



Kansas Medicaid Supplemental Clinical Criteria

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Introduction & Instructions for Use

Introduction

The following State or Contract Specific Clinical Criteria defined by state regulations or contractual requirements are used to make medical necessity determinations, mandated for members of behavioral health plans managed by Optum and U.S. Behavioral Health Plan, California (doing business as Optum Health Behavioral Solutions of California (“Optum-CA”)).

Other Clinical Criteria may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®. These may be externally developed by independent third parties used in conjunction with or in place of these Clinical Criteria when required, or when state or contractual requirements are absent for certain covered services.

Instructions for Use

When deciding coverage, the member’s specific benefits must be referenced. All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member’s benefits prior to using these Clinical Criteria. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this Clinical Criteria and the member’s specific benefit, the member’s specific benefit supersedes these Clinical Criteria.

These Clinical Criteria are provided for informational purposes and do not constitute medical advice.

Attendant Care

Attendant Care is a service provided to a child or adolescent with a Serious Emotional Disturbance or an adult with a Severe and Persistent Mental Illness who would otherwise be placed in a more restrictive setting due to functional impairment resulting from an identified behavioral health condition. This service enables the member to accomplish tasks or engage in activities that they would normally do themselves if they did not have a mental illness. Attendant Care is not covered when provided to a member who is in a hospital, nursing facility, intermediate care facility for persons with mental retardation, or an institution for mental diseases. Attendant Care is delivered by a paraprofessional who has completed state-approved training.

Admission Criteria

- The member is not in a hospital, nursing facility, intermediate care facility for persons with mental retardation, or an institution for mental diseases.
- The member requires assistance performing tasks or engaging in activities. Examples include:
 - The member requires direct support, supervision and/or cuing so that the member performs tasks of activities by him/herself.
 - The member requires assistance with Activities for Daily Living and Instrumental Activities for Daily Living and includes assistance with maintaining daily routines and/or engaging in activities critical to residing in their home and community.
- The member is likely to need Inpatient services in the absence of Attendant Care.
- Attendant Care is recommended by the member's treatment team.
- The member is not in imminent or current risk of harm to self, others, and/or property.
- Co-occurring behavioral health or medical-surgical conditions can be safely managed.
- The member and the member's family are willing and available to actively participate in Attendant Care.
- Care is medically necessary.
- For children and adolescents: The member meets criteria for a Serious Emotional Disturbance.
- For adults: The member meets criteria for a Severe and Persistent Mental Illness.

Community Based Wraparound Facilitation Services

Wraparound Facilitation is to form a wraparound team consisting of the member's family, extended family, and other community members involved with the member's daily life for the purpose of producing a community-based, individualized Plan of Care. This includes working with the family to identify who should be involved in the wraparound team and assembly of the wraparound team for the Plan of Care development meeting.

Admission Criteria

- Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the waiver member's medical record.
- Providers must receive ongoing and regular clinical supervision by a person meeting the qualifications of a Qualified Mental Health Professional (QMHP) and supervision shall be available at all times.
- A provider can perform 30 minutes of Case Conference during a Wraparound Facilitation meeting.

Service Delivery

- The wraparound facilitator guides the Plan of Care development process.
- The wraparound facilitator also is responsible for reassembling the team when subsequent Plan of Care review and revision are needed, at minimum on a yearly basis to review the Plan of Care and more frequently when changes in the member's circumstances warrant changes in the Plan of Care.
- The wraparound facilitator will emphasize building collaboration and ongoing coordination among the family, caretakers, service providers, and other formal and informal community resources identified by the family and promote flexibility to ensure that appropriate and effective service delivery to the waiver member and family/caregivers.

- Facilitators will be certified after completion of specialized training in the wraparound philosophy, waiver/grant rules and processes, waiver/grant eligibility and associated paperwork, structure of the waiver member and family team, and meeting facilitation.
- Limitations include:
 - Wraparound Facilitation is provided in addition to targeted case management to address the unique needs of waiver members living in the community and does not duplicate any other Medicaid State Plan service or services otherwise available to the waiver member at no cost.

Community Psychiatric Support and Treatment (CPST)

Community Psychiatric Support and Treatment Community Psychiatric Support and Treatments (CPST) are goal directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the member's individualized treatment plan. CPST is a face-to-face intervention with the member present; however, family or other collaterals may also be involved. The majority of CPST contacts must occur in community locations where the member lives, works, attends school, and/or socializes

Admission Criteria

- Adults, Children and Adolescents
 - The Member has a behavioral health condition meeting the criteria for a qualified DSM diagnosis which has created a reduced level of functioning and subjective distress.
 - Care is medically necessary.
 - Less intensive services would not be adequate to assist the member in reaching identified treatment goals.
 - Co-occurring mental health and substance use disorders and/or co-morbid physical conditions can be safely managed.
 - In collaboration with the CPST provider, the member is willing and able to connect with individual natural supports, community resources and activities that will enable community integration.
- Adults with SPMI
 - In addition to the Admission Criteria for Adults, Children and Adolescents, the member meets the State's criteria for Severe and Persistent Mental Illness.
- Children and Adolescents with SED
 - In addition to the Admission Criteria for Adults, Children and Adolescents, the member meets the State's criteria for Serious Emotional Disturbance.

Service Delivery

- A periodic review of the service plan shall include the following:
 - Input of all staff involved in treatment of the member;
 - The member, his or her family and/or other collaterals, as appropriate;
 - Assessment of the progress of the member in regard to the mutually agreed upon goals in the service plan;
 - Adjustment of goals, time periods for achievement, intervention strategies or initiation of discharge planning, as appropriate; and
 - The signature of the physician involved in the treatment.
- CPST may include the following components:
 - Assisting the member and family members or other collaterals to identify strategies or treatment options associated with the member's mental illness, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances or associated environmental stressors which interfere with the member's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.
 - Individual supportive counseling, solution focused interventions, emotional and behavioral management, and problem behavior analysis with the member, with the goal of assisting the member to develop and implement social, interpersonal, self-care, daily living, and independent living skills to restore stability, support functional gains, and adapt to community living.
 - Participation in and use of strengths-based planning and treatments, which include assisting the member and family members or other collaterals to identify strengths and needs, resources, and natural supports; to develop goals and

objectives; and to use personal strengths, resources, and natural supports to address functional deficits associated with the member's mental illness.

- Assisting the member with effectively responding to or avoiding identified precursors or triggers that would risk the member remaining in a natural community location, including assisting the member and family members or other collaterals to identify a potential psychiatric or personal crisis, develop a crisis management plan, and/or as appropriate, to seek other supports to restore stability and functioning.

CCTS and IISS Services

Consultative Clinical and Therapeutic Services (CCTS) and Intensive Individual Support Services (IIS) may be a covered benefit under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service provisions in Kansas if criteria are met. The intent of EPSDT is to correct or ameliorate an identified need early in development by checking children's health at age-appropriate intervals. This is done through screening services comprised of medical, mental health, dental, hearing, and vision. Diagnostic tests should be performed as a follow up when a need for further evaluation is identified. Rehabilitative services are designed to provide for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.

EPSDT (designated as KanBeHealthy in Kansas) screening services do not require prior authorization. Medical necessity for CCTS and IIS services must be met on an individual case-by-case basis. Prior authorization for these services will be reviewed after all requested documentation has been submitted. A determination will be made in a timely manner for approval or denial of services.

Applied Behavior Analysis (ABA) or Intensive Behavior Therapy (IBT) for Autism Spectrum Disorders (ASD) are complex and difficult due to the diversity of the presentation of symptoms and their severity. ASD includes disorders that were previously referred to as:

- Atypical autism
- Asperger's disorder
- Childhood autism
- Childhood disintegrative disorder
- Early infantile autism
- High-functioning autism
- Kanner's autism
- Pervasive developmental disorder, not otherwise specified

Admission Criteria

Criteria for Initial Treatment/Assessment for ASD:

- A licensed psychologist or MD has evaluated the member within the last 6 months for current validation of the ASD diagnosis using a comprehensive diagnostic evaluation. Standardized measures including ASD core features, general psychopathology, cognitive abilities, and adaptive functioning using published instruments administered by qualified members of a diagnostic team including the following selected examples of recognized diagnostic tools:
 - Autism Diagnostic Observation Schedule (ADOS); or
 - Autism Diagnostic Interview (ADI-R); or
 - Vineland
 - Childhood Autism Rating Scale (CARS)
 - Gilliam Autism Rating Scale (GARS)
- A licensed psychologist or MD has ruled out the following as a sole explanation for symptoms of ASD:
 - A neurological disorder (by an MD)
 - Heavy metal poisoning (by an MD)
 - Primary speech disorder, or
 - Primary hearing disorder, or
 - Diagnosis Not Otherwise Specified by other medical conditions
- Evidence based practice for the treatment of ASD (with Applied Behavioral Analysis as an example) is considered an effective intervention for ASD to correct or ameliorate this condition, which may include the following:
 - Reduce problem behavior such as aggression or self-injury;

- Increase socially appropriate behavior such as reciprocity;
- Improve acquisition of communication, self-help and social skills;
- Increase learning to tolerate changes in the environment and activities;
- Incorporate parent and/or caretaker training and support.
- The member falls within the eligible age and proposed interventions are appropriate for the individual's age and limitations:
 - Age 20 and under: Social, communication, or language skills or adaptive functioning that have been identified as deficient relative to age expected norms, which form the basis for an individualized treatment for no more than 40 hours per week. (Please note: ABA services for more than 40 hours per week have not been shown to be more effective and documentation as to why more than 40 hours per week is planned must be provided).

Continued Stay Criteria

Continuation of CCTS or IIS services are considered medically necessary if it meets the following:

- Continues to meet the above criteria
- There is reasonable expectation that the member will benefit from the continuation of this therapy as evidenced by the initial treatment plan and mastery of skills defined in the initial plan or a change of treatment approach from the initial plan; and
- The progress is reviewed by the CCTS Provider on a monthly basis with formal review of the treatment plan and request for renewal provided a minimum of every six months. The MCO may request updates during this six-month timeframe to insure continued need for services.
- Measurable progress is documented. Continued progress is determined based on improvement in goals as outlined in the provider treatment plan and will focus on improvements in verbal skills, social functioning, and
- Treatment is not making the symptoms worse; and
- Reasonable expectation, based on members' clinical history, that withdrawal of treatment will result in decompensation or recurrence of signs and symptoms.

Service Delivery

Treatment Plans for CCTS/IIS

Outcome-oriented interventions targeting specific baseline behaviors are identified in a written treatment plan describing the frequency, intensity, duration, and progress that will be updated monthly and a formal review completed a minimum of every 6 months. The updated treatment plan should include:

- Changes in treatment hours and level of care
- The member's progress, new goals, and visual representations of skills and behavioral gains
- Anticipated timeline for achievement of the goal based on both the initial assessment and subsequent interim assessments over the duration of the intervention; and
- The individual-specific treatment plan includes age and impairment appropriate goals and measures of progress:
 - The treatment plan should include measure of the specific behaviors or deficits targeted and also include assessments of social skills, communication skills, language skills, and adaptive functioning that reflect progress in the areas that were identified as negatively affected by the targeted behaviors and deficits. Clinically significant progress in social skills, communication skills, language skills, and adaptive functioning must be documented as follow: Interim progress assessment at least every 6 months based on clinical progress toward treatment plan goals; and developmental status as measured by standard scores using standardized assessments every 2 to 3 years.
- A transition plan detailing how the member will be transitioned out of services or to a lower level of care
- If the member is an older child or adolescent the treatment plan addresses the plan to transition members out of the ASD treatment into adult care.

Exclusion Criteria

CCTS/IIS treatment will not be authorized for any of the following purposes:

- Speech therapy
- Occupational therapy
- Vocational rehabilitation
- Supportive respite care
- Recreational therapy
- Orientation and mobility

- Services provided in the school setting or to replace educational services available to school age children
- Services provide in a PRTF/hospital setting
- Services are being provided in duplicate through any other source/setting

Transition/Discharge Planning

Members may reduce or end CCTS/IIS services after achieving their treatment goals. Upon successfully meeting treatment goals, members may qualify for lower levels of care. This can be demonstrated by the following:

- Member's and family's ability to generalize the skills in multiple settings and mastery of the majority of the program goals
- Step-down in program hours as recommended by the provider
- Member's readiness to move from current level of service to low level of service
- Communication and coordination of care between all other professionals involved in member's care

Termination/Denial of Services

If the MCO determines during the review that treatment does not appear to meet medical necessity criteria, the provider will be notified at that time and the case will be sent to formal medical necessity determination. The case will be sent to a Child Psychiatrist who will be informed of the issues and will review the case prior to telephonic peer review with the Provider.

Medical necessity denial of services may be due to one of the following being met:

- No meaningful, measurable change has been documented in the patient's behavior(s) for a period of three months or optimal treatment (For changes to be "meaningful" they must be durable over time beyond the end of the actual treatment session and generalized outside of the treatment setting to the patient's residence and to the larger community within which the patient resides.)
- Treatment is making the symptoms worse.
- The patient has achieved adequate stabilization of the challenging behavior and less intensive modes of therapy are appropriate.
- The patient demonstrates an inability to maintain long-term gains from the proposed plan of treatment.

Provider Qualifications

CCTS Provider Qualifications:

- Board-Certified Behavior Analyst (BCBA) or Assistant Behavior Analyst licensed through the Kansas Behavioral Sciences Regulatory Board (KSBSRB), or
- Board-Certified Behavior Analyst – Doctoral (BCBA-D), or Board-Certified Behavior Analyst (BCBA), or Board-Certified Assistant Behavior Analyst (BCABA), or
- An individual with a master's degree, preferably in Human Services or Education with documented experience working with a child with an Autism Spectrum Disorder and completion of the state-approved training curriculum.
 - Providers applying under this criterion shall present a letter signed by KDADS-HCBS showing acceptance of presented qualification/credential.
 - Such letter shall be signed by the HCBS director or agency-designated staff.
- Additionally, the individual must have a clean background, as evidenced through background checks of records maintained by the Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aide Registry, and Motor Vehicle screen.

Intensive Individual Supports (IIS) Provider Qualifications:

- Certification as a Registered Behavior Technician (RBT) under the supervision of a BCBA, or
- An individual of eighteen years of age or older with a high school diploma or equivalent and 40 hours of successfully applied behavioral analysis training following the Autism Center of Excellence (ACE) Program guidelines which would include:
 - 8 hours – supervised intervention work
 - 3 hours – ethics
 - At least 1 hour of:
 - Criterion reference
 - Social skills training
 - Parent training
 - Program development
 - Successful completion of an initial competency assessment
 - Providers applying under this criterion shall present a letter signed by KDADS-HCBS showing acceptance of presented qualification/credential.

- Such letter shall be signed by the HCBS director or agency-designated staff.
- This provider works under the direction of the BCBA or other Qualified CCTS Practitioner. The worker will adhere to all state-approved standards, training, and ongoing requirements.
- Meet all annual training requirements as specified by certification.
- Additionally, the individual must have a clean background, as evidenced through background checks of records maintained by the Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aide Registry, and Motor Vehicle screen.

Additional Provider Enrollment information:

- Currently enrolled KMAP providers that meet the criteria noted below will not be required to re-enroll.
- If an individual previously met the requirements for providing either the CCTS or IIS service or desires to enroll to provide state plan services, this entity is allowed to re-enroll or enroll but must attest that they will not seek reimbursement for these services unless such are provided by an individual who meets the stated provider qualifications.

Independent Living

Independent Living Independent Living/Skills Building services are designed to assist members who are or will be transitioning to adulthood with support in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to be successful in the domains of employment, housing, education, and community life and to reside successfully in home and community settings.

Admission Criteria

- Services include communication and coordination with the family and/or legal guardian, including any agency legally responsible for the care or custody of the member.
 - Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the member's medical record.
- All Independent Living services will be provided in the community.
 - For example, community settings could encompass: a grocery or clothing store, (teaching the young person how to shop for food, or what type of clothing is appropriate for interviews), unemployment office (assist in seeking jobs, assisting the youth in completing applications for jobs), apartment complexes (to seek out housing opportunities), Laundromats (how to wash their clothes).
- AND
- Services will include:
 - Learning cues for normal activities of daily living and instrumental activities of daily living.
 - Housekeeping, homemaking (shopping, childcare and laundry services) or basic services, solely for the convenience of a child receiving independent living/skills building, are not covered.
 - Life safety skills, ability to access emergency services, basic safety practices and evacuation.
 - Physical and mental health care (maintenance, scheduling physician appointments), recognizing when to contact a physician, self-administration of medication for physical and mental health conditions, understanding purpose and possible side effects of medication prescribed for conditions, other common prescription and non-prescription drugs and drug uses.
 - Use of transportation (accessing public transportation, learning to drive, obtaining insurance).

Service Delivery

- Components of Independent Living/Skills Building
 - Independent Living/Skills Building activities are provided in partnership with members to help arrange for the services needed to become employed, find transportation, housing, and continue their education.
 - Services are individualized according to each member's strengths, interests, skills, goals as specified in the Plan of Care.
 - It would be expected that Independent Living/Skills Building activities take place in the community.
 - This service can be utilized to train and cue normal activities of daily living and instrumental activities of daily living.
 - Housekeeping, homemaking (shopping, childcare, and laundry services), or basic services solely for the convenience of a member receiving independent living /skills building are not covered.
 - The following are examples of appropriate community settings rather than an all-inclusive list:
 - a grocery store to shop for food,
 - a clothing store to teach the member what type of clothing is appropriate for interviews,
 - an unemployment office to assist in seeking jobs or assist the member in completing applications for jobs,

- apartment complexes to seek out housing opportunities, and
 - Laundromats to teach the member how to wash clothing.
 - Other appropriate activities can be provided in other community setting as identified through the Plan of Care process.
- Transportation is provided between the member's place of residence and other services sites and places in the community and the cost of transportation is included in the rate paid to providers of this service.

Operation Community Integrations

Operation Community Integration (OCI) program service model demonstrates how services and supports will be provided in an evidence-based manner such that it enables individuals diagnosed with a behavioral health diagnosis to develop the skills necessary to become fully integrated into their communities, particularly in the areas of community integration, housing, and employment. All support services and interventions must be medically necessary and driven by member choice.

Intensive Community Residential Placement (ICRP)

Intensive Community Residential Placement Support Services (ICRP) The ICRP service level of need is targeted towards members whose screening indicates a need for medically necessary intensive on-site residential services, because of a history of unsuccessful integration in multiple community settings and/or the presence of an ongoing risk of harm to self or others which would otherwise require long-term psychiatric or incarceration.

Intensive Community Integration Support Services (ICI)

Intensive Community Integration Support Services (ICI) is targeted towards members who are unable to tolerate congregate living arrangements in which the presence of other members in their immediate living area tends to precipitate psychiatric and substance abuse relapse, aggression, or other behaviors associated with risk of re-hospitalization or incarceration.

Admission Criteria (ICRP)

- A DLA 20 screening has been completed by a certified screener indicating the member's level of need.
- The member has a history of unsuccessful integration in multiple community settings; or
- There is a risk of harm to self or others and without ICRP services would require long-term psychiatric care or incarceration.
- The member can tolerate regular interactions with peers.
- The member has significant difficulties with Activities of Daily Living (ADLs).
- The member may require round the clock observation and oversight and/or redirection for potentially harmful behaviors.
- The member's behaviors directly interfere with the member's ability to obtain or sustain independent living in the community.

Admission Criteria (ICI)

- A DLA 20 screening has been completed by a certified screener indicating the member's level of need.
- The member is unable to tolerate congregate living which precipitates psychiatric or substance abuse relapse, aggression, or re-hospitalization or incarceration.
- The member may be sufficiently competent in Activities of Daily Living (ADLs) but has difficulty managing socially appropriate behavior skills needed to obtain sustain permanent housing.
- The member requires direct care staff to ensure the member is not engaging in harmful behaviors towards themselves or others and not participating in activities that involve a high risk of relapse of psychiatric or substance use disorder symptoms that interfere with independent living.

Continued Stay Criteria

- Copy of the DLA 20 screening tool along with the recommendations made by the certified DLA 20 screener and a treatment plan (completed within 72 hours of admission to the program).
- Treatment plans must be modified and updated as necessary and reviewed with treatment team monthly. Proof of treatment plan review shall be placed in member's chart.

- Individuals in Residential Programming Intensive Community Residential Placement (ICRP) level of care must also have entries in a safety log as well as progress notes that reflect safety monitoring, and evidence of periodic safety checks overnight.
- Individuals in the Intensive Community Integration (ICI) level of care must have a critical intervention plan for all members participating in this level of care in the member's individual file.

Service Delivery

- Services are designed to provide medically necessary supports and interventions that are person centered and reflect the needs and choice of the member. Treatment planning and services are done in collaboration with the member and the services used to support the member reflect medical necessity and relate directly to the goal of community integration.
- The core principles of Operation Community Integration shall follow the Service Model for Housing First. At all times services provision shall reflect the following core principles:
 - Access and connection to community supports that offer safe and affordable housing options and identification of supports that will allow member to sustain housing.
 - Daily programming goals and face-to-face interventions needed to reflect the goal of community integration and housing stability in permanent housing.
 - Supports may look different from individual to individual and shall be based on developmentally appropriate needs and considerations, including those of transition aged youth, elders, persons with criminal records and homeless families.
 - Services should be client driven and targeted to support "housing readiness".
 - Services and treatment planning should address quality of life, health, behavioral health, and employment barriers that can be achieved through permanent supported housing.
 - Services shall be guided by medical necessity and the member's right to choose self-determination, dignity and respect.
 - Services for all OCI members include:
 - Assistance in performing, coaching and skill building around basic daily living and social skills.
 - Coaching and skill building regarding symptom management and community integration.
 - Prompting and skill building for conflict resolution.
 - Collaboration and member participation in HUD's Coordinated Entry System.
 - Recovery coaching and relapse prevention planning.
 - Case Management support to assist member with linkage to community resources to obtain and sustain safe, affordable housing.
 - Providing landlord/tenant dispute resolution to reduce the risk of eviction or other adverse action.
 - Assistance with entitlement advocacy and the application process by a certified SOAR staff member to support community integration.
 - Direct face-to-face interventions with members to assist with budget development, budget management, and provide education on the benefits of a budget.
 - Referral and collaborative support to assist member with barriers regarding legal issues.
 - Direct supports, prompting and skill building to address anger management issues that interfere with member's ability to successfully integrate into the community through interventions and guided by SAMHSA's Cognitive Behavioral Therapy Intervention workbook.
 - Assistance with medication management (which may include Medication Assisted Treatment).
 - Assistance with housing option searches, housing applications and securing permanent housing.
 - Coordination with social supports and activities that will improve community integration.
 - IPS Supported Employment EBP programming for members wanting to obtain employment to support community integration.
 - Assistance with creating and developing a housing support crisis plan to address symptom management while reintegrating and residing in the community.
 - Mobile Crisis response and stabilization services and/or collaboration with CIT teams-will allow the provider to begin crisis assessment where the at-risk member is located.

Parent Support and Training

Parent Support and Training Parent Support and Training is a service designed to benefit members experiencing a serious emotional disturbance who without PST would require state psychiatric hospitalization. This service provides the training and

support necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process.

Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the member. For the purposes of this service, "family" is defined as the persons who live with or provide care to the member, and may include a parent, spouse, children, relatives, grandparents, or foster parents. Services may be provided individually or in a group setting. Services must be recommended by a treatment team, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's individualized plan of care.

Admission Criteria

- The member resides with or receives regular care from a "family" member.
- Services include communication and coordination with the "family."
- Coordination with other child serving systems occurs as needed to achieve the treatment goals. All coordination is documented in the medical record.
- The member and the member's "family" are willing and available to actively participate in interventions as identified in the member's plan of care.
- There is no imminent risk of serious harm to self or others.
- Co-occurring mental health and substance use disorders and/or co-morbid physical conditions can be safely managed
- Providers receive ongoing and regular clinical supervision by a person meeting the qualifications of a Qualified Mental Health Professional (QMHP) and supervision shall be available at all times.

Continued Stay Criteria

- The member's "family" and/or other natural resources and supports are engaged to actively participate in the member's service needs as required by this service.

Service Delivery

- Evaluation and Treatment Planning
 - The provider actively engages and involves the member and "family" members the evaluation, planning and decision-making process throughout service delivery with the member's consent. This includes gaining an understanding of the following elements:
 - The strengths and limitations of the "family's" ability to support the member.
 - The immediate questions, challenges and priorities from the "family's" perspective.
 - The level of understanding and current attitudes/approaches the "family" has taken regarding the member's SED.
 - The "family's" capacities, personalities, willingness to take on new roles and developmental stage of the family unit (e.g., family with young children, late-life family, etc.).
 - The "family's" previous experiences providing care to an individual with a SED.
 - The provider determines the quality of the relationship with the member.
 - Any cultural and spiritual considerations relevant to caring for the member; and.
 - Identifying any existing mental health symptoms/conditions the "family" members may be experiencing and arranging for referral as appropriate.
- The service plan summarizes the "family's" goals in the context of the member's overall care plan and describes what services will be provided to accomplish those goals. The service plan should include the following elements:
 - Coordination of all elements of treatment and rehabilitation to ensure that everyone is working toward the same goals in a collaborative, supportive relationship.
 - Consideration of both the social and the clinical needs of the member and "family."
 - Ensuring the member is receiving optimum medication management and clinical intervention.
 - Listening to the "family's" concerns and involving them as equal partners in the planning and delivery of treatment.
 - Exploring the "family's" expectations of Family Support services and expectations for the member.
 - Developing goals that utilize the family's strengths and addresses limitations of the "family's" ability to support the member.
 - Helping resolve family conflict by responding sensitively to emotional distress.
 - Addressing feelings of loss.
 - Providing relevant information for the member and his or her "family" at appropriate times.
 - Developing an explicit crisis plan and professional response.

- Helping improve communication among “family” members.
- Providing training for the “family” using structured problem-solving techniques.
- Encouraging “family” members to expand their social support networks (e.g., to participate in family support organizations such as NAMI).
- Being flexible in meeting the needs of the family.
- Providing the family with easy access to another professional if the current work with the “family” ceases.
- Interventions include:
 - Assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the eligible child/youth in relation to their mental illness and treatment; development and enhancement of the families specific problem-solving skills, coping mechanisms and strategies for the child’s/youth’s symptom/behavior management.
 - Assisting the family in understanding various requirements of the waiver process, such as the crisis/safety plan and plan of care (POC) process.
 - Training on understanding the child’s diagnoses.
 - Understanding service options offered by service providers and assisting with understanding policies, procedures and regulations that impact the child with mental illness/addictive disorder concerns while living in the community (e.g., training on system navigation and Medicaid interaction with other child-serving systems).
 - The specialist may also conduct follow-up with the families regarding services provided and continuing needs.

Professional Resources Family

Professional Resource Family Care is intended to provide intensive supportive resources for the member and his or her family. This service offers intensive family-based support for the member's family through the utilization of a co-parenting approach provided to the member in a surrogate family setting. The goal is to support the member and family in ways that will address current acute and/or chronic mental health needs and coordinate a successful return to the family setting at the earliest possible time. During the time the professional resource family is supporting the member, there is regular contact with the family to prepare for the member's return and his or her ongoing needs as part of the family. It is expected that the member, family, and the professional resource family are integral members of the member’s individual treatment team.

Transportation is provided between the member’s place of residence and other services sites and places in the community and the cost of transportation is included in the rate paid to providers of this services.

Professional Resource Family Care can be provided anywhere in the community that is agreeable to the individual. Professional Resource Family Care may not be provided simultaneously with Short-Term Respite Care and does not duplicate any other Medicaid state plan service or service otherwise available to members at no cost.

Admission Criteria

- Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the waiver member’s medical record.
- Providers must receive ongoing and regular clinical supervision by a person meeting the qualifications of a Qualified Mental Health Professional (QMHP) and supervision shall be available at all times.

Service Delivery

- The goal is to support the waiver member and family in ways that will address current acute and/or chronic mental health needs and coordinate a successful return to the family setting at the earliest possible time.
- During the time the professional resource family is supporting the waiver member, there is regular contact with the family to prepare for the member's return and his or her ongoing needs as part of the family.
- It is expected that the waiver member, family and the professional resource family are integral members of the member’s individual treatment team.
- Transportation is provided between the waiver member’s place of residence and other services sites and places in the community, and the cost of transportation is included in the rate paid to providers of this services.
- Limitations include:

- Professional Resource Family Care may not be provided simultaneously with Short Term Respite Care services. The service being provided at midnight is the service to be billed that day.
- Professional Resource Family Care is not available to members in out of home placement because that service is available through Child Welfare Contractors. It can be provided to members who are in DCF or JJA custody but who are living at home. It may be provided to members in Native American child welfare agencies if the service is not otherwise available.
- Professional Resource Family Care does not duplicate any other Medicaid State Plan service or service otherwise available to the waiver member at no cost.

Psychiatric Residential Treatment Facility (PRTF)

Psychiatric Residential Treatment Facility PRTF is a sub-acute facility-based program which delivers 24-hour/7-day assessment and diagnostic services, and active behavioral health treatment to child or adolescent members who have significant functional impairments resulting from a behavioral health condition.

A child or youth (referred to here as ‘child’) needs a PRTF level of care when their psychiatric symptoms cause danger to themselves, or others and intensive community services have failed to keep the child and others safe and have failed to improve their psychiatric condition or prevent regression.

Admission Criteria

- Child must meet all the below:
 - Child must be under the age of 22.
 - Child’s current signs and symptoms meet criteria for a DSM diagnosis not solely due to Intellectual or Developmental Disability (IDD) and/or alcohol or drug use.
 - Community resources have been determined to not meet the current treatment needs of the child in the past 30 days, as evidenced by meeting ONE of (1-2) below:
 - The child’s Community-Based Services Team (CBST) or current treatment team believes that available intensive community services have been tried without sufficient success for at least 30 days, by meeting BOTH (a-b) below:
 - Child has participated in intensive community services for at least 30 days, including ALL of the following:
 - Psychotherapies, such as individual, family and group psychotherapy
 - Psychiatric medication treatment
 - Rehabilitative services, such as SED waiver services, Psychosocial Rehab, Community Psychiatric Support and Treatment, etc.
 - Intensive community services have not produced substantive improvement in the child’s behaviors and/or psychiatric symptoms.
 - The child’s psychiatric and/or psychosocial condition prohibit the child from utilizing community services, by meeting ONE of the below:
 - Multiple inpatient admissions prohibit child from utilizing consistent community services.
 - Child has moved to different areas which makes utilizing consistent outpatient services problematic.
 - Child’s behaviors/psychiatric condition are so severe that they prohibit child from utilizing consistent community services.
 - The families, schools, or community’s efforts to manage the child’s behaviors have exhausted all available and accessible resources.
 - In the past 60 days, the child’s behaviors have caused multiple episodes of acute risk of substantial harm to self or others, or the child has been unable to care for their own physical health and safety to create a danger to their life, as evidenced by meeting TWO or more of the below in the past 60 days:
 - Aggressive or assaultive behavior causing substantial harm to self, others, animals, or property, unresponsive to adult de-escalation or direction
 - Unable to maintain behavioral control for more than 48 hours that may cause acute risk of substantial harm to self or others or substantial dysfunction in the community
 - Pervasive rejection of adult requests, directions, and rules that puts the child or others at risk for substantial harm or dysfunction in the home, school or community
 - Hostile, threatening or intimidating behavior resulting in fear response in others
 - Delusions/hallucinations/psychotic symptoms causing substantial dysfunction in daily living
 - Fire setting/repeated property destruction

- Chronic non-suicidal, injurious behaviors
- Chronic suicidal and/or homicidal ideas, plans and/or behaviors
- Repeated arrests or confirmed illegal activity related to the psychiatric diagnosis that could place self/others at risk for substantial harm
- Poor impulse control that does/could result in substantial harm to self or others and is unresponsive to adult intervention
- Runaway that places self at risk for substantial harm
- High-risk sexually inappropriate or abusive behavior
- Support system unable or unavailable to manage intensity/safety regarding eating disorder symptoms
- Substance use that exacerbates other psychiatric symptoms
- o PRTF services can be reasonably expected to improve the child's chronic condition or prevent further regression so that services will no longer be needed, as evidenced by meeting at least ONE of the below:
 - PRTF treatment is expected to increase the child's capacity to form therapeutic relationships and collaborate in their treatment, OR
 - PRTF treatment is expected to increase the child's capacity to collaborate with their parents, teachers, coaches and other adults in their life, OR
 - PRTF treatment is expected to increase the child's capacity to relate with peers in safe, satisfying and meaningful ways.
- Note: Children who reside in a Qualified Residential Treatment Plan (QRTP) or are in Juvenile Department of Corrections (JDOC) custody would not be subject to all the above criteria as many of the described services are not available to these children.
- The following are excluded:
 - o Acutely suicidal or homicidal, acutely psychotic (unless the PRTF has the capacity to provide care in such situations, for example, 1:1 staffing, crisis management, 24/7 nursing and physician coverage), OR
 - o Acute substance use issues, OR
 - o Acute medical issues.

Continued Stay Criteria

- Child must be under the age of 22.
- Child's current signs and symptoms meet criteria for a DSM diagnosis not solely due to Intellectual or Developmental Disability (IDD) and/or alcohol or drug use.
- There is a substantial chronic risk of harm to self or others, or the child is unable to care for his or her own physical health and safety to create a danger to the lives of self, others or animals, not manageable at a lower level of care, as evidenced by meeting at least ONE of the below in the past two weeks in any setting (e.g., facility, home, and community):
 - o Aggressive or assaultive behavior causing harm to self, others, animals, or property
 - o Hostile, threatening or intimidating behavior resulting in fear response in others
 - o Poor or intrusive boundaries resulting in anger response in others and requiring frequent staff intervention
 - o Requires intensive staff interventions to co-regulate and/or contain emotional dysregulation and prevent substantial harm to self or others
 - o Requires external controls to prevent impulsiveness that would put self or others at risk of substantial harm
 - o Requires external controls to care for his/her own physical health and safety and prevent significant illness or injury
 - o Treatment-rejecting behavior that would represent a barrier to treatment in the community
 - o Pervasive rejection of adult requests, directions, and rules that puts the child or others at risk for substantial harm or dysfunction in the home, school or community
 - o Pervasive suicidal or homicidal ideation and/or action that puts the child or others at risk for substantial harm
 - o Delusions/hallucinations/psychotic symptoms impacting daily living
 - o The psychiatric medication regimen is still being adjusted to address symptoms, side effects, and manageability in the community that cause risk of harm or otherwise prevent successful return to the community
- PRTF services can be reasonably expected to produce clinically significant improvement in the child's chronic condition or prevent further regression so that services will no longer be needed, and positive impacts of continued stay outweigh the negative impacts, including separation of the child and family.
- Clinical best practices are being provided with sufficient intensity to address the child's treatment needs and meet regulatory requirements.
- Prior to discharge, the PRTF team has collaborated directly with community providers to facilitate successful transition of care.

Discharge Criteria

- Continued PRTF level of care is generally needed until 1 or more of the following occurs:
- Treatment of the child's chronic behavioral health condition no longer requires PRTF level of care under the direction of a physician due to adequate stabilization or improvement as indicated by ALL the following (1-3 below):
 - Risk status is acceptable as indicated by ALL the below (Time periods are minimums and may be longer as specified in the treatment plan by the CBST and PRTF treatment team):
 - For at least two weeks, child has not made a suicide plan or act of serious self-harm.
 - For at least two weeks, thoughts of suicide, homicide, or serious harm to self or to another are absent or are manageable at a lower level of care.
 - For at least two weeks, the child has been cooperative, and defiance, threats, aggression and property destruction have been absent or would be manageable at a lower level of care.
 - For at least two weeks, the child has responded to limits, challenges and setbacks by using coping skills or by asking adults for support within a reasonable period of time.
 - For at least two weeks, the child has stayed emotionally regulated, has stayed safe when emotionally dysregulated, or the level of emotional dysregulation could be managed at a lower level of care.
 - For at least two weeks, the child has made safe decisions or has exhibited no more risky impulsiveness than the community could sustainably manage.
 - For at least four weeks, the child has demonstrated safety during onsite visits and off-site passes with family or has exhibited no more risky behavior than the family could sustainably manage.
 - Child and supports understand the nature of the child's psychiatric condition, as well as the follow-up treatment and crisis plan.
 - The child would be safe in the community if accessing usual intensive community services.
 - Child can participate in needed monitoring (e.g., verify absence of plan for harm).
 - The CBST and PRTF treatment team have identified the services needed to meet the child's needs in the community and have scheduled appointments for within 2 weeks after discharge.
 - Functional status is acceptable as indicated by ONE or more of the below:
 - With appropriate support, child can collaborate with adults, attending school, and participating in recommended community treatment.
 - The child's family/support system has demonstrated on passes that they can manage the child's behavior and are willing to participate in community services as recommended by the CBST and PRTF treatment team.
 - Medical needs are manageable as indicated by ALL the below:
 - Adverse medication effects are absent or manageable at a lower level of care.
 - Medical comorbidity absent or manageable at a lower level of care.
 - Substance withdrawal absent or manageable at a lower level of care.
 - Medication regimen is appropriate for and sustainable in the community, without interfering with the child's ability to function.
- Residential care no longer appropriate due to the child's and family's progress in treatment or withdrawal of consent, as indicated by ONE or more of the below:
 - Child deterioration requires higher level of care.
 - Guardian no longer consents to treatment.
 - CBST and PRTF treatment team agree that the negative impacts of continued stay, including separation of the child and family, outweigh the benefits of the PRTF stay.
 - CBST and PRTF treatment team agree that PRTF services can no longer be reasonably expected to produce clinically significant improvement in the child's chronic condition or prevent further regression so that services will no longer be needed.

Service Delivery

- Discharge planning needs may include:
 - Decision and planning regarding next level of care includes:
 - Plan for monitoring for dangerous ideation or behavior if necessary
 - Plan for assisting child with self-care if necessary
 - Follow-up plan is developed with input from CBST and PRTF treatment team, community providers, child and child's support

- Preparation of the child for transition to lower level of care should include sufficient lead time (e.g., setting discharge date 2 weeks or more in advance) and includes:
 - Preparation of the child to participate in community treatment (attend therapy, groups, med management, etc.; take medication as prescribed)
 - Preparation of the child to collaborate with their parents, meaning that they can accept structure, direction, guidance, support and care
 - Preparation of the child to attend school successfully
 - Preparation of the child to relate with peers safely and enjoyably
 - Review of the crisis plan with the child and supports
- Preparation of child's family, providers, school and community for the child's transition to lower level of care should include sufficient lead time (i.e., setting discharge date 2 weeks or more in advance) and includes:
 - Ensure sufficient knowledge of (including written instructions for parents and others):
 - Child's illness
 - Medication
 - Risk factors for relapse
 - Warning signs of relapse
 - Ensure sufficient ability to:
 - Manage the child's psychiatric symptoms
 - Practice approaches to help the child to improve at home
 - Ensure sufficient resilience, self-regulation and skill to keep the child safe and emotionally regulated.
 - Review of the crisis plan with the child and supports.
- Follow-up appointments have been scheduled to occur within 2 weeks of discharge, including:
 - Psychotherapies, such as individual, family and group psychotherapy
 - Psychiatric medication treatment
 - Medical care visit (e.g., primary care)
 - Rehabilitative services, such as SED waiver services, Psychosocial Rehab, Community Psychiatric Support and Treatment, etc.
- Prior to discharge, the PRTF team has collaborated directly with community providers to facilitate successful transition of care.
 - The PRTF team has communicated directly with the outpatient team to create a reasonable plan to support the child and family in the child's transition home.
 - The PRTF medical provider has communicated directly with the outpatient medical provider to continue the medication regimen.
 - The PRTF therapist has communicated directly with the outpatient team to describe the child and family's response to therapy and potential future goals and modalities.
- Referrals for community assistance and support, including:
 - Self-help or support groups for child, family, and caregivers
 - Community services for housing, financial, or transportation needs
- Discharge medications, supplies, and information, including.
 - Psychotropic medications
 - Medications for comorbid medical conditions
 - List of discharge medications to community providers with rationale, response and adverse effects.
- Discharge Destination (for guidance purposes only)
 - Usual
 - Acute outpatient care
 - Alternate
 - Intensive outpatient program: appropriate if around-the-clock behavioral care is not necessary and needed type and frequency of treatment are available in intensive outpatient program but not in office or clinic setting.
 - Partial hospital program: appropriate if around-the-clock behavioral care is not necessary, and support is available to provide any needed monitoring of child's condition when partial hospital program is closed.
 - Qualified Residential Treatment Programs (QRTP)
 - Day Treatment programs

Short-Term Respite

Short Term Respite Care provides temporary direct care and supervision for the member. The primary purpose is to provide relief to families/caregivers of a member with a serious emotional disturbance.

The service is designed to help meet the needs of the primary caregiver as well as the identified member. Normal activities of daily living are considered content of the service when providing respite care, and these include:

- Support in the home, after school, or at night,
- Transportation to and from school, medical appointments, or other community-based activities,
- Any combination of the above.

Short Term Respite Care can be provided in an individual's home or place of residence or provided in other community settings. Other community settings include:

- Licensed Family Foster Home
- Licensed Crisis House
- Licensed Emergency Shelter
- Out-of-Home Crisis Stabilization House/Unit/Bed.

Short Term Respite care can be provided in a group setting if the safety of the waiver member is maintained.

The cost of transportation is included in the rate paid to providers of these services.

Admission Criteria

- Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record.
- Providers must receive ongoing and regular clinical supervision by a person meeting the qualifications of a Qualified Mental Health Professional (QMHP) and supervision shall be available at all times.

Service Delivery

- Limitations include:
 - Short Term Respite Care may not be provided simultaneously with Professional Resource Family Care services. The service being provided at midnight is the service to be billed that day.
 - Short Term Respite Care is not available to members in foster care because that service is available through child welfare contractors. It can be provided to members who are in DCF or JJA custody who are living at home. It can be provided to members who are in DCF custody but who are living at home.
 - Short Term Respite Care will not duplicate any other Medicaid State Plan service or other services otherwise available to recipient at no cost.

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Revision History

Date	Summary of Changes
05/20/2019	Version 1
01/31/2020	Version 2
10/19/2020	Version 3: Addition of PRTF, CCTS and IISS
04/19/2021	Version 4
10/19/2022	Version 5