Program requirements and guidelines for Family Centered Treatment (FCT) provided through In Lieu of Services

Definitions:

- **Family Centered Treatment® (FCT)** is a comprehensive, evidence-based model of intensive in-home treatment for at-risk children and adolescents and their families. FCT treats the youth and their family through individualized therapeutic interventions in the environment in which mental health symptoms are occurring. The service is designed to avoid treatment in institutional settings, including psychiatric hospitals and psychiatric residential treatment facilities (PRTFs), thereby reducing the length of stay in these facilities and decreasing readmissions to institutions. Children and adolescents eligible for FCT may be candidates for involvement in the juvenile justice system, out-of-home placements, or reunification. They may display severe emotional and behavioral challenges due to maltreatment (such as neglect, abuse), trauma (such as from domestic violence, sexual abuse, or substance use), or serious mental health disorders. By improving youth and family functioning, FCT provides an alternative to out-of-home placements. When it is in the youth's best interest to receive treatment outside the home, FCT may minimize the length of stay and reduce the risk of readmission. FCT is delivered by an assigned Qualified Professional (QP) with a caseload averaging four to six people/families. FCT teams are trained and certified to serve the youth and their families in home and community settings. The FCT teams provide treatment services, which include first responder services to address crises with the families. In FCT, a QP is available 24 hours a day, seven days a week during each phase of FCT to provide additional support and crisis services as needed.

  FCT's individualized interventions are designed to strengthen the family's capacity to improve the youth's functioning at home and in the community, thereby preventing the need for admission to an inpatient hospital, psychiatric residential treatment facility, or other treatment settings. Frequent, intensive therapy in the family or home setting facilitates sustainable change through immediate and on-site enactments or coaching for parents, offering support where and when suggestions are most needed. Services in the FCT Model include:
  - Family-based trauma services
  - Youth and family skills training
  - Behavioral interventions
  - Analysis of maladaptive behaviors that lead to home disruption
  - Implementation of behavior plans
  - Relationship/attachment building between youth and family members

- Active coaching with family members to identify and replace maladaptive behaviors with new positive behaviors
- Empowering families to develop goals for themselves toward improving family functions
- Crisis interventions 24 hours per day, seven days per week

- **In Lieu of Services** refers to the practice of providing cost-effective services, which are typically not covered by Medicaid and therefore are not PASSE-covered benefits, in place of more expensive care that is typically covered under the PASSE program. If the PASSE determines it is more cost-effective to provide a non-covered service instead of more expensive care, the cost of the non-covered service may be reported in the numerator of the plan's medical loss ratio (MLR), and the capitation rate development will include the cost of the covered service that was replaced by the non-covered *in lieu of* service.

Program requirements:

- FCT is delivered by an assigned Qualified Behavioral Health Professional (QBHP) with a human service-related bachelor's degree.
- The QBHP must be FCT Certified or in the process of completing FCT Certification.
- FCT team members must receive supervision from a licensed individual with an FCT Supervisor Certification, or one completing the certification.
- FCT supervisors can supervise up to 10 practitioners.
- FCT practitioners and supervisors are part of a weekly FCT Team, conducting peer supervision, case consultations, training, and other tasks as directed by the FCT Foundation.
- The provider agency must be licensed by the FCT Foundation to provide FCT services.
- Providers must comply with all standards set in their FCT License Agreement.
- All staff must maintain required certification, including recertification requirements.
- An FCT practitioner caseload should allow for adequate service intensity and urgent response, with an ideal average of five cases. A practitioner may manage up to six cases if a family is nearing discharge. Practitioners with an average caseload typically manage five families at any given time. Key notes about caseload include:
  - **Experienced practitioners** may temporarily manage up to six families, especially when transitioning a family out and needing to onboard a new one quickly.
  - **Less-experienced practitioners** may manage four families, particularly with complex cases or when covering large geographical areas.
  - **Caseload management** is the responsibility of FCT supervisors who ensure suitable caseload sizes for each practitioner.
  - **Service restrictions** apply for practitioners with a full caseload of five or more families, and they cannot provide other Home and Community-based services simultaneously.

Member eligibility requirements:

- Member must meet **all** the following criteria:

- Child is of an age 4 through 18 years and has a confirmed diagnosis of mental health or a co-occurring disorder (excluding solely intellectual or developmental disabilities).
- A mental health evaluation determines FCT is appropriate.
- Guardian or caregiver must be available to participate actively in the treatment process, as FCT is designed to promote family stability and prevent placements.

- Member must have at least **one** of the following:
  - Significant risk of losing current placement or undergoing potential out-of-home placement related to a mental health diagnosis or behavioral challenges
  - Presence of serious behavioral problems at home, in school, or amongst peers
  - Symptoms (such as) of physical aggression or severe emotional distress that are unmanageable in the current setting
  - Current need for crisis intervention services to mitigate multiple episodes of high-risk behaviors
- Member must also have **one** of the following:
  - Difficulties in coordinating appropriate care in the community
  - Will not or has not benefited from lower levels of care (multiple outpatient treatment episodes without long-term success)
  - Lack of success with previous level of care (such as residential, sub-acute, and Counseling Level services)
  - History of involvement with multiple systems, such as child welfare or juvenile justice, and documented difficulties in engaging with previous treatments

Medical necessity admission criteria:

- Mental health support services are necessary to gain skills required to reduce the risk of escalation of level of care or assist in maintaining the current living situation, as indicated by **all** the following:
  - Behavioral health disorder is present and appropriate for mental health support services, with **all** the following:
    - Moderate psychiatric, behavioral, or other comorbid conditions
    - Moderate dysfunction in daily living for adults, or moderate dysfunction in daily living for children or adolescents
  - Situation and expectations are appropriate for mental health support services, as indicated by **all** the following:
    - Recommended treatment is necessary and not appropriate for less intensive care (meaning that the member requires assistance in accessing services and that documented behavior, symptoms, or risk is inappropriate for outpatient office care or traditional case management).
    - Member is assessed as not at risk of imminent danger to self or others.
    - Current primary treatments (such as pharmacotherapy or psychosocial therapy) have been insufficient to meet care needs.

- Targeted symptoms, behaviors, and functional impairments related to underlying behavioral health disorder have been identified and are appropriate for mental health support services.
- Treatment plan addresses comorbid medical, psychiatric, and substance use disorders, and it includes coordination of care with other care providers and community-based resources, as appropriate.
- Treatment plan includes explicit and measurable recovery goals that will define patient improvement, with regular assessment to ensure progress toward goals is occurring, or that the condition would deteriorate in the absence of continued mental health support services.
- Treatment plan engages family, caregivers, and other people impacted by and in a position to affect patient behavior, as appropriate.
- Treatment intensity (number of hours per week) and duration are individualized and designed to meet patient needs and will be adjusted according to their response to therapy and ability to participate effectively.
- Patient is expected to be able to participate in and respond as planned to proposed treatment adequately.

Medical necessity continued stay criteria:

- The member is eligible to continue this service if:
  - The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the member's plan of care and Person-Centered Service Plan; or
  - The member continues to be at risk for out-of-home placement due to a mental health diagnosis, based on current clinical assessment, history, and the tenuous nature of the functional gains.
- Additionally, the member must continue to meet medically necessary criteria as established by Summit Community Care, and **one** of the following applies:
  - The member/family is making satisfactory progress toward meeting goals, and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the Treatment Plan and Person-Centered Service Plan; OR,
  - The member/family is making some progress, but the specific interventions in the Treatment Plan need to be modified so that greater gains, which are consistent with the member's premorbid level of functioning, are possible; OR,
  - The member/family has yet to make progress (or demonstrates regression) in meeting goals through the interventions outlined in the Treatment Plan. The member's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, and interventions or treatment recommendations shall be revised based on the findings. This includes consideration of alternative or additional services.

- FCT is designed to be a time-limited service. Therefore, all requests to extend services beyond six months will be carefully reviewed on a case-by-case basis to ensure appropriateness.

Discharge criteria:

- The member meets the criteria for discharge if support systems for the family have been put into place, and any one of the following applies:
  - The member has achieved goals and is no longer in need of FCT services; OR,
  - The member's level of functioning has improved with respect to the goals outlined in the Treatment Plan, inclusive of a transition plan to step down to a lower level of care; OR,
  - The member is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services; OR,
  - The member or legally responsible person no longer wishes to receive FCT services; OR,
  - The member, based on presentation and lack of improvement despite modifications in the Treatment Plan, requires a more appropriate best practice treatment modality.

Program treatment guidelines:

- Providers must ensure that each member receives a minimum of 10 hours of direct, documented service each month over a rolling 30-day period, using H0037 U4 V1 Monthly. The monthly rate will begin on the first day of FCT services.
- H0037 U4 V2 Per Diem services may be used for two purposes:
  - During the transition period (up to 45 days), when a member prepares for discharge from a residential setting. Eligible only on therapeutic home visit days when FCT services are provided in the home.
  - When there is an authorization in place but the family discharges before the authorization period ends. Encounter billing is applicable only on days when FCT services are delivered to the family.
- Providers will include the following when submitting authorizations:
  - FCT Monthly Update Form:
    - **https://provider.summitcommunitycare.com/docs/gpp/ARAR_CAID_BH_FCTMonthly.pdf?v=202511172316**
  - Behavioral Health Outpatient Prior Authorization Form:
    - **ARAR_CAID_BH_BHOutpatientTreatmentForm.pdf**
  - and any additional supporting documentation
- Targeted length of service is approximately six months.
- Telehealth is only allowable under the direction and written approval of the FCT Foundation and should be minimal and time-limited if needed. The reason for telehealth should be included on the FCT Monthly Update Form and included for prior authorizations.

- During the provision of FCT services, no other Home and Community-based services shall be provided. Only services from the Counseling and Crisis Manual may continue if medically necessary.
- FCT assessment is required when requesting initial authorization.
- FCT treatment plan and updates are required when requesting concurrent authorizations.

Expected outcomes:

- 25% reduction in Emergency Department admissions
- 25% reduction in Acute Inpatient Psychiatric admissions
- 25% reduction in Psychiatric Residential Treatment admissions
- 25% reduction in 30-day readmissions for Acute Inpatient Psychiatric
- 25% increase in days the member resides in their home/community versus residing in a hospital setting