CY2022 Authorization Criteria for Therapeutic Foster Care for Children (ACC)

Determination Timeline: Prior authorization for Therapeutic Foster Care (TFC) is required for admission to the facility. Determination will be made within 14 days of receipt for a standard request. Determination will be made within 72 hours of receipt for an expedited request.

Documentation Required Prior to Determination:

- Prior authorization: Health Choice requires the CFT (Child Family Team) to submit all the following prior to admission:
  - Updated treatment plan indicating the goal of the TFC
  - A recent psychiatric evaluation that reflects current behaviors,
  - Current diagnoses,
  - A Child Family Team note indicating the team's recommendations.

- Continued Stay Reviews: Health Choice requires the CFT to submit the following at least fourteen (14) days prior to the expiration of the current authorization:
  - CFT notes, updated facility/ treatment plan with detailed discharge plan,
  - Monthly clinical summary.

- **Length of Authorization**: up to 90 days

I. **ADMISSION CRITERIA** (Must Meet All)

1. The CFT recommends treatment at TFC
2. Following an assessment by a licensed BHP (Behavioral Health Professional) preferably a Behavioral Health Medical Professional (BHMP), i.e. MD, NP, PA, reflecting a behavioral health condition that reflects the symptoms and behaviors necessary for a request for TFC, and
3. As a result of behavioral health condition, there is evidence that the member has had a disturbance of mood, thought or behaviors which renders the member incapable of independent or age-appropriate self-care or self-regulation within the past 60days and all of the following:
   a. Per assessment by a BHP, cannot reasonably expected to improve in response to a less intensive level of care, and
   b. Does not require or meet medical necessity criteria for a higher level of care.
   c. Demonstrates that appropriate treatment in a less restrictive environment has not been successful or is not available, therefore warranting a higher level of care.
   d. Here at time of admission to a TFC, there is a documented plan for discharge which include:

- Tentative disposition/living arrangement identified,
- Recommendations for aftercare treatment based upon treatment goals.

II. **EXCLUSION CRITERIA** (Admissions to TFC shall not be used as a substitute for the following)

1. An alternative to detention or incarceration,
2. As a means to ensure community safety in an individual exhibiting primarily conduct disorder behaviors,
3. As a means of providing safe housing, shelter, supervision or permanency placement,
4. As an alternative to parents'/guardians' or other agencies' capacity to provide for the member,
5. A behavioral health intervention when other less restrictive alternatives are available and meet the member's treatment needs, including situations, when the member/health care decision maker is unwilling to participate in the less restrictive alternative, or
6. An intervention for member runaway behaviors unrelated to a behavioral health condition.

III. **CONTINUED STAY CRITERIA**

1. BEHAVIOR AND FUNCTIONING (must meet all criterion)
    a. The member continues to meet diagnostic threshold for behavioral health conditions that warranted admission to TFC,
    b. There is an expectation that continued treatment at the TFC shall improve the member's condition so that this type of service shall no longer be needed., and
    c. The CFT is meeting at least monthly to review progress and have revised the Treatment Plan and Service Plan to respond to any lack of progress, and for members, the biological family, kinship family, adoptive family, and/or transition foster family to whom the member shall transitioned after discharge from TFC has been identified and is actively involved in the member's care/treatment, if applicable.

(And at least one of the following is met)

1. The member continues to demonstrate (within the last 90 days) moderate functional or psychosocial impairment as a result of the behavioral health condition, as identified through disturbance of mood, thought or behavior, which substantially impairs independent or age-appropriate self-care or self-regulation, or
2. Active treatment is reducing the severity of disturbance of mood, thought, or behaviors, which were identified as reasons for admission to TFC, and treatment at the TFC is empowering the member to gain skills to successfully function in the community.

IV. **CRITERIA FOR DISCHARGE**

1. Sufficient symptom or behavior relief is achieved as evidenced by completion of TFC treatment goals.
2. The member's functional capacity is improved and the member can be safely cared for in a less restrictive level of care.
3. The member can participate in the monitoring and follow-up services or a caregiver is available to provide monitoring in a less restrictive level of care.
4. Appropriate services, providers, and support are available to meet the member's current behavioral health needs at a less restrictive level of care.
5. There is no evidence to indicate that continued treatment in a TFC would improve member's clinical outcome.
6. There is potential risk that continued stay in TFC may precipitate regression or decompensation of members' condition.
7. A current clinical Assessment of the member's symptoms, behaviors, and the treatment needs has been reviewed by the CFT and has established that continued care in TFC is setting no longer adequate to provide for the safety and treatment. The CFT will then discuss if a higher level of care is necessary.

V. TREATMENT OUTCOMES

Treatment outcomes shall align with:

a. The Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems as specified in AMPM Policy 100, and
b. The member's individualized physical, behavioral, and developmentally appropriate needs.

Treatment goals for members placed in an TFC shall be:

c. Specific to the member's behavioral health condition that warranted treatment,
d. Measurable and achievable,
e. Unable to be met in a less restrictive environment,
f. Based on the member's unique needs,
g. Inclusive of input from the member's family/Health Care Decision-Maker and Designated Representative's choices where applicable, and
h. Supportive of the member's improved or sustained functioning and integration into community.

Active treatment with the services available at this level of care can reasonably be expected to:

i. Improve the member's condition in order to achieve discharge from TFC at the earliest possible time, and
j. Facilitate the member's return to primarily outpatient care in a non-therapeutic/non-licensed setting.

VI **Transition and Coordination of Care for DCS/CHP Members**

Health Choice submits ETI within ten business days for children transitioning to receiving contractor for DCS/CHP as specified in (AMPM 520).

Health Choice Manager of Medical Management serves as the designated contact between health plans to coordinate and arrange a seamless transition for members receiving treatment at TFC.

Health Choice Care Manager and Behavioral Health Medical Management Specialist are assigned to assist with warm handoffs with outgoing and receiving DCS/CHP members.

The BH MM Specialist will contact the TFC provider for all transfers regardless of contractual status to help assist with the transition process. BH MM Specialist will also coordinate with the other Health Plan designated contact to assist with all transitional needs.

Health Choice BH Care Management is assigned to attend CFT to assist families and the clinical team with the transition.

Health Choice extends authorization up to 90 days when a member transitions out of DCS/CHP unless guardian or representative mutually agreed on a different date.