and monitoring medications</td>
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<tr>
<td>• Instruction on cultural competency and sensitivity relating to, and best practices for, providing adequate care to lesbian, gay, bisexual, and transgender youth in out-of-home care</td>
<td>• Crisis management/de-escalation techniques</td>
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<td>• Basic instruction on the existing laws and procedures regarding the safety of foster youth at school and the ensuring of a harassment and violence free school environment</td>
<td>• Cultural competence and culturally responsive services</td>
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<td>• Any other training a county or approving agency determines to be appropriate</td>
<td>• Child sensitivity training (including stories and content developed and delivered by peer roles (e.g. foster parents, former foster youth, bio parents, etc.)</td>
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<td>• Trauma effects including grief and loss, child abuse and neglect, child development and behavior and methods to behaviorally support children impacted by that trauma or child abuse and neglect</td>
<td>• Training around stress and well-being/self-care</td>
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<td>• Involvement and role in Child and Family Team (CFT)</td>
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<td>• Progress note training/medical necessity criteria</td>
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<td></td>
<td>• Health Insurance Portability and Accountability Act (HIPAA)</td>
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<td>• Access to other medically-necessary Specialty Mental Health Services (SMHS)</td>
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<td><strong>Ongoing Training</strong></td>
<td>Minimum of 8 hours of post-approval training on an annual basis</td>
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<td></td>
<td>• Trauma-informed care and attachment</td>
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<td>• Core Practice Model</td>
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<tr>
<td>Ongoing Training (Continued)</td>
<td>COLUMN A Resource Family Approval (RFA)</td>
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<td></td>
<td>• Crisis intervention</td>
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<td>• Behavior Management</td>
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<td>• Supporting children and non-minor dependents in school</td>
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<td>• Effects of drug and alcohol abuse on children and non-minor dependents</td>
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<td>• Administration of psychotropic medications</td>
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<td>• Emancipation and independent living</td>
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<td></td>
<td>• Any other training a county or approving agency determines to be appropriate</td>
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<td></td>
<td>In addition to the training specified above, the Resource Family shall maintain a current certificate for CPR and First Aid.</td>
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<tr>
<th>Supervision of Resource Parents</th>
<th>Approved Resource Families shall be provided with monthly financial assistance, agency sponsored resources, at least once monthly visits from the child, youth, or NMD’s social worker, and other supports.</th>
<th>The TFC parent provides plan development, rehabilitation, and collateral under the direction of the TFC Agency’s Licensed Mental Health Professional (LMHP) or Waivered or Registered Mental Health Professional (WMHP). The TFC Agency has overall responsibility for monitoring the TFC parent. The TFC Agency’s LMHP/WMHP will meet with the TFC parent to review the treatment plan, review and co-sign progress notes, and will provide support to the TFC parent as follows:</th>
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<td>A county or approving agency shall monitor Resource Families through the following:</td>
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<td>• Conducting annual updates as required by Section 08-01</td>
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<tr>
<td>Supervision of Resource Parents (Continued)</td>
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<td>• Conducting periodic evaluations and home environment assessments, as necessary</td>
<td>• Face-to-face supervision in the home a minimum of one (1) hour per week to review the treatment plan, review and co-sign the progress note, ensuring that each progress note meets Medi-Cal SMHS and contractual requirements, and supervise the provision of the following TFC service model SMHS service activities:</td>
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<td>• Investigating complaints against a Resource Family</td>
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<td>• Developing corrective action plans to correct identified deficiencies</td>
<td>o Rehabilitation</td>
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<td>• Requiring a Resource Family to comply with corrective action plans</td>
<td>o Plan development (as part of the CFT)</td>
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<tr>
<td>• Investigating, as provided for in All County Letter (ACL) 13-64, possible address matches of registered sex offenders</td>
<td>o Collateral</td>
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</table>

CDSS shall review annually a random sample of Resource Families in a county for compliance with applicable laws and the Written Directives. The review shall include the following Resource Family information:

- Application
- Background checks, including any exemptions
- Annual updates
- Complaints and investigations
- Enforcement actions and administrative reviews
- Reports of serious complaints and incidents involving Resource Families
- Any other information deemed necessary to evaluate compliance with applicable laws and the Written Directives
<table>
<thead>
<tr>
<th><strong>COLUMN A</strong> Resource Family Approval (RFA)</th>
<th><strong>COLUMN B</strong> Additional Requirements for Therapeutic Foster Care (TFC) Services</th>
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<tr>
<td><strong>Annual Evaluation and Renewal</strong></td>
<td>The annual evaluation incorporates input from the child and family team members, as well as a self-evaluation by the TFC parent. The home visit should be strength-based and solution-focused. It should address:</td>
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<td>At least annually a county or approving agency shall update the approval of a Resource Family</td>
<td>• The TFC parent’s role and performance as therapeutic change agent, including treatment strategies; and</td>
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<td>• The update shall begin no sooner than 60 days prior to their anniversary date and shall be completed no later than 30 days after</td>
<td>• Case records and documentation.</td>
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<td>Included in an annual update are the following:</td>
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<td>• Interview all individuals living in the home</td>
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<td>• Updated home environment assessment</td>
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<td>• Verify that a subsequent arrest notification (rap back) service is in place for all adults living in the home</td>
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<td>• If there are new adults in the home, a background clearance must be completed for each new adult living in the home, including a subsequent arrest notification service</td>
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<td>• A change in the number of people residing in the home, including when the resource family becomes a guardian or conservator for any child or other person, or an adult moves out of the home</td>
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<tr>
<td>TFC Parent Qualifications</td>
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<tr>
<td><strong>COLUMN A</strong></td>
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<td><strong>Additional Requirements for Therapeutic Foster Care (TFC) Services</strong></td>
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### Annual Evaluation and Renewal (Continued)
- Updated psychosocial assessment to address any changes that have occurred in the Resource Family’s circumstances
- A change in the physical or mental health of a child, NMD or any other residents in the home, including the Resource Family
- A move to a new home location within the county, to another early implementation county, to a non-participating county, or returning to the approving county
- A change in marital status
- An update to an existing approval may be completed earlier than annually if in the county’s judgment changes have occurred in the family’s circumstances that warrant such an update
- Personal and professional development goals and training
- Barriers encountered and strategies for resolution through positive reinforcement
APPENDIX H

NON-REIMBURSABLE ACTIVITIES

CCR, Title 9, Chapter 11, § 1840.312.

Non-Reimbursable Services - General.

The following services are not eligible for FFP:

(a) Academic educational services

(b) Vocational services that have as a purpose actual work or work training

(c) Recreation

(d) Socialization is not reimbursable if it consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors of the beneficiaries involved.

(e) Board and care costs for Adult Residential Treatment Services, Crisis Residential Treatment Services, and Psychiatric Health Facility Services

(f) Medi-Cal program benefits that are excluded from coverage by the MHP, as described in Section 1810.355

(g) Specialty mental health services covered by this Article provided during the time a beneficiary under 21 years of age resides in an institution for mental disease other than an institution for mental disease that has been accredited in accordance with Title 42, Code of Federal Regulations, Sections 440.160 and 441.150 through

1. The beneficiary was receiving, prior to his/her twenty-first birthday, services in an institution for mental diseases and the services are rendered without interruption until no longer required, or until his/her twenty-second birthday, whichever is earlier; and

2. The facility has been accredited in accordance with Title 42, Code of Federal Regulations, Section 440.160, and complies with Title 42, Code of Federal Regulations, 441.150 through 441.156. Facilities at which FFP may be available include, but are not limited to, acute psychiatric hospitals and psychiatric health facilities certified by the State Department of Health Services as a Medi-Cal provider of inpatient hospital services.

(h) Specialty mental health services covered by this Article provided during the time a beneficiary under 21 years of age resides in an institution for mental disease other than an institution for mental disease that has been accredited in accordance with Title 42, Code of Federal Regulations, Sections 440.160 and 441.150 through
441.156. Facilities at which FFP may be available include acute psychiatric hospitals and psychiatric health facilities certified by the State Department of Health Services as Medi-Cal providers of inpatient hospital services.

(i) The restrictions in Subsections (g) and (h) regarding claiming FFP for services to beneficiaries residing in institutions for mental disease shall cease to have effect if federal law changes or a federal waiver is obtained and claiming FFP is subsequently approved.

(j) Specialty mental health services that are minor consent services as defined in Title 22, Section 50063.5, to the extent that they are provided to beneficiaries whose Medi-Cal eligibility pursuant to Title 22, Section 50147.1 is determined to be limited to minor consent services.

(k) The MHP may not claim FFP for specialty mental health services until the beneficiary has met the beneficiary’s share of cost obligations under Title 22, Sections 50657 through 50659.
APPENDIX I

TFC SERVICE MODEL AT-A-GLANCE

SERVICE DESCRIPTION

1. What is the TFC service model?

The TFC service model allows for the provision of short-term, intensive, highly coordinated, trauma-informed, and individualized Specialty Mental Health Services (SMHS) activities to children and youth up to age 21 who have complex emotional and behavioral needs, and who are placed with trained and intensely supervised and supported TFC parents. Specialty mental health services delivered through the TFC service model assist the child or youth to achieve client plan goals and objectives, and improve functioning and well-being. The TFC service model is intended for children and youth who require intensive and frequent mental health support in a family environment.

The TFC parent works under the supervision of a TFC Agency that will recruit, train, and oversee the TFC parent. Specifically, the TFC parent will provide SMHS service activities through the TFC service model, under the direction of a Licensed Mental Health Professional (LMHP) or a Waivered or Registered Mental Health Professional (WRMHP) who is able to direct services and is employed by the TFC Service Model Agency (TFC Agency).

The TFC service model allows for the provision of certain Medi-Cal SMHS service activities available under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, as a home-based alternative to high level care in institutional settings, such as group homes and, in the future, as an alternative to Short Term Residential Therapeutic Programs (STRTPs). TFC homes also may serve as a step down from STRTPs. The SMHS service activities provided through the TFC service model should not be the only SMHS that a child or youth would receive. Children and youth receiving SMHS service activities through the TFC service model must receive ICC and other medically necessary SMHS, as set forth in the client plan. The SMHS activities provided through the TFC service model are part of a continuum of care for eligible children and youth.
INDICATORS OF NEED FOR THE TFC SERVICE MODEL AND IMPORTANT CONSIDERATIONS FOR THE TFC HOME

2. Who should receive SMHS through the TFC service model?

Full-scope Medi-Cal children and youth, up to age 21, who have more complex emotional and mental health needs and, therefore, meet medical necessity criteria (California Code of Regulations (CCR), Title 9, Chapter 11, Section 1830.205 or Section 1830.210) for SMHS delivered through the TFC service model.

The SMHS activities provided through the TFC service model are appropriate for children and youth with more intensive needs, or children and youth who are in or at risk of residential, inpatient, or institutional care, but who could be effectively served in the home and community.

The following are the circumstances in which SMHS service activities provided through the TFC service model may be appropriate to address the child’s or youth’s mental health needs:

1. The child or youth is at risk of losing his or her placement and/or being removed from his or her home as a result of the caregiver’s inability to meet the child’s or youth’s mental health needs; and, either

   a. There is recent history of services and treatment (for example, ICC and IHBS) that have proven insufficient to meet the child’s or youth’s mental health needs, and the child or youth is immediately at risk of residential, inpatient, or institutional care; or

   b. In cases when the child or youth is transitioning from a residential, inpatient or institutional setting to a community setting, and ICC, IHBS and other intensive SMHS will not be sufficient to prevent deterioration, stabilize the child or youth, support effective rehabilitation, or avoid the need to initiate or continue a more intensive level of care in a more restrictive setting.

3. Is a TFC parent able to serve more than one child or youth at a time? If so, is there a limit?

Yes, however, in many cases it is more desirable to have only one child/youth receiving TFC SMHS placed in a TFC home. In some, limited circumstances, it can be in the best interest of the child/youth for there to be two children/youth placed in a TFC home. For instance, it would be appropriate to have two children/youth receiving services in a TFC home if it will keep a sibling group together.
4. Can other foster children live in the TFC home if they are not receiving TFC SMHS?

Yes, however, child welfare regulations and standards regarding the number of children that can reside in a foster home are still applicable and must be followed. For example, pursuant to Welfare and Institutions Code (WIC) Section 18358.15(b), no more than one emotionally disturbed child or child who has a serious behavioral problem shall be placed in a certified Intensive Treatment Foster Care (ITFC) (now referred to as Intensive Services Foster Care (ISFC)) family home, unless the participating Foster Family Agency (FFA) provides the placing or participating county welfare department with a written assessment of the risk and compatibility of placing together two children who are emotionally disturbed or have a serious behavioral problem. More than two children who are emotionally disturbed or have serious behavioral problems who are siblings may be placed together, in the same certified family home, if the placement is approved by the county interagency review team or the county placing agency of the participating county. However, there shall be no more than a total of five children living in a certified family home with two adults, and there shall be no more than a total of three children living in a certified family home with one adult, except in cases where children living in the home other than those placed pursuant to this chapter are 15 years of age or older.22

TFC AGENCY

5. Who can be a TFC Agency?

FFA as the TFC Agency

A Foster Family Agency (FFA) may be a TFC Agency if it is a California licensed FFA that meets licensure and accreditation requirements established by the California Department of Social Services (CDSS) to approve foster homes and accept children and youth for placement from county placing agencies. The FFA must also meet applicable Medi-Cal SMHS provider requirements and be certified by the county Mental Health Plan (MHP) as a Medi-Cal provider. The FFA must also have a contract with the MHP to provide SMHS as a TFC Agency. If the FFA is county owned and operated, the Department of Health Care Services (DHCS) will conduct the Medi-Cal certification.

22 For related information, please refer to question #31 regarding the relationship between ITFC and TFC services
County as the TFC Agency

If the county (child welfare services (CWS) and mental health plan (MHP)) does not have an FFA available or suitable to serve as a TFC Agency, the county may assume the functions of the FFA. DHCS and CDSS understand that counties have their own unique structures; however, under this approach, the county child welfare services agency may recruit, train, approve, and provide direct supervision and support of the TFC parents as resource parents.

TFC: DELIVERY OF MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES (SMHS)

6. Why does the MHP and DHCS sometimes call the foster child/youth a “beneficiary”?  
The word “beneficiary” is an insurance health plan term. Medicaid is a federal health insurance plan, called Medi-Cal in California. Foster children/youth receiving SMHS service activities through Medi-Cal do so as Medi-Cal beneficiaries.

7. Does the TFC Agency need to have a Medi-Cal contract with the county MHP?  
Yes, an FFA that is not owned and operated by the county must have a contract with the MHP, if the FFA is to provide Medi-Cal SMHS, including TFC.

8. Is a Medi-Cal certification required for the TFC Agency?  
Yes, a Medi-Cal certification is required if an FFA is the TFC Agency. The county MHP will certify non-county owned and operated FFAs. If the county established a county owned and operated FFA, DHCS will conduct the Medi-Cal certification.

9. Can the FFA receive placements from more than one county’s Child Welfare Services (CWS) or Probation Department? If so, which county MHP must the FFA contract with?  
Yes, the FFA may receive placements from multiple counties, but the FFA must be Medi-Cal certified and have a contract with each of the county MHPs that are responsible for providing or arranging for SMHS service activities for each beneficiary.
10. Is the TFC service model intended to be a “stand alone” service delivery method?
No, the SMHS service activities delivered through the TFC service model are but one option in the continuum of care for children and youth. A child or youth should receive other medically necessary Medi-Cal SMHS (including, but not limited to, Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)) as set forth in the child’s or youth’s client plan.

11. How often do evaluations for the need for the TFC service model need to occur?
Since SMHS delivered through the TFC service model are intended to be high intensity and relatively short-term, the child’s or youth’s progress should be reviewed in coordination with the Child and Family Team (CFT), at a minimum, within the first three (3) months/90 days after the service model is initiated and every three (3) months/90 days thereafter. Service authorization should be consistent with the county MHP process for authorizing mental health services.

12. The service delivery through the TFC service model says that the use of the TFC service model should be short-term; what is “short-term”?
There is not a maximum time limit for using the TFC service model to deliver SMHS service activities. The SMHS service activities should be delivered through the TFC service model when it is medically necessary for each child or youth. However, the progress of this service model should be reviewed in coordination with the CFT, at a minimum, within the first (3) months/90 days after the service model is initiated, and every three (3) months/90 days thereafter. Service authorization should be consistent with the county MHP process for authorizing mental health services.

OVERSIGHT OF TFC PARENT

13. What is the oversight role of the TFC Agency?
The TFC Agency will confirm that the TFC home and TFC parent(s) meet all CDSS community care licensing standards and the requirements of the resource family approval process:

   a. The TFC Agency will confirm that the TFC parent meets all requirements as a Medi-Cal “other qualified provider,” and complies with Medi-Cal documentation standards.
b. The TFC Agency will employ a Licensed Mental Health Professional (LMHP) or a Waivered or Registered Mental Health Professional (WRMHP) who is able to direct services, provide support and direction of service delivery, and review and approve the child’s or youth’s client plan.

TFC PARENT

14. What Medi-Cal SMHS activities will the TFC parent be able to provide? And what is included in the interim daily rate listed in All County Information Notice (ACIN) No. I-52-16E Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice No. 16-031E?

The TFC parent will provide the following Medi-Cal SMHS service activities, documented in a daily progress note:

a. Plan development (limited to when it is part of the CFT): The TFC parent will participate as a member in the CFT in care planning, monitoring, and review processes. The TFC parent also will observe, monitor, and alert the TFC Agency and members of the CFT about changes in the child’s or youth’s needs.23.

b. Rehabilitation: The TFC parent will implement in-home informed practices which include trauma-informed rehabilitative treatment strategies set forth in the child’s or youth’s client plan. Examples of services to be provided include: providing skills-based interventions (including coaching and modeling); developing functional skills to improve self-care; and improving self-management in areas of anger management or self-esteem or peer relations;24

c. Collateral: The TFC parent will meet the needs of the child or youth in achieving his or her client plan goals by reaching out to significant support person(s), and providing consultation and/or training for needed medical, vocational, or other services to assist in better utilization of SMHS by the child or youth.25

23 The TFC parent will not be developing or approving client plans; the TFC parent will be monitoring the child’s or youth’s progress through participation in the CFT.

24 Examples of rehabilitation services provided by the TFC parent will be included in the Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services and Therapeutic Foster Care Services.

25 Examples of collateral services provided by the TFC parent will be included in the Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services and Therapeutic Foster Care Services.
15. What requirements will the TFC Parent need to meet?

The TFC parent will need to meet and comply with:

a. Resource Family Approval (RFA) process requirements (see Appendix G: TFC Service Model Parent Qualifications); and

b. Medi-Cal requirements of “other qualified provider,” as specified in California’s Medicaid State Plan, in addition to specific TFC SMHS requirements. “Other qualified provider” is defined as an individual at least 21 (for TFC the age is increased from 18 to 21) years of age with a high school diploma, or equivalent degree, determined to be qualified to provide the services. In addition, the TFC parent must meet the following:

   i. Have a National Provider Identifier;

   ii. Obtain a Rendering Provider number from the MHP;

   iii. Use a taxonomy code;

   iv. Complete progress notes that meet Medi-Cal specialty mental health service documentation standards;

   v. Maintain the Health Insurance Portability and Accountability Act requirements; and

   vi. Participate on the Child and Family Team.

16. Will the TFC home require a Medi-Cal site certification?

No, the TFC home will not need to have a Medi-Cal site certification.

17. Who will supervise the TFC parent?

An LMHP/WRMHP who is able to direct services and is employed by the TFC Agency will provide support and direction to the TFC parent. The LMHP/WRMHP will ensure that the TFC parent is following the child’s or youth’s client plan. The LMHP/WRMHP responsible for directing services, and assumes ultimate responsibility of the TFC SMHS service activities provided by the TFC Parent.
18. How often must the LMHP/WRMHP meet with the TFC Parent?
The TFC Agency’s LMHP/WRMHP will meet with the TFC parent in the home a minimum of one (1) hour per week to review the treatment plan, review and co-sign progress note, ensuring that each progress note meets Medi-Cal SMHS and contractual requirements, and supervise the provision of services by the TFC parent.

19. Will the TFC Agency do home visits? Will the beneficiaries be visited by the TFC Agency on a regular basis?
In the case of FFAs, Title 22, CCR requires that the FFA social worker meet with the child/youth and caregiver in the home at least once a month. That will be no different in the TFC home. If circumstances warrant, due to clinical or placement issues, the FFA will visit with the child/youth and/or TFC parent in the home more frequently. Beneficiaries may visit the TFC Agency program site if appropriate and/or necessary.

20. What Medi-Cal SMHS documentation will TFC parents need to maintain?
The TFC parent will need to write and sign a daily progress note for each day he/she provides TFC SMHS service activities (plan development, rehabilitation and collateral). In addition, the supervising LMHP/WRMHP who directs TFC service model SMHS service activities, will review and co-sign the daily progress note. Before co-signing the daily progress note, the supervising LMHP/WRMHP also will ensure that the daily progress note meets the Medi-Cal documentation standards of the child’s/youth’s qualifying behavior, activities, progress, and achievements or progress toward specific outcomes outlined in the child’s/youth’s client plan.

21. Can a foster care relative caregiver (kin) be a TFC parent?
Yes, however, the relative caregiver will need to meet all TFC service model parent qualifications and training requirements. The TFC service model design does not prohibit relative caregivers and non-related extended family members from being TFC parents.

22. Will TFC parents have access to the client’s Electronic Health Record (EHR)? Will they document in the EHR directly?
Most likely, the TFC parent will not have access to the child’s/youth’s EHR and will not document into it directly.
23. Will the TFC parent need to have a National Provider Identifier (NPI) number?

Yes, the TFC Parent will need to have an NPI number. The NPI is a single identification number issued by the federal government to health care providers. It is intended to improve the efficiency of the health care system and help to reduce fraud and abuse.

CHILD AND FAMILY TEAMS

24. What is the frequency of the Child and Family Team (CFT) meeting? Where will these CFT meetings take place?

The CFT and the associated process are described in detail in the Katie A. Core Practice Model (CPM) Guide, the Katie A. Medi-Cal Documentation Manual (2nd Edition) and in the joint CDSS/DHCS All County Letter #I-52-16E/MHSUDS ACIN #16-031E. As stated in the CPM Guide, the CFT should take place as frequently as necessary to address the needs of a child/youth and family, or no less than every 90 days. The CPM Guide states: “Depending on the level of complexity of the child’s and family’s needs, the team may not meet frequently and/or may come together only around special tasks.” The CFT meetings also may be as frequently as weekly in cases where there are intensive services provided to the child/youth, and needs being addressed, such as in cases where Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and/or TFC service model services are being provided. The CFT meetings should take place at a location chosen by the youth, family, and other CFT members.

PROGRAM INTEGRITY

25. How will the Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance be ensured?

Each county MHP and its contracted providers must have policies and procedures related to confidentiality and HIPAA compliance, as required by the DHCS/MHP contract (Exhibit F, Privacy and Information Security Provisions). The TFC Agency must have policies and procedures to ensure the TFC parent’s compliance with HIPAA standards for securing progress notes and related documentation of the Medi-Cal children/youth receiving SMHS service activities under the TFC service model.
26. What requirements regarding the grievance process will a TFC Agency need to meet?

The TFC Agency must comply with requirements prescribed by the MHP under its responsibility to maintain the beneficiary problem resolution processes pursuant to the contract between DHCS and the MHP and Title 9, CCR, Chapter 11, Section 1850.205 (b)(c). Beneficiary problem resolution processes include:

a. A grievance process;
b. Appeal process; and
c. Expedited appeal process.

27. What requirements regarding informing materials will a TFC Agency need to meet?

The TFC Agency will be required by its contract with the MHP to provide the beneficiary access to all informing materials. County site certification processes generally require the contractor to demonstrate their ability to meet this requirement in all threshold languages.

COMPLIANCE

28. What requirements regarding compliance (i.e., training regarding fraud, waste and abuse, direct lines of communication, etc.) will a TFC Agency Provider need to meet?

The DHCS/MHP contract requires that the MHPs ensure contracted providers are in compliance with all Title 9, CCR, standards and regulations. Additional training related to the TFC service model also will be required as specified in the TFC service model parent qualifications.

REIMBURSEMENT

29. What is reimbursement rate for TFC SMHS services?

An all-inclusive per diem rate under Medi-Cal will be paid to the MHP to cover the Medi-Cal SMHS service activities provided by a TFC provider using the TFC service model. The FFA will be reimbursed for Medi-Cal SMHS in accordance with terms of its contract with the MHP.

Local Child Welfare, using federal IV-E or other state or local funding sources, provides a board, care, and supervision Level of Care (LOC) rate, as determined by the placing agency, to the TFC Agency, and the TFC Agency, in turn, pays the TFC parent. This LOC rate is a non-Medi-Cal rate.
30. If a child or youth is assessed as being in need of LOC associated with an Intensive Services Foster Care home, does the child or youth automatically meet medical necessity for TFC service model SMHS service activities?

No, not all children and youth placed in Intensive Treatment Foster Care homes (ITFC) (now referred to as Intensive Services Foster Care (ISFC)) will need TFC services. In addition, it is possible that TFC SMHS may be appropriate for children/youth placed in other levels of care (most likely children and youth placed in LOC 4). If the child/youth meets medical necessity criteria for TFC SMHS and the foster parent is a qualified TFC foster parent under the Therapeutic Foster Care services model and parent qualifications, a child/youth in LOC 4 may receive TFC SMHS.

31. Are SMHS service activities provided through the TFC service model only available to children/youth in child welfare? If not, who pays for the room and board?

No, SMHS service activities provided through the TFC service model are not limited to children/youth in the child welfare system. Child welfare, probation, or education may pay the room and board rate.
APPENDIX J

KATIE A. SETTLEMENT BACKGROUND

On July 18, 2002, a lawsuit entitled Katie A. et al. v. Bontà et al. was filed seeking declaratory and injunctive relief on behalf of a class of children in California who are in foster care or are at imminent risk of foster care placement,

(1) have a mental illness or condition that has been documented or—if an assessment had been conducted—would have been documented, and

(2) need individualized mental health services, including, but not limited to, professionally acceptable assessments, behavioral support and case management services, family support, crisis support, TFC and other medically necessary services in the home or in a home-like setting, to treat or ameliorate their illness or condition.

In December, 2011, a settlement agreement was reached in the case. As part of this agreement, the California Department of Health Care Services (DHCS) and the California Department of Social Services (CDSS) agreed to perform a number of actions, including the development and distribution of this Documentation Manual, with the following objectives:

• To facilitate the provision of an array of services delivered in a coordinated, comprehensive, community-based fashion that combines service access, planning, delivery and transition into a coherent and all-inclusive approach, hereinafter referred to as the Core Practice Model or CPM, as defined in Chapter 3.

• To address the need for subclass members with more intensive needs to receive medically necessary mental health services that include Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) and TFC. (The descriptions for IHBS and ICC are described fully in Chapter 5, supra)

• To clarify and provide guidance on the coverage and documentation requirements under Medi-Cal of IHBS and ICC so that counties and providers can understand these requirements and consistently apply them.

The Katie A. settlement further provides that:

• CDSS and DHCS, in consultation with the joint management taskforce, will develop and endorse practice tools, training curriculum, practice improvement protocols, and quality control systems to support the shared CPM, in order to support service integration and/or coordination of mental health services for class members.

• CDSS and DHCS will develop cross-system training curriculum and educational materials for child welfare and mental health staff.
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County Behavioral Health Directors Association of California
County Welfare Directors Association of California
Therapeutic Foster Care Implementation Committee
Members of the Pathways to Wellbeing Community Team
Counties
Youth and Parent Partners
Providers
California Institute for Behavioral Health Solutions