INDIANA HEALTH COVERAGE PROGRAMS

Division of Mental Health
and Addiction

Child Mental Health

Wraparound Services

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: September 10, 2015	New document	FSSA's OMPP and DMHA
1.1	Policies and procedures as of October 1, 2015 Published: February 25, 2016	Conversion to modular format, scheduled review	FSSA's OMPP and DMHA; HPE
1.2	Policies and procedures as of June 1, 2016 Published: September 20, 2016	Scheduled review	FSSA's OMPP and DMHA; HPE
1.3	Policies and procedures as of June 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: February 13, 2017	*Core*MMIS updates	FSSA's OMPP and DMHA; HPE
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3.0	Policies and procedures as of July 1, 2018 Published: July 10, 2018	Scheduled review: • Reorganized and edited text as needed for clarity • Added a reference to High Fidelity Wraparound and updated web link information in the *Purpose of the Provider Module* section • Updated references in *Table 1 – Child Mental Health Wraparound Program* • Updated name of Training and Support for the Unpaid Caregiver services (formerly Family Support and Training) where needed • Updated the tasks for the CFT meetings in *The Child and Family Team* section • Updated references in the *Coaching Observation Measure for Effective Teams (COMET)* section	FSSA's OMPP and DMHA, DXC

Library Reference Number: PRPR10019   *iii*
Published: July 10, 2018
Policies and procedures as of July 1, 2018
Version: 3.0

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		• Added the *Wraparound Fidelity Index Short Version WFI EZ* section • Updated Access Site responsibilities in the *High Fidelity Wraparound Access Site Responsibilities and Expectations* section • Updated the *Target Group Criteria* section: – Changed DSM-IV-TR to DSM-V – Updated the note regarding coverage past 18th birthday with new policy • Updated the web reference for a list of Access Sites in the *CMHW Application Process* section • Added a freedom of choice right in the *Applicant Evaluation* section • Updated the *Submission of the CMHW Application* section: – Added consent to contact for WFI EZ form – Added 10-day deadline • Updated the *POC Development* section • Updated the *Participant Termination, Interrupt, and Re-Start Status* section with new policy of coverage past 18 years of age • Updated the *Participant Transition from CMHW Services* section • Completely updated *Section 11: Critical Events and Incident Reporting* • Updated *Section 12: Participant Complaints and Grievances* • Added reference to the *Rendering Provider Application* form and added information about facility-based Respite Care providers in the *Accredited*	

iv

Library Reference Number: PRPR10019
Published: July 10, 2018
Policies and procedures as of July 1, 2018
Version: 3.0

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		Agency, *A Nonaccredited Agency*, and *An Individual Provider* sections • Clarified information about the child abuse registry screen in the *General Provider Requirements* section • Removed form listings from the *CMHW Provider Application* section • Updated the *Qualifying SED Experience Requirements* section • Updated the *Application Process* section and subsections • Added that required training would be considered ongoing professional development training for the purposes of reauthorization in the *Wraparound Facilitator Training Requirements* section • Added the following sections: – *Indiana Requirements for Wraparound Facilitator Agency Policy* and subsections – *Ongoing Requirements for Wraparound Facilitator Agencies* – *Core Training Course Descriptions* – *Skill-Based Supervision for Wraparound Practice* – *Training for New Wraparound Facilitators* and subsections • Added list of forms and descriptions to the *Provider and Service Addition Requests* section • Added restriction for sharing family brochure or bio in the *Solicitation of CMHW Services* section	

Library Reference Number: PRPR10019
Published: July 10, 2018
Policies and procedures as of July 1, 2018
Version: 3.0

v

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		• Updated standards and requirements in the *Documentation of Supervision* section • Updated documentation requirements in the *Content Standards for Service Notes* section • Added claim-submission information and references in the *Medicaid Claim Tips and Reminders* section • Updated the *Quality Assurance Review* section • Updated the *Quality Improvement Strategic Planning Process* section • For Wraparound Facilitation: – Updated *Table 3 – Qualifications and Standards for Wraparound Facilitators* – Clarified CFT meeting minutes in the *Documentation Requirements* section – Updated the *Child and Family Team Meeting Documentation* section • For Habilitation: – Updated the rate in *Table 4 – Service Code and Billing Information for Wraparound Facilitation* • For Respite Care: – Updated *Table 7 – Qualifications and Standards for CMHW Respite Care Providers* – Updated the *Documentation Requirements* section – Updated *Table 8 – Service Codes and Billing Information for Respite Care Services* – Added the *Provider Supervision Requirements* section	

vi

Library Reference Number: PRPR10019
Published: July 10, 2018
Policies and procedures as of July 1, 2018
Version: 3.0

Version	Date	Reason for Revisions	Completed By
		• For Training and Support for the Unpaid Caregiver: – Updated the *Documentation Requirements* section – Updated *Table 10 – Service Code and Billing Information for Training and Support for the Unpaid Caregiver Services* • Updated *Section 24: Glossary of Terms and Acronyms*	

Library Reference Number: PRPR10019
Published: July 10, 2018
Policies and procedures as of July 1, 2018
Version: 3.0

vii

Table of Contents

Library Reference Number: PRPR10019   ix
Published: July 10, 2018
Policies and procedures as of July 1, 2018
Version: 3.0

Section 1: Purpose of the Provider Module

The purpose of this module is to provide a reference document for service delivery under the Indiana Health Coverage Programs (IHCP)-approved home and community-based High Fidelity Wraparound (HFW) services provided through the 1915(i) Child Mental Health Wraparound (CMHW) Services State Plan Amendment (SPA) *TN 12-013* and supported by the *Indiana Administrative Code 405 IAC 5-21.7*. The 1915(i) CMHW Services Program is an SPA pursued by the Indiana Family and Social Services Administration (FSSA) through its Office of Medicaid Policy and Planning (OMPP) and Division of Mental Health and Addiction (DMHA) to support and promote Indiana's strategic plan.

This module is intended as a resource for the following:

- All DMHA-approved Access Sites, Wraparound Facilitators, service providers, and agencies

- State staff who administer, manage, and oversee Indiana's CMHW Services Program

- Entities interested in applying to become service providers for CMHW services

This module not only defines the CMHW Services Program, provider requirements, services, billing information, and State expectations for providers, but also provides useful guidelines and resources for those providing services under the CMHW State Plan Amendment.

Providers and participants in the CMHW Services Program may find additional information and resources by visiting the following websites:

- The IHCP website at indianamedicaid.com

- The *CMHW Program Description* page at in.gov/fssa/dmha

- The *CMHW Provider Information* page at in.gov/fssa/dmha

Providers can sign up for the DMHA System of Care email database on the *Announcements* page at in.gov/fssa/dmha to receive program updates. All service providers are required to sign up for the DMHA website mailing list to receive CMHW Services Program email announcements and invitations from the DMHA. It is the service provider's responsibility to check the website regularly for information, updates, and announcements that might affect their delivery of CMHW services.

> *Note:* *Providers are responsible for adhering to the CMHW Services policies, program standards, requirements, and expectations, as documented in this module and updated by the DMHA and the OMPP. All amendments to the CMHW Services Program, policies, and/or provider are binding upon receipt or publication. Updates are posted on the DMHA website. The DMHA distributes notifications regarding policy and program updates and changes on the Indiana System of Care website and through the website's email database.* **Providers are required to add their email addresses to the DMHA System of Care email database. It is recommended that each staff approved to provide services also be listed in the email database.**

Library Reference Number: PRPR10019
Published: July 10, 2018
Policies and procedures as of July 1, 2018
Version: 3.0

1

Section 2: Overview of 1915(i) Child Mental Health Wraparound Services Program

The 1915(i) Child Mental Health Wraparound (CMHW) Services Program is a State Plan Amendment (SPA) pursued by the Indiana Family and Social Services Administration (FSSA) through its Office of Medicaid Policy and Planning (OMPP) and the Division of Mental Health and Addiction (DMHA) to support and promote Indiana's strategic plan. The 1915(i) CMHW Services SPA is supported by *Indiana Administrative Code 405 IAC 5-21.7*. This service program is a Medicaid Home and Community-Based Services (HCBS) program provided as an option for states under the *Social Security Act*.

History of State Plan HCBS

The provision of home and community-based services (HCBS) first became available in 1983 when Congress added section 1915(c) to the *Social Security Act*, giving states the option to receive a waiver of Medicaid rules governing institutional care. In 2005, HCBS became a formal Medicaid State Plan option. Several states include HCBS services in their Medicaid State plans. Forty-seven states and the District of Columbia (DC) are operating at least one 1915(c) waiver. HCBS services are intended to provide the following benefits:

- Opportunities for Medicaid beneficiaries to receive services in their own homes or communities

- Services for a variety of targeted population groups, such as people with mental illnesses, intellectual disabilities, and/or physical disabilities

To provide services that meet the unique needs of the state's population, the federal regulations surrounding HCBS services provide states with the following options:

- Target one or more specific populations.

- Establish needs-based criteria.

- Define a new Medicaid eligibility group for people who can receive state-plan HCBS.

- Define the HCBS included in the benefit, including state-defined and Centers for Medicare & Medicaid Services (CMS)-approved "other services" applicable to the population.

- Allow any or all HCBS to be self-directed.

States can develop HCBS benefits to meet the specific needs of populations within federal guidelines, including:

- Establish a process to ensure that assessments and evaluations are independent and unbiased.

- Ensure that the benefit is available to all eligible individuals within the state.

- Ensure that measures are taken to protect the health and welfare of participants.

- Provide adequate and reasonable provider standards to meet the needs of the target population.

- Ensure that services are provided in accordance with a Plan of Care (POC).

- Establish a quality assurance, monitoring, and improvement strategy for the benefit.

Library Reference Number: PRPR10019
Published: July 10, 2018
Policies and procedures as of July 1, 2018
Version: 3.0

3

Indiana's history of providing HCBS services to youth with serious emotional disturbances (SED) began in 2007 and includes the following:

- Indiana received approval from the CMS to provide services under the Community Alternative to Psychiatric Residential Treatment Facility (CA-PRTF) Grant in October 4, 2007:
  – Enrolled its first client January 31, 2008.
  – Served over 1,600 youth.
  – Indiana demonstrated through its successful implementation of the CA-PRTF Demonstration Grant in 2008 that home and community-based intervention services and strategies, provided through multiple Systems of Care (SOC) and within a wraparound model of service delivery, can lead to positive outcomes for youth and families, thus reducing the need for out-of-home placements.

- The Psychiatric Residential Treatment Facility (PRTF) Transition Waiver began October 1, 2012, to sustain services to those enrolled in CA-PRTF at the expiration of that grant. The last enrolled youth transitioned from the program December, 2016.

- Money Follows the Person-PRTF (MFP-PRTF), a collaboration between the DMHA and the Division of Aging (DA), began in December 2012 and provided 365 days of HCBS services available to qualifying youth after 90-day placement in a PRTF. The services were authorized by the DA, with service providers approved by the DMHA. The MFP-PRTF transitioned its last enrolled youth December, 2016.

- The Wraparound Practitioner Organization Certification Program was implemented and required for all Wraparound facilitators, regardless of State wraparound funding source. The certification process began in February 2012.

- The Department of Child Services (DCS), in collaboration with the DMHA, began providing wraparound services for youth with SED in 2012 through the Children's Mental Health Initiative (CMHI).

- The 1915(i) Child Mental Health Wraparound Services State Plan Amendment was approved by the CMS, and Indiana promulgated *405 IAC 5-21.7* Child Mental Health Wraparound Services in the spring of 2014.

Indiana's HCBS Programs for Youth with SED

The FSSA, through the OMPP, and the DMHA, offers the CMHW program to assist youth and families.

Table 1 – Child Mental Health Wraparound Program

Program Name	Supported By	Administered By	
1915(i) Child Mental Health Wraparound Services HCBS State Plan Amendment (CMHW Services Program) Additional provider resources: in.gov/fssa/dmha/2764.htm	CMS-Approved SPA: TN 17-022 Indiana Administrative Code: *405 IAC 5-21.7*	DMHA	FSSA's OMPP
Note State and federal rules and regulations are outlined in the supporting regulations listed in the table and supersede all other instruction. A glossary of frequently used terms is also posted on the DMHA Indiana System of Care website.			

CMHW Services Overview

CMHW services provide youth with SED with intensive home and community-based wraparound services provided within an SOC philosophy and consistent with wraparound principles. Services are intended to augment the youth's existing or recommended behavioral health treatment plan (Medicaid Rehabilitation Option, managed care, and so on) and address the following:

- The unique needs of the CMHW participant

- Building upon the strengths of the member and the member's family or support group; Services, and strategies that assist the participant and family in achieving more positive outcomes in their lives

> *Note:*   *Indiana's wraparound services sustainability goal continues to ensure that youth in community settings receive effective mental health services and support, at the appropriate level of intensity, based on their needs and the needs of their families.*

CMHW services are provided by qualified, DMHA-approved service providers who engage the participant and family in a unique assessment and treatment planning process characterized by the formation of a Child and Family Team (CFT). The team makes available to the participant/family an array of strategies that include, but are not limited to, the following:

- High Fidelity Wraparound (HFW) services

- Mental health services and support

- Crisis planning and intervention

- Parent coaching and education

- Community resources and supports

The State's purpose for providing CMHW services is to serve eligible participants who have SED and enable them to benefit from receiving intensive wraparound services within their home and community with natural family/caregiver supports. The CMHW services available to the eligible participant may include:

- Wraparound Facilitation

- Habilitation

- Respite Care

- Training and Support for the Unpaid Caregiver (formerly Family Support and Training)

The CMHW Services Program is governed by the CMS in the approved 1915(i) CMHW SPA and *405 IAC 5-21.7*. This provider reference module, which was developed by the DMHA and approved by the OMPP, defines the CMHW Services Program requirements, standards, and expectations, including but not limited to, the following:

- CMHW participant eligibility, application, assessment/evaluation, treatment planning, and service delivery

- CMHW provider qualifications, including the DMHA authorization process and provider responsibilities

- State expectations for HFW Access Sites, Wraparound Facilitators, and other CMHW service providers

- CMHW services scope, limitations, and exclusions

- Requirements for service delivery and reimbursement

- CMHW services participant and family rights

- Participant fair hearings, grievances, and appeals

Indiana's quality management process includes monitoring, discovery, and remediation processes implemented to identify opportunities for ongoing quality improvement within the service program. The quality management process also assists the State in ensuring the CMHW Services Program is operated as follows:

- In accordance with federal and State requirements

- To ensure participant health and welfare

- To ensure that participant needs, desired outcomes, and preferences are part of the person-centered planning process and reflected in the POC

Overview of Administrative Oversight

As required by the CMS, CMHW services are administered, evaluated, and monitored in accordance with the CMS-approved 1915(i) CMHW SPA and *405 IAC 5-21.7-*. The following State entities provide administration and oversight for CMHW services:

- FSSA: The single State Medicaid agency. The FSSA is an umbrella agency that houses multiple divisions such as the OMPP, the DMHA, the Division of Disability and Rehabilitative Services (DDRS), the DA, and the Division of Family Resources (DFR).

- FSSA's OMPP: The office within the Indiana Families and Social Services Administration that administers the Indiana Health Coverage Programs (IHCP). The OMPP is responsible for developing the policies and procedures for the health plan programs, which include the Healthy Indiana Plan and Hoosier Healthwise.
  – Retains the authority and oversight of the 1915(i) program delegated to the DMHA through routine monthly meetings to discuss issues, trends, member appeals, and provider issues related to the program operations, including service plan approvals.
  – Reviews and approves policies, processes, and standards for developing and approving the care plan based on the terms and conditions of the State Plan; may review, approve, or overrule the approval or disapproval of any specific POC acted upon by the operating agency.

- FSSA's DMHA:
  – Serves as the operating agency that oversees the day-to-day functions of the CMHW program.
  – Develops program policies and procedures.
  – Authorizes potential providers to be eligible to enroll in the IHCP as CMHW providers.
  – Determines eligibility for CMHW services.
  – Creates initial POC.
  – Monitors implementation of services.
  – Conducts Quality Improvement Reviews.
  – Receives Incident Reports and Complaints.

- FSSA's DFR: The State agency that offers help with job training, public assistance, the Supplemental Nutrition Assistance Program (SNAP), Medicaid, and other services

- Surveillance Utilization Review (SUR): The Program Integrity Division responsible for billing and payment concerns

- CMS: The agency within the U.S. Department of Health and Human Services that is responsible for administering Title XIX and Title XXI of the *Social Security Act*. The CMS oversees the Medicaid and Medicare programs and is responsible for the IHCP, including HCBS programs.

Section 3: DMHA Indiana System of Care

Because 1915(i) Child Mental Health Wraparound (CMHW) Services are administered within the Division of Mental Health and Addiction (DMHA), Indiana System of Care (INSOC) framework and according to SOC principles, this section has been included to help providers understand the State's SOC expansion initiatives.

Indiana Strengthening Our Communities (INSOC)

The Substance Abuse and Mental Health Services Administration (SAMHSA) SOC Expansion Planning Grant awarded in July 2013 has provided support for Indiana to develop a comprehensive strategic plan for expansion of Indiana's SOC capacity across all 92 Indiana counties. The expansion plan is based on feedback gathered from youth, families, child-serving agencies and key stakeholders at regional focus groups, a Search Conference, a self-assessment survey, and strategic planning sessions held during the initial start-up. Indiana has identified strategies and activities to develop and incorporate SOC support and oversight at a state level to foster continued SOC growth, accessibility, and standardization at the local level. Indiana's SOC capacity builds on partnerships among similar systems at the State and local levels.

Indiana System of Care Definition

The community takes responsibility for services and supports that lead to sustainable success for youth and families.

- These services and supports are offered with respect and compassion.

- The services and supports are responsive and tailored to the unique, whole person.

- Services and supports are created and maintained based on community data by multiple, varied stakeholders who work in true partnership characterized by honest communication, a shared philosophy and approach, and shared resources.

- A community-based infrastructure plans and coordinates implementation of the services and supports within the system and sustains them through accountability, evaluation, and quality assurance.

Targeted areas addressed in the SOC expansion plan include:

- Promote *collaboration* across youth, families, child-serving agencies, and stakeholders to build relationships around a shared vision that are based on a formal structure and culture to co-create, implement, and evaluate Indiana's SOC.

- *Develop core SOC values* that are infused throughout the State and every local SOC to guide the process, services, supports, and outcomes of the local SOC.

- Ensure youth and family *access to effective, individualized, culturally and linguistically competent services and supports* to promote positive mental health and address related needs.

- Assess Indiana's workforce needs and implement strategies to *ensure a well-staffed workforce that is competent and cross-trained* in common topics. This workforce can contribute to a system that provides appropriate services and supports with a shared SOC approach within multiple environments.

- *Creatively braid and blend funding from multiple sources and stakeholders* to provide the most effective, appropriate, and comprehensive system for all children, regardless of payer.

- *Raise awareness and change behavior and public perception* around mental health and related needs.

- *Ensure partnerships within State and local governance are effective, dynamic, and sustainable* – and share responsibility for co-creation, implementation, and evaluation of the State and local SOC.

Indiana's vision for the State is that all young people, surrounded by supportive adults, achieve wellness, engage in their community, and together, promote wellness for generations to come.

Child Mental Health Wraparound (CMHW) services will be provided according to wraparound principles and supported by a System of Care (SOC) philosophy. Wraparound, for purposes of the CMHW (and all State-funded wraparound programs), is defined as an ecologically based process and approach to care planning that builds on the collective action of a committed group of family, friends, community, professional, and cross-system supports mobilizing resources and talents from a variety of sources, resulting in the creation of a Plan of Care (POC) that is the best fit between the family vision and story, team mission, and youth and family strengths, needs, and strategies. Wraparound provides youth and their families with *access, voice, and ownership* in the development and implementation of their POCs.

> *Note:* **High Fidelity Wraparound** *(HFW) is a process of delivering services that is usually reserved for youth at risk for out-of-home placement.*

Wraparound Principles

Wraparound operates by following a set of values to guide the work done with families. This process adheres to the SOC philosophy and is guided by the following principles:

- *Family voice and choice*: Family and youth perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.

- *Team-based*: The team consists of individuals approved by the family and committed to the family through informal, formal, and community support and service relationships.

- *Natural supports*: The team actively seeks out and encourages the full participation of team members drawn from the family's network of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support.

- *Collaboration*: Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources.

- *Community-based*: The team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible, and that safely promote child and family integration into home and community life.

- *Culturally competent*: The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the youth, family, and their community.

- *Individualized*: To achieve the goals laid out in the wraparound plan, the team develops and implements customized strategies, supports, and services to achieve the youth and family's desired outcomes.

- *Strengths-based*: The wraparound process and POC identify, build on, and enhance the capabilities, knowledge, skills, and assets of the youths and their families, their communities, and other team members.

- *Unconditional care*: Regardless of challenges that may occur, the team persists in working toward the goals in the plan until the team agrees that a formal wraparound process is no longer required.

- *Outcome-based*: The goals and strategies of the plan are tied directly to observable or measurable indicators of success. The team monitors progress in terms of these indicators and revises the plan accordingly.

> *Note:*   *Wraparound works best when supported by a larger SOC effort. Wraparound is a small component of a System of Care.*

The Four Key Elements of Wraparound

How wraparound principles are operationalized is an important distinction in the practice of wraparound. Four key elements make wraparound unique, and these four key elements are necessary to ensure that a HFW process and quality practice are occurring. The National Wraparound Implementation Center (NWIC) has identified four key elements and four phases in an HFW process. The wraparound process has four phases, and within those four phases, essential process components need to occur for high-fidelity wraparound:

- *Grounded in a strengths perspective*: Wraparound is a strengths-based process reflecting a basic commitment to strength seeking, generating, and building. The strengths of the youth, family, all team members, service environment, and community are purposefully and transparently used in all decision making and service delivery.

- *Driven by underlying needs:* A core concept in effective wraparound is the concept of underlying needs rather than superficial or simply spoken needs. When challenging or risky behaviors arise, services are often focused on managing the behavior rather than meeting the need. If the need continues to go unmet, the behavior is likely to escalate, resulting in more attempts to contain the behavior. This is typically evidenced by continually increasing services and higher levels of care, often with minimal positive results. Wraparound is focused on meeting needs rather than containing problems.

- *Supported by an effective team process:* Wraparound is not a process that can be accomplished by a single individual, family, or organization. The process is predicated on the notion that a group of people working together around common goals, objectives, and team norms are likely to produce more effective outcomes. The team should be composed of people who have a strong commitment to the family's well-being.

- *Determined by families:* The family's perspective, preferences, and opinions are first understood and then considered in decision making. These preferences and opinions influence team decision making. Team members are expected to have enough depth of understanding so they not only know what the family wants, but why they want it and how those choices relate to unique family strengths, culture, and needs. Wraparound is about family access, voice, and ownership.

The Four Phases of the Wraparound Process

The four phases of the wraparound process are described in this section:

- *Phase One: Engagement and Team Preparation*: The Wraparound Facilitator educates the participant and family about CMHW services and the team process. The Wraparound Facilitator assists the family with identifying the Child and Family Team (CFT) members and holds a team meeting to begin developing the POC. The CFT members include the Wraparound Facilitator, the participant, family, service providers, and any other supports chosen by the family. Team membership may vary over time. Friends, educators, providers, informal caregivers, probation officer, a Child Protective Services family case manager, therapist, clergy, and anyone else requested by the family may be on the team.

- *Phase Two: Initial Plan Development*: The Wraparound Facilitator facilitates the CFT process for developing the POC and ensures that the youth and family are active participants leading the POC development process. Using the family's story, the CMHW assessment, and the results of the Child and Adolescent Needs and Strengths (CANS) assessment, the team assists the family in identifying and prioritizing participant and family strengths and underlying needs that are the basis for the POC. The Wraparound Facilitator is responsible for organizing and coordinating team efforts and resources to

develop a unified intervention plan that meets the unique needs of the participant and family. These services may be diverse and cross a number of life domains, including family support, behavior management, therapy, school-related services, habilitation, medical services, crisis services, and independent and interpersonal skills development.

- *Phase Three: Implementation*: This phase also includes modification of the POC, as needed. The POC specifies who is responsible for each strategy, service, or support, and who is responsible for ongoing monitoring of the plan. The Wraparound Facilitator is ultimately responsible for all plan development, implementation, and monitoring, including knowledge of when the participant's and/or family's needs or preferences change.

- *Phase Four (Final Phase): Transition*: This phase begins when the CFT members agree that the identified needs have been addressed and the participant/family can transition out of CMHW services to a less intensive form of services and supports. The Wraparound Facilitator helps the team develop a transition plan for the participant/family. This plan includes any remaining needs to be addressed and the strengths of the participant/family. The team identifies resources that will continue to be available to the participant/family after CMHW services have ended.

> *Note:*   *This final-phase transition process also occurs when the participant no longer meets eligibility criteria for CMHW services (for example, when the child turns 18 years old).*

The essential wraparound process components are detailed in Table 2 by the four key elements and the four phases of wraparound. Wraparound Facilitators receive process-based supervision to reinforce HFW skills to guide teams through the essential wraparound process components.

Table 2 – Essential Wraparound Process Components by Key Element and Phase

	Phase 1: *Engagement and Team Preparation*	Phase 2: *Initial Plan Development*	Phase 3: *Implementation*	Phase 4: *Transition*
Key Element: *Grounded in a Strengths Perspective*	Starting with family's view, family's story is heard and summarized from variety of sources, eliciting family possibilities, capabilities, interests, and skills.	Strengths of family, all team members, and the family's community are collectively reviewed and matched to chosen strategies.	Team continues to identify and make meaningful use of strengths, supports, and resources in an ongoing fashion.	Purposeful connections, including aftercare options, are negotiated and made based on family strengths and preferences, and reflect community capacity.
Key Element: *Driven by Underlying Needs*	Family's story is heard and summarized by starting with the family's view and blending perspectives from a variety of involved sources to elicit shared perspective of the meaning behind a behavior or situation related to the family's current situation.	Team develops an understanding of underlying reasons behind situations or behaviors. Needs generated from underlying conditions and those aligning with family's vision are summarized, reviewed, prioritized, and used as basis for developing strategies.	Team deepens their understanding of underlying reasons behind situations and adapts strategies based on that new information.	Team forecasts potential unmet needs and strategizes options for after wrap-around ends.
Key Element: *Supported by an Effective Team Process*	Family's perspectives around success are summarized and reflected to the team, and the team understands their roles and expectations within the wraparound process.	Family's interests and preferences are summarized and integrated into a team mission and subsequent strategies that include the perspectives of all team members.	Team delivers and modifies strategies that align with chosen outcomes and reflect family perspective.	Team mission is achieved and family is closer to their stated vision.
Key Element: *Determined by Families*	Family's culture, values, traditions, and beliefs are elicited and summarized to inform responses to the wraparound process.	Family's perspective is reflected as critical to a successful process and is the basis for decision making and creative problem solving.	Family perspective is used in modifying mix of strategies and supports to ensure best fit with family perspective.	Family perspective of met need is used to identify and develop transition activities.

The Child and Family Team

HFW is an intensive, individualized care-planning process that builds on the collective action of a committed team of people who mobilize resources and strengths, resulting in the creation and implementation of a POC. The youth and family are critical in developing the CFT, with support and guidance provided by the Wraparound Facilitator. Members of the CFT may include, but are not limited to, the following:

- The youth and family, who lead the treatment planning process

- The Wraparound Facilitator, who coordinates service delivery and assists the participant and family in linking with the community and natural supports (See *Section 20* in this module for detailed information on Wraparound Facilitation service definition and scope.)

- CMHW service providers and non-CMHW community providers who will provide the youth and family with resources, services, and supports during the treatment process

- Any other individuals the youth or family selects to assist in implementing the POC

The Wraparound Facilitator is responsible for monitoring and overseeing the development and implementation of the POC and will facilitate a CFT meeting at least once a month. In each team meeting, the following tasks are accomplished:

- Review and rating of family vision and team mission

- Review of team member functional strengths and addition of new functional strengths

- Review of progress made toward meeting underlying needs

- Tracking of changes toward Outcome Statements

- Prioritization of strategies

- Barriers addressed

- Review of the Crisis Plan

On a weekly basis, or more often as needed, the Wraparound Facilitator is in contact with the family and team members through home or community-based visits or by email, telephone, or text to monitor progress and implementation of the POC, and address any immediate needs. During each of these contacts, the Wraparound Facilitator is not only monitoring POC implementation, but the welfare and safety of the child throughout the wraparound process.

Assessing Wraparound Fidelity

The DMHA contracts with the University of Maryland/National Wraparound Implementation Center for the use of their copyrighted tools to assess and monitor HFW. This information is used to improve outcomes and quality of intensive community-based services.

Coaching Observation Measure for Effective Teams (COMET)

The purpose of the COMET is to provide a framework for developing a skilled workforce and for use as a tool to provide feedback as well as frame supervision conversations for developing quality wraparound practitioners building on an HFW process. The COMET is an instrument to be used when assessing a wraparound practitioner's skill level throughout the four phases of the wraparound process. This instrument will be utilized as a document, skill, and process review across a number of settings including team observations, family visit observations and in supervision with facilitators. The COMET is designed to be

Library Reference Number: PRPR10019   *13*
Published: July 10, 2018
Policies and procedures as of July 1, 2018
Version: 3.0

used in a coaching process to enhance skill, not as a punitive tool to illustrate deficiencies in skill. Often this instrument will be used in conjunction with other tools developed by The Institute, such as the Coaching Response to Enhance Skill Transfer (CREST), Supervisory Assessment System (SAS), and the Supportive Transfer of Essential Practice Skills (STEPS).

The COMET is scored by the user determining whether or not the identified skill is present in the observation or document review. There is no scale of demonstrated skill; the skill is either evident or not evident. The COMET can only be used by supervisors and coaches trained by the Institute for Innovation & Implementation.

For more information, see the *High Fidelity Wraparound* page at theinstitute.umaryland.edu or email theinstitute@ssw.umaryland.edu.

Wraparound Fidelity Index Short Version WFI EZ

The Wraparound Fidelity Index, Short Version (WFI-EZ) is a brief, self-administered survey that measures adherence to the Wraparound principles. The WFI-EZ was developed in 2011 to offset the burden of conducting lengthy interviews for the full WFI-4 protocol, and to include items that assess satisfaction. Respondents (caregivers, youth, facilitators, and team members) answer questions in three categories:

- Experiences in Wraparound (25 items)

- Satisfaction (4 items)

- Outcomes (9 items)

The WFI-EZ can be self-administered on paper or online, and takes approximately 10 minutes to complete. Data result in quantitative summaries of Total Fidelity, Key Element Fidelity Scores (Effective Teamwork, Needs-Based, Natural & Community Supports, Strength and Family Driven, and Outcomes-Based), Satisfaction, and Outcomes. More information can be found at the Wraparound Evaluation and Research Team website at depts.washington.edu.

Section 5: High Fidelity Wraparound Access Sites

Purpose of a High Fidelity Wraparound Access Site

A High Fidelity Wraparound (HFW) Access Site is considered the single point of entry to explore a youth's eligibility for state and federally-funded home and community-based services, such as HFW, as an alternative to psychiatric residential treatment facility (PRTF)/State-Operated Facility (SOF) levels of care. The Access Site serves a geographical area defined by the local System of Care (SOC). The Access Site also provides the following functions for the local SOC area it serves:

- Performs outreach, education, application-processing to communities and families regarding HFW.

- Provides referral to and resources for interim supports to applicants, as well as applicants not meeting eligibility criteria.

- Reports outcomes data on a regular basis as determined by the local SOC Governance, Division of Mental Health and Addiction (DMHA), and Department of Child Services (DCS).

Access Sites are authorized by the DMHA in cooperation with local SOCs for a period of 3 years from the date of authorization. DMHA will authorize one Access Site per SOC area/region, endorsed by the local SOC governance board. Based on community need, the DMHA may authorize additional Access Sites.

High Fidelity Wraparound Access Site Application Process

To become an Access Site, an entity must submit an application in the form of an Access Plan to the local System of Care governance counsel (see the *Requirements of an Access Site Plan* section).

The local SOC will review all submitted Access Site Plans and make a recommendation as to which entity to endorse. The local SOC will submit a copy of the recommended Access Site Plan with a letter of endorsement addressed to the DMHA and should include:

1. A statement of the governance counsel's support, which is inclusive of youth and family participation, of the entity as the Access Site

2. A written explanation for the entity endorsed from among all plans submitted

3. A list of counties to be served by the Access Site

4. Names and titles of the individual members of the local SOC

5. The dated signatures of the individual members of the local SOC present at the meeting, for which there was a quorum, when the endorsement was made

DMHA Authorization of the High Fidelity Wraparound Access Site

The DMHA will review submitted materials and may request additional information or assurances prior to authorization or denial. The final determination will be communicated to the local SOC and the endorsed HFW Access Site.

High Fidelity Wraparound Access Site Responsibilities and Expectations

The HFW Access Site is responsible to work collaboratively with the local SOC to ensure youth and families have access to HFW services and supports to stabilize and maintain youth in their community.

The Access Site will provide the local SOC and DMHA with the following quarterly and annually:

1. HFW Access Site data reporting:
    a. Number of applicants
    b. Referral source
    c. Number eligible for HFW:
        i. Enrolled in CMHW
        ii. Enrolled in Children's Mental Health Initiative (CMHI)
        iii. Reasons given by those found eligible who did not enroll and their disposition
    d. For those ineligible:
        i. Reason for denial
        ii. Alternative supports and services to which the family was linked

2. Updates related to outreach and education activities as outlined in the approved HFW Access Site Plan

3. Attendance and active participation in local SOC meetings

Access Sites will use a data collection tool supplied by DMHA to collect this information.

The Access Site must notify the DCS, the local SOC, and the DMHA of any Access Site Contact changes within 3 business days of the knowledge of the change.

Ongoing Authorization and High Fidelity Wraparound Access Site Changes

Reauthorization of the Same High Fidelity Wraparound Access Site

Ninety days prior to the expiration of the current authorization period, the authorized HFW Access Site will submit a plan for reauthorization (see the *Requirements of Access Site Plan Reauthorization* section) to the local SOC.

The local SOC will review and submit its letter of recommendation to DMHA in no less than 30 days prior to the expiration of the current authorization period.

Authorization of Additional High Fidelity Wraparound Access Sites in a Local SOC

If a local SOC determines that an additional HFW Access Site entity is needed, the local SOC should follow the same process as for the initial authorization. A written justification of the need for a second entity should be included.

High Fidelity Wraparound Access Site Voluntary Withdrawal

Should an authorized entity determine it is no longer able to function as the HFW Access Site for a local SOC, the entity will provide a written 30-day withdrawal notice to the local SOC and DMHA. The entity will continue to function as the HFW Access Site until a new entity is authorized.

High Fidelity Wraparound Access Site Revocation of Authorization

If an authorized HFW Access Site is determined by DMHA and/or the local SOC to be not functioning, authorization will be revoked.

Reasons for revocation include, but are not limited to:

1. Lack of adherence to the Access Site Policy

2. Lack of demonstrated ability to make referrals for the behavioral needs of youth and families in the community

If concerns are identified by a stakeholder and need to be brought to the attention of the DMHA, the stakeholder should submit his or her concern to DMHAYouthServices@fssa.in.gov, or to the Assistant Deputy Director of Youth Services in DMHA.

The DMHA will work with the current Access Site to review and address substantiated concerns. If those concerns are not able to be successfully resolved, DMHA, DCS, and the local SOC, which is inclusive of youth and family participation, will begin the process to authorize a new Access Site entity.

Access Site Plan

Requirements of an Access Site Plan

The Access Site Plan must address the following:

1. Assurance entity can meet DMHA standards for access, referrals and support of youth and families seeking assistance at the Access Site.

2. A written process for access that includes a "No Wrong Door" streamlined approach to accepting referrals and provider/family access to information about local home and community-based programs and services.

3. Demonstrate depth of experience with HFW. Items that could demonstrate experience could include:
   a. Outcomes reports
   b. Trainings hosted
   c. Participation in the local SOC or similar community collaboration
   d. Operational HFW practices
   e. Personnel who has experience with or meets qualifications to provide HFW

4. In cases of screening eligibility for HFW, entities must demonstrate the plan for addressing the following:
   a. Making referrals to meet each applicant's immediate mental health needs pending the service screening, CANS assessment, and enrollment process
   b. Ability to make referrals for support and resources for eligible program participants who are awaiting the start date of approved program services
   c. Ensuring appropriate referrals for youth/families not eligible for HFW
   d. Assurance that the Access Site will follow all policies, procedures, and rules as outlined in the most recently approved state or federally funded wraparound service program plan

5.　A 3-year plan for outreach and education about HFW and the referral process for HFW

6.　Plan for sustainability of Access Site staff

7.　Assurance that the Access Site has personnel that meets qualifications including:
   a.　CANS SuperUser
   b.　Background screens as required by DCS and/or DMHA for direct service professionals
   c.　Eligible to receive access to State databases for application processing

8.　Statement of agreement to adhere to the Assessment and Referral process as outlined in the *High Fidelity Wraparound Application Assessment and Referral Process* section

9.　Knowledge and understanding of SOC values

Requirements of an Access Site Plan Reauthorization

The Access Site Reauthorization Plan must address the following:

1.　Assurance that the approved entity can continue to meet DMHA standards for access, referrals, and support of youth and families seeking assistance at the Access Site

2.　Current written process for access that includes a "No Wrong Door", streamlined approach to accepting referrals and provider/family access to information about local home and community-based programs and services

3.　Summary of experience as the Access Site for HFW since most recent authorization, including:
   a.　Annual reports provided to the local SOC and DMHA
   b.　Description of outreach and education activities as outlined in the approved HFW Access Site Plan
   c.　Log of attendance and participation in local SOC meetings
   d.　Quality improvement strategy:
      i.　Lessons learned
      ii.　Identified challenges
      iii.　Strategies to address challenges
      iv.　Request for support from local SOC and DMHA
   e.　Report on actions taken/support received to ensure sustainability of the Access Site

4.　Updated plan for:
   a.　Making referrals to meet each applicant's immediate mental health needs pending the service screening and enrollment process
   b.　Ability to make referrals for support and resources for eligible program participants who are awaiting the start date of approved program services
   c.　Ensuring appropriate referrals for youth/families not eligible for HFW
   d.　Assurance that the Access Site will follow all policies, procedures, and rules as outlined in the most recently approved State or federally funded HFW service program plan

5.　Updated 3-year plan for outreach and education about HFW and the referral process for HFW

6.　Updated plan for sustainability of Access Site staff

7.　Assurance that the Access Site has personnel that meets qualifications including:
   a.　CANS SuperUser
   b.　Background screens as required by DCS and/or DMHA for direct service professionals

8.　Eligible to receive access to State databases for application processing

9.　Statement of agreement to adhere to the Assessment and Referral process as outlined in the *High Fidelity Wraparound Application Assessment and Referral Process* section.

10.　Knowledge and understanding of SOC values

High Fidelity Wraparound Application Assessment and Referral Process

The DMHA and the DCS has determined the following process for referral and application to the CMHW Services Program and Children's Mental Health Initiative.

To be completed within 2 business days:

1. Referral received:
   a. Referral is received by the Access Site.
   b. The Access Site will contact the referral source to make sure the caregivers are aware a referral for HFW has been made.
   c. The Access Site will gather the referral source's perspective and outcomes desired from Wraparound.
   d. The Access Site will contact the caregiver and youth and explain the process of HFW.

2. Prescreen:
   a. Information gathered at prescreen must include but is not limited to:
      i. Youth's diagnosis/diagnoses
      ii. Age
      iii. Insurance coverage
      iv. Current supports and services
      v. Family configuration
   b. Schedule CANS assessment, or review current CANS information that has been completed by a CANS Super User. (The CANS must have been completed within the last 90 days.)

After CANS has been completed/validated:

1. Assess the likelihood of an applicant being found eligible by the State:
   a. Youth appears to meet eligibility criteria for HFW – Follow application procedures.
   b. Youth does not appear to meet eligibility for HFW:
      i. The youth and family will be advised that the youth is not likely to be found eligible.
      ii. Youth and family will be informed of their right to apply despite potential denial. (Access Site must process application if requested to do so as a requirement of Medicaid.)
      iii. Youth and family will be referred to other mental health services, Community Partners for Child Safety, DCS local office, multidisciplinary team, and/or the appropriate agency for the child and family to obtain supports to meet the family/youth needs.

Application submission:

The Access Site will submit an application on behalf of the youth and family following all required time frames, policies, procedures, and rules as outlined in the most recently approved state modules for the CMHI and the CMHW.

Section 6: Participant Eligibility and Application for CMHW Services

Indiana's Child Mental Health Wraparound (CMHW) services provide youth diagnosed with serious emotional disturbances (SED) who also meet specific criteria with intensive home and community-based services. The determination of eligibility for CMHW services must adhere to standards and criteria outlined in the 1915(i) CMHW services rule *(Indiana Administrative Code 405 IAC 5-21.7)* and the Centers for Medicare & Medicaid Services (CMS)-approved *Indiana State Plan Amendment (TN 12-013)*.

Participant Eligibility

All participants in the CMHW program must be assessed by the Division of Mental Health and Addiction (DMHA) as meeting CMHW target group criteria and needs-based criteria.

Target Group Criteria

Indiana's CMHW program is designed to serve youth meeting the following *target group criteria*:

- Age 6 through 17

- Resides in his or her home or community

- Eligible for Medicaid

- Meets criteria for two or more DSM-V (or subsequent revision) diagnoses not excluded as exclusionary criteria (see the following section)

- Youth does not meet exclusionary criteria for CMHW (see the *Exclusionary Criteria* section)

> Note: Effective July 1, 2018, youth found to be eligible for CMHW services in their 17th year will be entitled to receive 12 months of services so long as all other eligibility requirements continue to be met. For example, a youth enrolled at 17 and a half years of age may continue his or her approved level-of-need year through age 18 and a half as long as the youth continues to meet all other eligibility criteria.

Exclusionary Criteria

The following *exclusionary criteria* are used to identify youth the CMHW program is not designed to serve. A youth with any of the following criteria is not eligible for CMHW:

- Primary substance use disorder

- Pervasive developmental disorder (autism spectrum disorder)

- Primary attention deficit hyperactivity disorder

- Individual with an intellectual disability/disabilities

- Dual diagnosis of serious emotional disturbances and intellectual disability

- Youth that resides in an institutional or otherwise HCBS noncompliant setting

Library Reference Number: PRPR10019
Published: July 10, 2018
Policies and procedures as of July 1, 2018
Version: 3.0

21

In addition to exclusions noted in the CMHW State Plan Amendment and the *Indiana Administrative Code* (IAC), it is DMHA policy to exclude any youth who is at imminent risk of harm to self or others. Any youth identified as not able to feasibly receive intensive community-based services without compromising his or her safety, or the safety of others, will be referred to a facility capable of providing the level of intervention or care needed to keep the youth safe. After the youth has been deemed safe to return home to community-based treatment, CMHW services may be applied for at that time.

Needs-Based Criteria

In addition to meeting the CMS-approved target group criteria, the applicant must also meet CMHW *needs-based criteria*, which includes:

- Applicant demonstrates dysfunctional patterns of behavior, due to one or more of the following behavioral or emotional needs, as identified on the Child and Adolescent Needs and Strengths (CANS) assessment tool:
    – Adjustment to trauma
    – Psychosis
    – Debilitating anxiety
    – Conduct problems
    – Sexual aggression
    – Fire-setting

- Family/caregiver demonstrates significant needs in at least one of the following areas, as indicated on the CANS assessment:
    – Mental health
    – Supervision
    – Family stress
    – Substance abuse

Clinical Requirements for Completing the Applicant Evaluation

The individual administering the CANS assessment tool and collecting clinical information and data used to determine an applicant's/participant's Level of Need (LON) for CMHW must meet the following qualifications and standards:

- Affiliated with a DMHA-approved Access Site

- Possesses one of the following clinical qualifications:
    – A psychiatrist
    – A physician
    – A licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP)
    – A licensed clinical social worker
    – A licensed mental health counselor
    – A licensed marriage and family therapist
    – An advanced practice nurse under *IC 25-23-1-1(b)(3)* who is credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
    – A licensed independent practice school psychologist

    – An individual who does not have a license to practice independently but practices under the supervision of one of the formerly mentioned persons; and possesses one of the following:

        ➢ A bachelor's degree, plus 2 years' clinical experience

        ➢ A master's degree in social work, psychology, counseling, nursing, or other mental health field, plus 2 years' clinical experience

- Successfully completed the DMHA/Office of Medicaid Policy and Planning (OMPP)-required training and certification

CMHW Application Process

The purpose of the CMHW application process is to provide families a means to explore whether their youth would be eligible for and benefit from CMHW services. Families interested in exploring CMHW service options for their youth must contact a DMHA-approved Access Site for information and assistance in exploring eligibility requirements. (A listing of Access Sites is located on the *Community Access Sites* page at in.gov/fssa.) The Access Site provides the following information to interested youth and families:

- Information about CMHW services and their potential benefit for the youth and family

- The eligibility and exclusionary criteria for the CMHW program

- The CMHW eligibility application process

> *Note:*   *An Access Site is a DMHA-approved agency that provides a local point of access for CMHW applicants and families wishing to complete the CMHW eligibility application process. See Section 5 in this module for additional information.*

Together, the Access Site staff member, youth, and family will discuss whether CMHW services might be an option that could meet the youth's and family's needs. The youth/family will choose whether to pursue the CMHW application process, which includes the components described in the following sections.

Applicant Evaluation

Applicant evaluation includes the following:

- *Face-to-face evaluation*: Each applicant/family referred for CMHW services must receive a face-to-face evaluation by a DMHA-approved Access Site. The evaluation and supporting documentation provides specific information about the applicant's:
  – Strengths
  – Needs
  – Health status
  – Current living situation
  – Family functioning
  – Vocational status
  – Social functioning
  – Living skills
  – Self-care skills
  – Capacity for decision making
  – Potential for self-injury or harm to others
  – Substance use/abuse
  – Medication adherence

Library Reference Number: PRPR10019   *23*
Published: July 10, 2018
Policies and procedures as of July 1, 2018
Version: 3.0

- *Child and Adolescent Needs and Strengths (CANS) Assessment Tool*: CMHW is intended for youth with a high LON for services. This LON is partly determined by the ratings derived from the administration of the CANS assessment tool. The CANS assessment is used to assess the participant's and caregiver's strengths and needs and the patterns of CANS assessment ratings (for example, behavioral health needs, functioning, safety and risks, caretaker needs and strengths) are used to develop a Behavioral Health Decision Model (algorithm). This algorithm (referred to as a behavioral recommendation) identifies a LON and is used to indicate an appropriate intensity of behavioral health services recommended to address the youth's identified needs.
    - The CANS assessment tool must be administered by an individual who has completed the required training to administer the CANS assessment and is certified as a CANS SuperUser.
    - The Access Site enters the results of the CANS assessment into the Data Assessment Registry Mental Health and Addiction (DARMHA) system.

- *CMHW Eligibility Referral Application*: The Access Site, in conjunction with the applicant and family, must complete the CMHW services application. The Access Site reviews the following information with the applicant and family to ensure their understanding of the information:
    - *Conflict of interest*: The Access Site will review with the youth and family the safeguards in place to avoid a conflict of interest between the Access Site and the family's right to choose a service provider. Confirmed by youth and family signature on the *Youth & Family Rights Attestation Form*.
    - *Freedom of choice:* The Access Site informs the applicant and family of their freedom of choice regarding the following aspects of CMHW services and development of the Plan of Care (POC) (confirmed by youth and family signature on the *Youth & Family Rights Attestation Form*):
        - ➢ Development of the applicant/family's desired treatment outcomes on the POC and the methods for achieving those outcomes
        - ➢ CMHW services, as supported by the child's assessment and LON, which will be included in the POC
        - ➢ Choice of DMHA-approved CMHW providers that will provide, oversee, and monitor service delivery
        - ➢ The right to change CMHW providers anytime during enrollment in CMHW Service State Plan Amendment program
        - ➢ The right to choose to receive services in a non-disability-specific setting selected by the youth/family

- *Selection of a Wraparound Facilitator*: To enable the applicant/family to select a Wraparound Facilitator to lead the CMHW service delivery, the Access Site provides the applicant and family with a provider pick list. The pick list consists of the DMHA-approved providers enrolled to provider services in the same county as the family's residence. The applicant/family reviews the provider pick list, and selects the provider of choice. The signed pick list is then uploaded to the database and submitted with the application.

Submission of the CMHW Application

Following completion of the evaluation and the CMHW application, the Access Site submits the application packet electronically to the DMHA for review through Tobi, the DMHA database.

The Access Site must ensure that the following are completed before submitting the application packet to the DMHA:

- All fields are completed on the CMHW application in Tobi.

- Signatures have been obtained on the following documents that will be retained in the applicant's record on site at the Access Site:
    - *Youth & Family Rights Attestation Form*

- Provider pick list
- Consent to contact for participation in the Wraparound Fidelity Index, Short Version (WFI EZ)

- Supporting documentation (any clinical documentation used by the provider to support the applicant's need for CMHW services) is collected and uploaded for submission with the application packet.

- Ensure that the CANS assessment recommendation has been entered into DARMHA. Upload the entire CANS assessment report from DARMHA into Tobi.

- After the Rights Attestation form is signed, the Access Site has 10 days to submit the application to DMHA via the Tobi system.

> *Note:* If the applicant is not eligible for CMHW services, the Access Site will assist the youth and family by providing coordination and linkage with other services and/or supports appropriate for the LON indicated in the youth's evaluation and assessment.

DMHA Review and Eligibility Determination

The DMHA, which makes the final eligibility determination for all CMHW applicants, reviews the submitted application and supporting documentation within 5 business days of submission in Tobi, and will notify the Access Site regarding the review and eligibility determination, which includes:

- *Approval of applicant for enrollment in CMHW*: If the eligibility and needs-based criteria are met, the DMHA will notify the Wraparound Facilitator selected by the youth and family that the youth has been deemed eligible for CMHW services. The Wraparound Facilitator will be given access to the youth's file in Tobi, so the Wraparound Facilitator and the family may begin to develop a POC with the Child and Family Team (CFT).

- *Denial of applicant for enrollment in CMHW services*: If the needs-based eligibility criteria are not met, the DMHA will notify the Access Site that the applicant was deemed not eligible for CMHW services. The Access Site is required to notify the family of the determination in writing within 3 business days. The Access Site will provide the family with information regarding the family's rights to a fair hearing and appeal, should the family wish to appeal the DMHA eligibility determination. The Access Site is required to assist applicant and family in coordination and linkage with other services and/or supports appropriate for the LON indicated in the youth's evaluation and assessment.

If the DMHA deems an applicant eligible for the CMHW program, an initial POC is created by the DMHA that includes 2 months of Wraparound Facilitation services. The Wraparound Facilitator, in partnership with the family, develops a CFT that is inclusive of the child and family. The CFT develops an updated, individualized, POC that includes the Intervention Plan, Care Plan, and Crisis Plan. Until the updated POC is developed by the CFT, submitted by the Wraparound Facilitator, and approved by the DMHA, no other CMHW service may be accessed.

Section 7: Plan of Care and Service Authorization

The Plan of Care (POC) drives the delivery of Child Mental Health Wraparound (CMHW) services and provides a road map for the Child and Family Team (CFT) in regard to providing support for the participant and family.

> *Note: The POC consists of three component parts, the Intervention Plan (service authorizations), the Care Plan, and the Crisis Plan.*

The POC is a written document developed by the CFT with active participant and family input and involvement. Adhering to wraparound principles, the POC blends team members' perspectives, skills, and resources, and is based on participant and family strengths, needs, preferences, values, and culture. The key drivers of the POC, from the participant and family's perspective, include:

- *Needs*: The set of underlying conditions that cause a behavior or situation to occur or not occur; explains the underlying reasons why behaviors or situations happen

- *Outcomes*: Targeted to address how the team will know the need has been met; are tied to the initial reason for referral; and are measureable

- *Strategies*: Unique interventions and supports brainstormed and individualized to meet the prioritized needs of the family

> *Note: Needs can be thought of as "the holes in our heart that drive us to do the things that we shouldn't and keep us from doing the things that we should."*
> *– Patricia Miles*

The POC provides a description of the youth and family's functional strengths, needs, desired outcomes, and strategies agreed upon by the team and must be updated as needs are addressed or change. The POC serves as the primary communication tool between the Wraparound Facilitator and the Division of Mental Health and Addiction (DMHA) regarding the participant's progress while enrolled in CMHW. Additionally, the POC provides a means for the team (through the Wraparound Facilitator) to request the DMHA's prior authorization of CMHW services for an eligible participant.

This section describes the DMHA expectations for, and the CMHW provider's responsibilities associated with, the development and implementation of the POC and requesting CMHW service authorization.

POC Development

The Wraparound Facilitator is responsible for facilitating and overseeing the wraparound process. POC development is completed at the first CFT meeting with the input of the entire team. This DMHA-approved provider helps the child and his or her family along with all other team members understand the wraparound principles and process that guide the development and implementation of the POC.

The development of the POC includes active participation (voice, choice, and ownership) of the participant and family and the CFT. It begins with retelling of the family story by the Wraparound Facilitator. The family's functional strengths and their needs are discussed, and needs are prioritized. The team develops outcome statements and brainstorms a mix of strategies (services and supports) to meet the participant and family's identified needs.

The following concepts outline the core processes underlying the development of the POC:

- *Family story*: Developed in partnership with the family, Wraparound Facilitator, and the relevant people in the family and child's life, the family story is a comprehensive strengths-based history starting with caregivers' births.
  - Created around the reason for referral, behaviors placing youth at risk for out-of-home placement, patterns of behavior, and coping strategies used in the past.
  - Includes all family members and pertinent information.
  - Is intended to create a picture of the youth's early caretaking environment, including resources and functional strengths as well as risk factors and challenges.

- *Family vision*: Created by the family, the family vision is a positive statement the family creates that finishes the statement, "Things will be better when…"
  - Guides the wraparound process.
  - Guides the establishment of outcomes.
  - Tells the team who the family is and what they are striving for.
  - Every meeting opens with the family's vision of how they will know life is better.

- *Team mission*: Created by the team, the team mission is what the whole team will be working on together.
  - Developed at the first CFT meeting to provide direction to the team and build cohesiveness.
  - Is about the whole team and not what the team will be doing for the family.

- *Functional strengths*: Identification of functional strengths is a process that occurs from the first meeting with the family and throughout the wraparound process. Functional strengths have to do with the depth of a youth and family's capacity that enables them to endure and cope with difficult situations.
  - The ability to use external challenges as a stimulus for growth
  - Excelling despite the barriers that may be presented
  - Using social supports, family rituals, and traditions as sources of resilience

- *Needs*: The underlying reasons that are driving the behaviors that led to the youth's referral to the CMHW. The team prioritizes two to four needs statements to address on the POC.
  - Needs can be thought of as "the holes in our hearts that drive us to do things we shouldn't and keep us from doing things we should." (Patricia Miles)
  - Well-written needs statements will modify the context of the family's current situation.
  - Needs are not services or goals.

- *Outcomes*: Team members determine goals that identify how the team will know a need has been met. Outcomes must be:
  - Tied to the initial reason for referral
  - Measurable

- *Strategies*: Team members are responsible for brainstorming a list of possible strategies to meet each need and prioritizing a workable strategy list based on these options; the team will clearly define who is responsible for implementation.
  - Each strategy should be tied to the youth and/or family members' functional strengths.
  - For every paid strategy, there should be two unpaid strategies and supports.
  - Strategies need to identify who is responsible for their implementation.

- Strategies must not be provider-driven (what the provider wants to provide).
- Strategies are not meant as permanent interventions. The POC must be evaluated on a regular basis and revised as the participant's needs change and/or the strategy fails to have the anticipated outcome.

DMHA Authorization of CMHW Services

The DMHA prior authorizes CMHW services for each eligible participant by reviewing and approving the POC developed by the CFT. The following describes the process for gaining the DMHA's approval of the POC and authorization for the participant to utilize one or more CMHW services:

- On approval of a youth as an eligible CMHW services participant, the DMHA creates an initial POC authorizing Wraparound Facilitation. The Wraparound Facilitator is responsible for ensuring that an updated POC (Intervention Plan, Care Plan, and Crisis Plan) is further developed with the CFT, as described earlier in this section, and to request additional CMHW services.

- After the team has met to hear the family vision and identify the team mission, needs, outcomes, and strategies, the Wraparound Facilitator will submit the updated POC to the DMHA by entering the plan into Tobi, the DMHA database for the CMHW.

- The DMHA will review the submitted POC and within 5 business days will return one of the following determinations:

  – *POC approval*: POC is approved and authorization granted for the CMHW services indicated on the approved POC. A Notice of Action (NOA) is generated to document the DMHA's approval and the CMHW services authorized. On approval of the POC, the Wraparound Facilitator is responsible for completing the following:

  ➢ Notifying the participant, family, and team members regarding the DMHA-approved POC

  ➢ Printing a copy of the DMHA-approved POC to review with the participant and family. The NOA is attached to the POC and documents the CMHW services authorized by the DMHA.

  ➢ Obtaining the parent/guardian's signature on the DMHA-approved POC

  > *Note:*   *The NOA is a letter relating the DMHA's decision regarding the submitted POC and/or CMHW services authorized.*

  > *Note:*   *Because the POC may be modified during the approval process, a parent or guardian's signature on the original plan created with the CFT is not an acceptable substitute for the parent/guardian's signature on the approved POC.*

  ➢ Ensuring that a copy of the DMHA-approved POC with the parent/guardian's signature is maintained in the participant's case file and uploaded into the DMHA's database (Tobi).

  – *POC denial*: The POC is denied. The Wraparound Facilitator is responsible for the following:

  ➢ Notifying the participant, family, and team of the DMHA's denial of the submitted POC

  ➢ Providing the participant/family with information regarding the fair hearing and appeal rights available to them

  ➢ Submitting a revised POC or additional documentation, as requested by the DMHA, to support approval of CMHW services within 5 business days

  > *Note:*   *Following the State's decision to approve or deny the POC, an NOA is generated and sent to the Wraparound Facilitator and providers listed on the POC.*

  – *DMHA request for additional information*: Based on a review of any component of the POC, the DMHA may require additional information to make a determination regarding approval of the POC.

Library Reference Number: PRPR10019   *29*
Published: July 10, 2018
Policies and procedures as of July 1, 2018
Version: 3.0

> ➢ If additional information is requested, the Wraparound Facilitator has the opportunity to address the DMHA's concerns, and if needed, submit the required documentation within 5 business days.

> ➢ If the Wraparound Facilitator does not submit the required information within 5 business days, the DMHA will deny the POC.

Note: *The DMHA denies or rejects any POC that does not adequately follow the required need/outcome/strategy/POC development procedures and requirements described previously.*

Implementing and Monitoring the Plan of Care

The POC is a document in three parts:

- Intervention Plan

- Care Plan

- Crisis Plan

The approved Intervention Plan becomes the prior authorization for CMHW services. The Care Plan becomes the direction for service delivery. The Wraparound Facilitator and team members are responsible for monitoring the Intervention Plan, as well as the other two components of the POC, to be sure it continues to meet the needs of the participant and the family. The following applies to the implementation and monitoring of the approved POC:

- The Wraparound Facilitator is responsible for coordinating and monitoring service delivery after the initial POC has been approved by the DMHA.

- Providers may provide only CMHW services documented on the DMHA-approved POC. If the provider feels the services/strategies/units on the POC do not adequately support the defined *participant needs and desired outcomes*, the provider must notify the Wraparound Facilitator so team discussions may occur regarding POC appropriateness for the participant.

- The POC is effective for 1 year from the initial approval date and will be updated during the year by the team during team meetings to address the participant's and family's changing needs.

- The team must meet at least monthly to discuss the plan's implementation and progress.

- A Child and Adolescent Needs and Strengths (CANS) reassessment is completed 6 months after the initial CANS assessment to document the participant's progress and areas of changing need. This reassessment is facilitated by the Wraparound Facilitator with the participant and family.

- As the participant and family needs change, the POC will be reevaluated. Changes to the POC must be entered into Tobi and approved by the DMHA. The Wraparound Facilitator is responsible for submitting POC changes via Tobi.

- If additional information is requested, the Wraparound Facilitator has the opportunity to address the DMHA concerns, and if needed, submit the required documentation within 5 business days.

- Changes in service delivery must not occur unless the DMHA approves the updated POC and generates an NOA documenting the additional service authorizations.

Section 8: Crisis Plan Development

Youth meeting criteria for the Child Mental Health Wraparound (CMHW) are at risk and susceptible to crises due to their high-level needs. To ensure a participant's safety and successful enrollment in the program, a Crisis Plan is an important part of the Plan of Care (POC) development. This section offers the service provider information and resources to assist the provider with the development and implementation of the required Crisis Plan for a participant in CMHW services.

Initial Crisis Plan Development

- A Crisis Plan is required for each participant in the CMHW program. The Crisis Plan must be developed and entered into Tobi by the Wraparound Facilitator at the same time as the Care Plan. The participant and family receive a copy of this plan until a more comprehensive plan can be established at the first Child and Family Team (CFT) meeting.

- Discussion about a Crisis Plan begins with the Child and Adolescent Needs and Strengths (CANS) assessment and is directly tied to the reasons for referral to the CMHW.

- Appropriate clinical and support interventions are initiated at this time through the usual service delivery system to address emergent needs until the comprehensive Crisis Plan is complete.

Comprehensive Crisis Plan Guidelines

- The comprehensive Crisis Plan or emergency backup plan must be developed with the team and entered into Tobi within 60 days of the Division of Mental Health and Addiction's (DMHA's) approval of the CMHW participant.

- Early in the wraparound process, during the engagement and initial planning phases, the Wraparound Facilitator with the participant and family develop a formal Crisis Plan that addresses reasons for referral and risks for the participant and others.

- The following applies to the development of the comprehensive Crisis Plan:
  – Reason for referral to the CMHW program
  – Safety issues that are non-negotiable
  – Brief history of crises, as defined by the youth and family, in the home, school, and community
  – Triggers
  – Strategies that have worked in the past
  – Action steps that start with the least restrictive, utilizing functional strengths, and end with the most restrictive
  – Action steps include identifying the responsible party for each strategy, including a backup or contingency plan if the responsible party cannot be accessed during the crisis. The Wraparound Facilitator should work to ensure the Crisis Plan is inclusive of natural support on the team as well as community-based services and supports.
  – Strategies to build coping skills, defuse a situation, or provide support during crises
  – Emphasis on identifying and defusing situations, ensuring safety, and debriefing the situation to maximize the learning opportunity for the youth and family.
  – The plan will reflect the youth and family choices and preferences.

Library Reference Number: PRPR10019   *31*
Published: July 10, 2018
Policies and procedures as of July 1, 2018
Version: 3.0

- – Seclusion and restraint are not allowed interventions in the Crisis Plan.
  - ➢ If an unauthorized seclusion, restraint, or restrictive intervention is used, an incident report to the DMHA is required.
  - ➢ This situation automatically triggers a review of the Crisis Plan and POC and re-evaluation of the team's ability to safely serve the participant through intensive community-based services.

- The Wraparound Facilitator documents the Crisis Plan and distributes copies to all team members.

- The Crisis Plan is an integral part of the overall POC that addresses the reasons for referral to the CMHW program. Effectiveness must be routinely monitored and reviewed at every team meeting.
  - – The plan is evaluated to ensure that it is workable for the family, keeping youth and family strengths in mind when assisting with challenges and crises.
  - – Changes are made if needed or requested by the family and team members.
  - – The Wraparound Facilitator must enter changes to the plan in Tobi to ensure that all team members and providers have the most up-to-date documentation to support the family in the event of a crisis.

- After a crisis occurs, the team should reconvene within 72 hours to make any needed changes to the POC.
  - – The next team meeting must include a review of the successes or the challenges of the current plan and include any necessary changes.
  - – At that point, the plan can be modified to add skills and resources identified as necessary to assist the family in ensuring the youth's safety and well-being in the home and community. This process builds the basis for future stability for the family.

Features of Effective Crisis Plans

(Excerpt from *Crisis Plans: Setting the Expectation for Unconditional Care*, by Patricia Miles)

- Effective crisis plans anticipate crises based on past knowledge. The best predictor of future behavior is past behavior.

- Great crisis plans assume the "worst case" scenario and plan accordingly.

- As you build a crisis plan, always research past crises for antecedent, precipitant, and consequent behaviors.

- Effective plans incorporate child and family outcomes as benchmarks or measures of when the crisis is over.

- Good crisis plans acknowledge and build on the fact that crisis is a process with a beginning, middle, and end, rather than just a simple event.

- Crisis plans change over time based on what is known to be effective.

- Clearly negotiated crisis plans, with clear behavioral benchmarks, help teams function in difficult times.

- Behavioral benchmarks (number of runs, number of stitches in a cut, and so on) need to change over time to reflect progress and changing capacities and expectations of the youth and family.

Section 9: CMHW Service Utilization and Ongoing Eligibility

Until an updated Plan of Care (POC) – including Intervention Plan, Care Plan, and Crisis Plan – is developed by the Child and Family Team (CFT) and approved by the Division of Mental Health and Addiction (DMHA), a youth is not eligible to receive any Child Mental Health Wraparound (CMHW) services other than Wraparound Facilitation. The Wraparound Facilitator and team are responsible for developing an updated POC, and the Wraparound Facilitator is responsible for submitting it to the DMHA for review. All approved DMHA services will be documented on a Notice of Action (NOA). All service authorizations are based on the participant's documented Level of Need (LON) and the DMHA-approved POC.

Utilization of Services

Eligibility for CMHW services depends on the participant continuing to meet all CMHW eligibility criteria. The Wraparound Facilitator is responsible for ensuring that the participant is regularly evaluated for meeting CMHW eligibility. The following activities are required:

- Monthly CFT meetings to assess the participant's progress in meeting the identified outcomes of the POC

- If the participant's needs have changed, requiring a change in service delivery, an updated POC must be submitted to the DMHA through the Tobi system for review and approval before making a change in CMHW services.

Participant Termination, Interrupt, and Re-Start Status

At times, participants may experience an interruption in or termination of CMHW services, for reasons that include but are not limited to:

- The participant achieves treatment outcomes on the POC, resulting in a change in LON as reflected on annual Child and Adolescent Needs and Strengths (CANS) reassessment for eligibility purposes.

- The participant will be out of his or her home/place of residence for more than 72 hours (for example, admission to an acute facility, and so on).

- The participant has exhausted his or her eligibility in his or her 18th year, resulting in "aging out" of the CMHW program. For example, a youth enters the program at age 17 years and 6 months; provided all other eligibility requirements continue to be met, the youth would continue to receive services until the annual POC has been exhausted at approximately 18 years and 6 months of age.

- The participant loses Medicaid eligibility (see the *Medicaid Eligibility and Service Delivery* section in this module regarding Medicaid eligibility and its impact on CMHW services).

A change in the participant's status is to be recorded in the Tobi system. The Wraparound Facilitator is responsible for recording the Interrupt or Termination status, along with the effective date and reason.

> *Note:* When a participant's status changes, it is the Wraparound Facilitator's responsibility to ensure the Tobi system is updated and all members of the team are notified.

- *Interrupt status*: Occurs when a participant's eligibility status and ability to participate in CMHW services are temporarily affected by an increase in LON or other factors that interrupt service delivery

Library Reference Number: PRPR10019   *33*
Published: July 10, 2018
Policies and procedures as of July 1, 2018
Version: 3.0

(for example, the youth needs higher LON and is admitted to a more restrictive setting, such as an acute hospital setting; or the participant is away from home for reasons other than treatment).

– The participant's status in Tobi should reflect a move to interrupt status. This move assumes that the eligibility issue will be resolved within 30 days and that after eligibility is re-established, the participant will be able to resume an active role in CMHW services.

– Once eligibility issues are resolved, a status change of re-start is completed to move the participant back to *active status*.

- *Termination status*: This status is indicated if the eligibility issue is likely to be permanent or will not be resolved within 30 days (for example, the participant achieves treatment outcomes and LON no longer meets CMHW eligibility; the participant requires treatment in a psychiatric rehabilitation treatment facility [PRTF] or other long-term treatment or correctional facility; and so on). The participant's status in Tobi should reflect the participant's move to *termination status*.

– If an *interrupt* status reaches 30 days without moving to active, the participant then moves to *termination* status.

– On updating the status to reflect termination, the Wraparound Facilitator will complete and update to "zero-out" the service authorizations in the months after the termination's effective date. This action results in the NOA being generated for the participant/family with the appeal information.

- *Re-start status*: To return a participant to active status, a re-start status change must be completed before restarting CMHW services after a service interruption. If a participant's eligibility was terminated, the participant must reapply for CMHW services and obtain the DMHA's approval to restart CMHW services.

- When an *interruption* or *termination* status is recorded, one of the following reasons is used to document the cause of a participant's change of status:

– Aged out of program

– Transfer to PRTF

– Transfer to inpatient facility – Non-PRTF

– Increase in functioning – Transition CMHW services no longer needed

– Not eligible for Medicaid

– Incarcerated/juvenile justice involvement

– Voluntary disengagement from wraparound services

– Moved/moved out of state

– Parent chooses to opt out of transition CMHW services

– Other: explain in comments

Participant Transition from CMHW Services

To provide a smooth transition for youth who are moving out of CMHW services due to a change in eligibility (for example, improvement in level of functioning, moving out of state, aging out, and so on), the following applies:

- For all participants who become ineligible for CMHW services due to an improvement in their level of functioning or aging out of the program, a transition plan will be developed.

- The transition plan will be discussed and developed in the team meeting, as well as documented in the meeting minutes.

- The Wraparound Facilitator must update the Tobi system to document the termination of CMHW services.

- For a youth who is aging out, and therefore no longer meets eligibility, the Wraparound Facilitation provider is responsible for working with the youth and Child and Family Team (CFT) to develop a transition plan before the termination of services.

Medicaid Eligibility and Service Delivery

The participant must be eligible for Medicaid to receive CMHW services. If a participant loses Medicaid eligibility, even due to the family's failing to submit required information to Medicaid in the time requested, the participant may not be eligible to receive CMHW services.

Due to the impact on a participant's treatment that a potential gap in coverage may have, see the *Member Eligibility and Benefits* module for more information about member eligibility. The Wraparound Facilitator is responsible for monitoring the participant's Medicaid eligibility status:

- Wraparound Facilitators can become Authorized Representatives for the youths they serve through the Department of Family Resources (DFR), so the Wraparound Facilitators have the authority to coordinate with the DFR and assist participants/families with any issues that may arise with the participant's Indiana Health Coverage Programs (IHCP) eligibility.

- Providers are responsible for verifying IHCP eligibility.

- IHCP eligibility may change from month to month; therefore, it is recommended that providers verify/re-verify IHCP eligibility for the participant as follows:
  - Before delivering the first CMHW service
  - Before providing the first service each month and again at mid-month

- If a participant loses eligibility for the IHCP, the Wraparound Facilitator must record a status change in Tobi. See placing the participant on *interrupt* status in the *Participant Termination, Interrupt, and Re-Start Status* outlined earlier in this section. CMHW services provided during this time will not be reimbursable under the IHCP. The Wraparound Facilitator should coordinate with the Access Site to ensure that the youth and family are referred to other services and support needed.

- The participant may remain on *interrupt* status for up to 30 days. If IHCP eligibility cannot be reestablished in that time, the Wraparound Facilitator must terminate CMHW services (by recording a status change).

- If the participant regains IHCP eligibility and wants to return to CMHW services before the 30 days of the *interrupt* status has expired, the Wraparound Facilitator must complete a *restart* status change, and CMHW service delivery may resume. If the participant regains IHCP eligibility after being terminated from CMHW services and wants to reenroll in CMHW services, the participant must reapply for CMHW.

Section 10: Level of Need Redetermination

In accordance with the Centers for Medicare & Medicaid Services (CMS)-approved Child Mental Health Wraparound (CMHW) State Plan Amendment, the member must be reevaluated for continued eligibility for CMHW services within 12 months from the date of initial eligibility for the CMHW Services Program. The Wraparound Facilitator is responsible for monitoring the authorization limits and end dates of the participant's POC as well as the participant's CMHW Services Program end date. Prior to expiration of a service authorization or the participant's eligibility, the Wraparound Facilitator is responsible for ensuring that an updated POC or reevaluation is completed. Any services provided after CMHW eligibility has expired will be considered non-reimbursable.

The process for re-determining Level of Need (LON) for CMHW services includes the following:

- A face-to-face re-evaluation of the participant shall be conducted at least every 12 months by a qualified service provider (or sooner if there is a significant change in LON). The evaluation will include, but is not limited to, the following:
  – Administration of the Child and Adolescent Needs and Strengths (CANS) assessment tool to determine the participant's LON for services
  – Assessment of the participant's progress toward meeting treatment outcomes and underlying needs established on the POC
  – Evaluation of current participant strengths and underlying needs
  – Documentation that the participant still meets all eligibility criteria for CMHW services (see *Section 6* in this module for eligibility criteria)
  – An updated POC (Intervention Plan, Care Plan, and Crisis Plan)

- The Child and Family Team (CFT) will meet to contribute input regarding the participant and family's progress toward meeting treatment goals. If changes are required, the POC will be updated and submitted to the Division of Mental Health and Addiction (DMHA) within 10 days of parent or guardian signature.

- The re-evaluation application must be reviewed by the DMHA, which will determine whether the youth is eligible to continue in the CMHW Services Program. The Wraparound Facilitator is responsible for submitting the re-evaluation results and documentation to the DMHA for review in the Tobi system within 30 calendar days of the expiration date for the participant's eligibility period/POC. The reevaluation components include:
  – The completed re-evaluation application
  – CANS assessment results
  – Updated POC (Intervention Plan, Care Plan, and Crisis Plan)

- The DMHA reviews the submitted POC and, within 5 business days, returns one of the following determinations:
  – *POC approval*: The POC is approved and authorization granted for the CMHW services indicated on the approved POC. A Notice of Action (NOA) is generated to document the DMHA's approval and the CMHW services authorization. On approval of the Intervention Plan, the Wraparound Facilitator is responsible for completing the following:
    ➢ Notifying the participant, family, and members of the team regarding the DMHA-approved POC
    ➢ Printing a copy of the DMHA-approved POC to review with the participant and family. The NOA is attached to the POC and documents the CMHW services authorized by the DMHA.

- Obtaining the parent's/guardian's signature on the DMHA-approved POC

> *Note:* Because the POC may be modified during the approval process, a parent or guardian's signature on the original plan created with the CFT is not an acceptable substitute for the parent/guardian's signature on the approved *POC*.

- Ensuring that a copy of the DMHA-approved POC with the parent's or guardian's signature is maintained in the participant's case file and uploaded to the state database (Tobi).

> *Note:* *Failure to complete the reevaluation before the termination of the participant's eligibility period will result in non-reimbursement of services provided after the eligibility end date.*

  – *POC denial*: The POC is denied and no additional CMHW services are DMHA-approved for the participant. An NOA, including appeal rights, is generated and sent to the Wraparound Facilitator. If the POC is denied by the DMHA, the Wraparound Facilitator is responsible for completing the following:
    ➢ Notifying the participant, family, and team of the DMHA denial of the submitted POC
    ➢ Providing the participant and family with information regarding the fair hearing and appeal rights available to them
    ➢ Submitting a revised LON/POC or documentation required to support approval of the previously submitted POC within 5 business days
    ➢ If the DMHA determines that the youth no longer meets eligibility criteria for the CMHW program, the Wraparound Facilitator and the CFT prepare the family for transition to other services that will appropriately meet their needs.
  – *DMHA request for additional information*: Based on a review of the POC, the DMHA may require additional information to make a determination regarding approval of the POC.
    ➢ If additional information is requested, the Wraparound Facilitator has the opportunity to address DMHA concerns, and if needed, submit the required documentation within 5 business days.
    ➢ The Wraparound Facilitator will have 5 days to submit the requested information or documentation. If the Wraparound Facilitator does not submit the required information, the POC will be denied by the DMHA.

- The approved Intervention Plan becomes the DMHA prior authorization for CMHW services, and the NOA is issued for the Wraparound Facilitator to distribute to all team members. The DMHA database system communicates with the Indiana Medicaid database system. The Indiana Medicaid database system stores the prior authorization, which allows for billing and payment of approved units of service within the prior authorization.

Section 11: Critical Events and Incident Reporting

All service providers are required to adhere to Family and Social Services Administration (FSSA) expectations regarding protecting the health and welfare of each participant served in the Child and Mental Health Wraparound (CMHW) program.

Providers witnessing, learning about, or involved in an incident are required to report these events to the Division of Mental Health and Addiction (DMHA) using the DMHA Incident, Follow-up and Complaint Reporting website at dmhareport.fssa.in.gov.

In addition to reporting incidents to DMHA, reporting incidents to the Indiana Department of Child Services (DCS) may also be required. DCS receives reports of child abuse and neglect and is the single State agency responsible for administering the federal Child Abuse Prevention and Treatment Act. *Indiana Code IC 31-33-5-1* requires any individual who has reason to believe that a child is a victim of child abuse or neglect to make a report. Abuse, neglect, and exploitation, under *IC 31-33-5-1*, is defined as follows:

> *"[T]he child's physical or mental health condition is being seriously impaired or seriously endangered as a result of the inability, refusal, or neglect of the child's parent, guardian, or custodian to supply the child with necessary food, clothing, shelter, medical care, education, or supervision and/or the child's physical or mental health is seriously endangered due to injury by the act or omission of the child's parent, guardian, or custodian; the child's parent, guardian, or custodian allows the child to participate in an obscene performance; or the child's parent, guardian, or custodian allows the child to commit a sex offense"*

Reporting to DCS can be made by calling the DCS Child Abuse and Neglect Reporting Hotline at 1-800-800-5556.

Reportable Incidents

Two categories of incidents must be reported to DMHA: sentinel and critical.

Sentinel Incidents

Sentinel incidents must be reported to the DMHA within 24 hours of the provider's discovery of the incident.

Sentinel incidents are defined as serious and undesirable occurrence involving the loss of life, limb, or gross motor function for a participant.

Critical Incidents

Critical incidents must be reported to DMHA within 72 hours of the provider's discovery of the incident.

Critical incidents are described as any of the following:

- *Use of restraint* – A *restrain* is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a client to move his or her arms, legs, body, or head freely; or a drug or medication when it is used as a restriction to manage the client's behavior or restrict the client's freedom of movement and is not a standard treatment or dosage for the client's condition. An example is restraints used by police or medical personnel.

- *Elopement* – Anytime a youth leaves a designated area without consent of the caregiver. If the youth is allowed a "cooling off" time per the POC where they are allowed to go to a specific place to "cool off", then this should not be considered elopement.

- *Medication error* – Report all instances of intentional or accidental medication errors. Medication errors may be any of the following:
  - Youth given the wrong medication
  - Youth took someone else's medication
  - Youth took too many or too few medications

  In general, any time medication is not administered (by a caregiver or self-administered) to the youth as prescribed, the incident should be reported as a medication error.

  > *Note:*   *All medications, whether prescribed by a doctor or purchased over the counter are included under medication error.*

- *Serious injury* – Physical injury sustained by the youth that requires emergency or immediate medical intervention. Serious injuries sustained by the youth's caregiver are not recorded under serious injury; another format of reporting would be used in that case.

- *Suicide attempt* – Report instances of the youth committing an act with the intention of causing one's own death. If the youth commits an act and the intention is not to cause their own death, it would not be considered a suicide attempt. For example, the youth intentionally takes an overdose of medications because they are having trouble sleeping. This incident would be reported as a medication error (see previous bullet) and not a suicide attempt, because the youth's intention was not to cause death. Youth experiencing suicidal thoughts or ideation would not be counted under this heading.

- *Seclusion* – Seclusion is the involuntary confinement of a client alone in a room or area from which the client is physically prevented from leaving.

- *Violation of rights* – Refers to the violation of a child's rights based on their culture, family beliefs, and customs. Children have the right to live and engage in communities that respect their values and beliefs. Parents also have the right to raise their children in a manner that protects them from abuse, neglect, and exploitation. When considering whether or not the situation is a violation of rights, you should consider the child's age as well as the family dynamics.

  The following are examples of violation of children's rights:
  - Child is denied the right to communicate with one or both parents without cause.
  - Child resides in foster care and desires a vegetarian diet. Foster parents force the child to eat meat and/or do not provide the child with vegetarian dietary options.
  - Child resides in foster care and is forced to participate in or denied access to religious or cultural practices of his or her choice.
  - Child is denied access to a product or service based on his or her race, ethnicity, or sexual orientation.
  - Child is often degraded or "put down" by a caregiver or provider.
  - Child does not have access to a product or service in a language of his or her choice.

- *Police response* – When a participant has contact with a police officer, a report must be made to the DMHA. *Contact* means the child spoke to or was detained by a police officer. Contact usually occurs when police are called to the family's home, or if the youth is arrested. Contact with probation or school officers is not counted under this heading.

- *Emergency room* – Any time a youth visits the emergency room or an immediate care center for any illness or injury, a report must be made. Emergency room visits may sometime overlap with the serious injury category described in a previous bullet. However, the emergency room category is intended to capture visits to the emergency room for illnesses and injuries that are nonphysical in nature, such as if the child is diagnosed with the flu.

- *Emergency psychological evaluation* – Incident reports must be completed if the youth is sent for an emergency psychological evaluation. The evaluation may take place at a hospital or another facility.

Incidents Requiring DCS Report

Not all incidents require making a report to the DCS. However, depending on the circumstances, it is possible for any sentinel or critical incident (described in the *Reportable Incidents* section) to meet the threshold of abuse, neglect, or exploitation. Professional judgment and internal agency policies should be used when determining if an incident should be reported to the DCS. All reports to the DCS should be made immediately.

For more information on how to recognize signs of abuse, neglect, and exploitation, consult the *Child Welfare Information Guide* at childwelfare.gov.

Nonreportable Incidents

Sentinel, critical, and other incidents that are reported to the DCS should be reported to the DMHA. Incidents that are not sentinel incidents; critical incidents; or incidents of abuse, neglect, or exploitation are not reportable. For example, an injury sustained by a parent that does not impact the youth's safety is not a reportable incident. Questions regarding whether or not to report an incident should be directed to your agency management or by contacting the DMHA at DMHAyouthservices@fssa.in.gov.

Be cognizant that timelines for reporting incidents to DMHA still apply in all circumstances.

Filing an Incident Report with DMHA

All CMHW providers – Wraparound Facilitator, Respite Care, Habilitation, and Training and Support for the Unpaid Caregiver providers – are responsible for ensuring the health and welfare of participants in the CMHW program. Any provider that is notified of a reportable incident must complete and submit an incident report.

Incident reports are child specific, meaning that an incident report must be completed for each child who is involved in the incident. For example, if a reportable situation occurs in the home and two children enrolled in services were impacted, an incident report must be filled for each child. The description of the report should detail how that specific child was impacted by the incident.

Only one report, per child, per incident is required. This means that if the Habilitation provider is notified of an incident, that individual is required to complete and submit an incident report. No other providers are required to complete and submit a report on this incident. For example, if providers learn of a reportable incident during a team meeting, the Wraparound Facilitator is required to submit the incident report. By default, Wraparound Facilitators are required to submit the incident report if knowledge of the incident occurs in a situation where the Wraparound Facilitator and at least one other provider is present. If two or more providers, minus the Wraparound Facilitator (for example, Habilitation and Training and Support for the Unpaid Caregiver), learn of an incident, they will need to decide who will submit the report.

Habilitation, Training and Support for the Unpaid Caregiver, and Respite providers are required to inform the Wraparound Facilitator if they submit an incident report. Wraparound Facilitators and Wraparound Facilitator Supervisors will then be able to access the submitted report through Tobi.

As stated previously, incident reports should be completed and submitted within the appropriate time frames based on the type of incident. Reports that are not filed within the appropriate time frames are subject to corrective action.

All incident reports must be completed online on the [DMHA Incident, Follow-up and Complaint Reporting website](#) at dmhareport.fssa.in.gov.

Follow-up Reports

In some instances, the DMHA may determine that a follow-up incident report is required. The follow-up incident report is always the responsibility of the Wraparound Facilitator. The Wraparound Facilitator will be notified of the follow-up report expectation via email. The time frame for the follow-up report will be indicated in the email notification. If follow-up reports are not received within the allotted time frames, corrective action may be taken.

After they are submitted, follow-up reports can be accessed through Tobi by the Wraparound Facilitator and the Wraparound Facilitator Supervisor.

Documentation

As previously stated, copies of incident and follow-up reports can be accessed through Tobi. However, copies of these reports must also be maintained in the client's file managed by the provider. This requirement is only for Wraparound Facilitators. Habilitation, Training and Support for the Unpaid Caregiver, and Respite Care providers are not required to maintain copies of incident reports in their client files.

Incident Report Training

Incident Report Training is a required DMHA training that must be completed by all CMHW providers on a yearly basis. The DMHA tracks the completion of this training and providers receive training credit for attendance. Failure to complete the training requirement could result in corrective action.

42

Library Reference Number: PRPR10019
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Policies and procedures as of July 1, 2018
Version: 3.0

Section 12: Participant Complaints and Grievances

When a program participant, family member, provider or interested party wishes to share a concern, complaint, or grievance related to the Child Mental Health Wraparound (CMHW) program with the Division of Mental Health and Addiction (DMHA), he or she may do so in any of several ways:

- Express concerns to the Wraparound Facilitator, who then makes a report to the DMHA.

- Call the DMHA youth provider specialist at (317) 232-7800 or send email to DMHAYouthServices@fssa.in.gov.

- Submit via the web-based DMHA Incident, Follow-Up and Complaint Reporting website at dmhareport.fssa.in.gov.

- Deliver to the Office of Consumer and Family Affairs on the DMHA website at in.gov/fssa/dmha.

- Deliver in-person to a DMHA staff member.

- Deliver via written complaint or email submitted to the DMHA.

The following information is requested:

- Description of the concern, complaint, or grievance

- Name of program participant, if applicable

- Name of the provider, if applicable

- Contact information (email or telephone)

  Contact information is optional but helpful if the DMHA staff member investigating the complaint has additional or clarifying questions. Information regarding the identity of the individual may be kept confidential.

The receipt of a complaint or grievance shall be recorded in the office's data system with a copy attached to the provider's file. An investigation shall begin within 72 hours of receipt of the complaint or grievance.

When an investigation is complete, if the complainant is the member or their legal guardian, and the complaint relates to the provision of their services, the following will occur:

- The individual filing the complaint or grievance will be informed of the outcome of the office's investigation through a letter from an office staff member.

- The individual who filed a grievance or complaint must be informed that filing a grievance or complaint is neither a prerequisite nor a substitute for a fair hearing.

- If indicated by the results of an investigation, a letter of findings will be sent to the CMHW service provider who is the subject of the complaint or grievance. The CMHW service provider will correct any identified deficiency within the timeline established by the office.

If the CMHW service provider fails to correct the deficiency within the established timeline, the office may pursue sanctions up to, and including, revoking authorization for the provider to deliver CMHW services. Additional resources available to participants and family members wishing to file a formal complaint or concern include the following:

- The participant's Wraparound Facilitator

- The DMHA website at in.gov/fssa/dmha

The state of Indiana has made assurances to the Centers for Medicare & Medicaid Services (CMS) that all providers are qualified (initially at provider authorization and continually through service delivery) to deliver home and community-based services (HCBS) to Child Mental Health Wraparound (CMHW) participants. Only a Division of Mental Health and Addiction (DMHA)-authorized agency or individual enrolled as an Indiana Health Coverage Programs (IHCP) provider of CMHW services may be reimbursed for delivering a CMHW service to an eligible participant. A CMHW service provider must be authorized by the DMHA according to the specific qualifications for and standards of the service that the individual provider or agency is applying to provide. To ensure that CMHW service providers meet licensure and authorization requirements before furnishing CMHW services, the DMHA requires all providers to undergo an application process to verify the qualifications of the agency or individual requesting to provide CMHW services. All agencies and individuals wishing to enroll as CMHW service providers must complete the provider application process described in this section.

> *Note: References to "provider" and "applicant" in this module include agency and individual providers and applicants, unless specifically differentiated.*

Provider Types

CMHW services are provided to CMHW participants by DMHA-authorized service providers. Each of the provider types must meet specific standards to qualify as CMHW providers. The service provider types who may apply include accredited agencies, nonaccredited agencies, and individuals.

Accredited Agency

To be considered an accredited provider agency, the agency must meet the following standards:

- The agency must submit a copy of at least one of the following:
  – DMHA approval as a community mental health center
  – Accreditation by one of the following nationally recognized DMHA-approved accrediting bodies:
    ➢ Accreditation Association for Ambulatory Health Care, Inc. (AAAHC)
    ➢ American Council for Accredited Certification (ACAC)
    ➢ Council on Accreditation (COA)
    ➢ Utilization Review Accreditation Commission (URAC)
    ➢ Commission on Accreditation of Rehabilitation Facilities (CARF)
    ➢ Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)
    ➢ National Committee for Quality Assurance (NCQA)

- If applying to provide Wraparound Facilitation, the applicant must also provide one of the following:
  – A letter of support signed by the governance council of the local System of Care (SOC) region (which includes a governing coalition and service delivery system that endorses the values and principles of wraparound); OR
  – If the area of the state does not have an organized SOC, the applicant must demonstrate that it is a DMHA-approved and -designated Access Site for services. Contact the DMHA at DMHAyouthservices@fssa.in.gov for additional information regarding qualifications as an Access Site.

- The agency must employ and apply for approval of individual staff members meeting the criteria and standards required to qualify as a CMHW service provider. Authorization of an agency to be a CMHW service provider flows up from its authorized individual staff members. There is no blanket authorization of an agency to provide services. See the *Rendering Provider Application* form available on the [CMHW Provider Information](#) page at in.gov/dmha for additional information regarding provider criteria. Facility-based Respite Care providers are an exception. For facility-based respite care, licensed agencies are authorized, not individual rendering providers.

> *Note: An accredited agency is the only provider type that may qualify as a provider of Wraparound Facilitation services.*

A Nonaccredited Agency

A nonaccredited provider agency interested in becoming a CMHW service provider must submit articles of incorporation to the DMHA for consideration. Additionally, the agency must employ and apply for authorization of individual staff members meeting the criteria and standards required to qualify as a CMHW service provider. Authorization of an agency to be a CMHW service provider flows up from its authorized individual staff members. There is no blanket authorization of an agency to provide services. See the *Rendering Provider Application* form available on the [CMHW Provider Information](#) page at in.gov/dmha for additional information regarding provider criteria. Facility-based Respite service providers are an exception. For facility-based respite, licensed agencies are authorized, not individual rendering providers.

An Individual Provider

An individual service provider is an individual who practices privately and not under an agency. Applicants must submit their Social Security or tax identification number. Additionally, applicants must meet the criteria and standards required to qualify as a CMHW service provider. See [CMHW Service Utilization and Ongoing Eligibility](#) in this module or the *Rendering Provider Application* form available on the [CMHW Provider Information](#) page at in.gov/dmha for additional information regarding provider criteria. Facility-based Respite Care providers are an exception. For facility-based respite care, licensed agencies are authorized, not individual rendering providers.

General Provider Requirements

All rendering provider applicants are required to complete the following screenings and certifications as part of the provider application process:

- Current cardiopulmonary resuscitation (CPR) certification

- Fingerprint-based national and State criminal history background screen for every state in which the applicant has resided for the past 5 years (completed within the last year)

- Local law enforcement screen for every county in which the applicant has resided for the past 5 years (completed within the last year)

- Child abuse registry screen (completed within the last year).for each state in which the applicant has lived for the past 5 years. For Indiana, this information must be obtained from the Central Office Background Check Unit (COBCU) within the Indiana Department of Child Services (DCS).

- Five-panel drug screen (completed within the last year); or agency meets the same requirements established for federal grant recipients specified under *41 U.S.C. 10 Section 702(a)(1)*. See the following additional information regarding drug screen requirements

Accredited agencies are required to maintain proof of screens and certifications on location in each applying staff member's record. Nonaccredited agencies and individual providers must submit proof of the screens with the provider application in addition to maintaining the staff member's records.

Drug Screen Requirements

Individuals and agencies that submit applications to become DMHA-authorized providers must complete a five-panel drug test (tetrahydrocannabinol [THC], cocaine, amphetamines/methamphetamines, opiates, and phencyclidine [PCP]). The process follows:

- The DMHA accepts urine screens only from agencies or places of business that conduct urine screens. The results must be submitted on the agency or place of business letterhead.

- The Department of Health and Human Services cut-off levels determine whether the test is positive or negative.

- A five-panel drug test will not be required if the agency meets the same requirements as federal grant recipients specified under *41 U.S.C 10 Section 702(a)(1)*.

- The DMHA will deny all applicants that test positive for any of the previously mentioned drugs.

CMHW Provider Application

DMHA approval of a CMHW service provider is service-specific. Individual/agency staff member applicants must meet the qualifications and standards for the specific services they wish to provide, as defined in the federally approved 1915(i) CMHW HCBS State Plan Amendment and in *405 IAC 5-21.7*.

> *Note: Agencies must submit application packet materials for each staff member applying under the accredited or nonaccredited agency application.*

- To apply for approval, the applicant must complete the DMHA provider application process, including training prior to application for some services as described under the training requirements for each service.

Qualifying SED Experience Requirements

The requirement for experience working with youth with serious emotional disturbance (SED) is intended to ensure that providers have the knowledge and understanding related to the rewards and challenges of working with this population. Building functional skills with a child facing impairments associated with an SED diagnosis requires creativity, patience, and sound communication. For this reason the DMHA requires that providers possess demonstrable and direct experience with this demographic.

The length of SED experience required depends on the service the provider will offer. For the services of Habilitation, Respite, and Training and Support for the Unpaid Caregiver, applicants must have experience with youth between the ages of 6 and 17 who present with SED. The SED experience requirement for services is as follows:

- Habilitation – minimum of 2 years of qualifying experience as defined by the DMHA

- Respite Care – minimum of 1 year of qualifying experience as defined by the DMHA

- Training and Support for the Unpaid Caregiver – one of the following:
    – Minimum of 2 years of qualifying experience, as defined by the DMHA
    – Certification as a Parent Support Provider through National Alliance on Mental Illness Indiana

Qualifying experience includes experience working directly with youth with SED between the ages of 6–17 in a way that builds functional skills, such as group counseling, one-on-one counseling, provision of skills training, and/or provision of therapeutic recreational activities. Also included would be experience providing therapeutic foster care or working in a capacity that may not involve mental health care, but where the work is targeted at a defined SED population. Experience in case management, therapy, and/or skills training in conjunction with a mental health center may also be considered as qualifying experience.

The most recent qualifying experience should be no more than 3 years prior to the date of application. Experience more than 8 years in the past will not be considered as qualifying.

The SED experience requirement excludes incidental experience. This means that the work of the provider may have been with a youth with SED, but the defined work role was not intended to address the SED condition directly, so the experience does not qualify toward the requirement. Examples of incidental experience include:

- An owner of a day care for children who throughout his or her years of experience has cared for children classified as seriously emotionally disturbed

- A bus driver with children on his or her bus route who have been classified as seriously emotionally disturbed

- The facilitator of a youth group or bible school whose groups included some children classified as seriously emotionally disturbed

The DMHA reserves the right to make the final determination of whether an applicant's SED experience meets CMHW services qualification criteria.

Application Process

Application to become a CMHW service provider is a multi-step process The DMHA recommends that interested applicants take time to review Sections 13 and 14 in this module, as well as the provider application forms and the *DMHA Youth Home and Community-Based Services Provider Agreement* before undertaking the application process.

Resume and Letter Submission

Applicants of any service must submit for review and approval a résumé with contact information (email required), the services of interest, and a description of their experience. The description of experience (maximum of three pages) must include references to allow for verification of statements in the resume and letter. Résumés and SED experience documentation (if applicable) should be emailed to DMHAYouthServices@fssa.IN.gov or mailed to:

> **Division of Mental Health and Addiction**
> **Attn: DMHA Indiana System of Care Team**
> **402 W. Washington St., W353**
> **Indianapolis, IN 46204-2739**

The DMHA will review the applicant's résumé and letter to determine if the applicant's experience meets DMHA-defined criteria for a CMHW service provider. The number of years and type of experience required is based on the service for which the applicant is applying. See the provider qualifications and requirements in the services sections of this module. The DMHA reserves the right to make the final determination regarding whether the applicant meets experience criteria for CMHW service providers. Applicants receive notification of the DMHA decision via email.

- Applicants meeting the provider criteria and experience requirements will be invited to attend the required CMHW provider training correlating to the service for which the applicant has met criteria to

48   *Library Reference Number: PRPR10019*
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Policies and procedures as of July 1, 2018
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apply (for example, Wraparound Facilitator, Habilitation, Respite Care, Training and Support for the Unpaid Caregiver).

- Applicants not meeting provider criteria and experience requirements will be denied approval as CMHW service providers.

Orientation Training

Orientation training is based on the type of service for which approval is being sought:

- Applicants seeking to become Wraparound Facilitators will receive orientation training via an on-demand webinar specifically and exclusively for Wraparound Facilitators and Wraparound Facilitator Supervisors, as well as training in High Fidelity Wraparound (HFW) beginning with the *Introduction to Wraparound* course.

- For applicants pursuing approval as providers of Habilitation and/or Training and Support for the Unpaid Caregiver, training will include 1 day of in-person training conducted free-of-charge by DMHA staff.
  – The successful completion of competency measures is required to receive training credit and to apply for approval to the CMHW program.
  – Training attendees who do not successfully complete training may attend a future training event.

- For applicants pursuing approval as a provider of Respite Care services, training will include orientation training via an on-demand webinar specifically and exclusively for Respite Care providers.

Provider Application Packet Submission

> *Note:* *Conditions that will delay processing for DMHA approval and Indiana Medicaid enrollment include:*
> - *Any part of the application or attachments is incomplete or illegible*
> - *The packet is missing a required attachment*
> - *Forms requiring signatures are not signed*

Applicants meeting all provider criteria and successfully completing the required CMHW services training must submit a Provider Application Packet to the DMHA for review and final approval. The provider application forms are available on the *DMHA Indiana System of Care* web page at in.gov/fssa/dmha. The forms include:

- *Application Cover Sheet*: All applicants must complete this form to indicate the purpose of the application.

- *Provider Demographic Form*: Provider applicants must complete this form if they are requesting initial authorization or reauthorization as CMHW service providers, or when updating demographic information.

- *Rendering Provider Application Form*: This form is used to request DMHA authorization as a rendering provider for CMHW services, including Wraparound Facilitation, Habilitation, Respite Care, and Training and Support for the Unpaid Caregiver.

- *Facility Based Respite Application Form*: This form is only used to request DMHA authorization as a facility-based Respite Care provider.

- *Provider Agreement*: This agreement is only required to accompany the application for approval or renewal of approval.

- All other required collateral documentation: For each applicant, collateral documentation verifying the qualifications of the applicant are required. Collateral documentation requirements are listed on the following forms:
  – *Rendering Provider Application Form*
  – *Application Cover Sheet*
  – *Facility Based Respite Application Form*
  – *Provider Demographic Form*

> *Note:* If a form or document requires a signature, the applicant must sign the original document and retain in his or her files. The DMHA no longer requires "wet" signatures, and will accept electronic copies of signed documents for the application.

DMHA Review of the Provider Application Packet

After receiving the application packet, the DMHA reviews the packet for completeness. The DMHA will only process complete application packets.

Incomplete Applications

If an application is not complete, it will not be processed. The applicant will receive an email from the DMHA Youth Provider Team notifying the applicant of the missing required elements with an attached checklist. Applications will then be set aside for no longer than 2 weeks to give the applicant time to select from the following options:

1. The applicant may respond to the DMHA Youth team via email, saying that the application packet may be securely purged.
   – The DMHW will shred the incomplete application.
   – The applicant will then complete a new application packet for subsequent submission to DMHA Youth Services.

2. The applicant may respond to the DMHA via email and request to pick up the incomplete application from the DMHA front desk. Applications will be available for no longer than 2 weeks from the date of the original email from DMHA notifying the applicant of the missing elements. If the incomplete application packet is not retrieved from the DMHA receptionist by the deadline, it will be securely purged.

3. The applicant may include in the original application a self-addressed, stamped envelope (SASE) for return of the application with a checklist of missing elements. The inclusion of sufficient postage to cover the expense of shipping is the responsibility of the applicant, and must be via United States Postal Service delivery. Applicants may also notify the DMHA via email that they are sending to the Youth Services team a self-addressed stamped envelope, so the incomplete application packet may be shipped to the applicant. If choosing this option, the SASE must be received before the expiration of the initial 2-week period for response, after which the application packet will be securely purged.

Calls and emails from provider applicants inquiring about the status of their applications at the DMHA may not receive a response unless there is an issue that requires a response from the DMHA. *Please refrain from contacting the DMHA regarding your application's status unless it has been longer than 30 business days since it was mailed.*

DMHA Final Decision and Approval Letter

After review of a complete application packet, the DMHA will render a decision regarding an applicant's eligibility to be a DMHA-authorized CMHW service provider. The decision will be communicated by

email in a dated letter on Family and Social Services Administration (FSSA) letterhead and will contain an official signature.

Approval letters direct the eligible provider applicant to contact the IHCP fiscal agent (DXC Technology) Provider Enrollment Unit for the IHCP provider application (see the *Provider Enrollment* provider module at indianamedicaid.com) to complete the IHCP provider enrollment process.

> *Note:*   *Regardless of an individual's or agency's status as an existing IHCP provider, the entity must also be enrolled as a CMHW service provider before rendering or billing a CMHW service. See the Medicaid IHCP Provider Enrollment section for more information.*

Applicant Disqualification Criteria

> *Note:*   *The following is not an exhaustive list but represents circumstances which may result in immediate disqualification of the applicant as a DMHA-approved CMHW provider.*
>
> *Any conviction in the past 5 years is subject to review by the DMHA. Based on the circumstances of the conviction, the DMHA reserves the right to deny the application.*

The DMHA disqualifies applicants, including individual staff applying as part of an agency, based on the following criteria:

- Any conviction for a misdemeanor related to the health and safety of a child

- Any felony conviction

- Any pending criminal charges

- The applicant has been convicted of four or more misdemeanors (that are not related to the health and safety of a child).

- The applicant is currently on probation or parole.

- The applicant has been identified as a perpetrator of child abuse or neglect.

- The applicant has a record of substantiated child abuse or neglect.

- The applicant had approval revoked as an individual or staff of an agency by any division within the FSSA or DCS.

- The applicant tested positive for any of the drugs tested for in the five-panel drug test described in the *Drug Screen Requirements* section.

> *Note*   *If, during the approval period, a provider is convicted of a disqualifying crime or otherwise faces any of the previous outlined circumstances, he or she must notify the DMHA immediately.*

IHCP (Medicaid) Provider Enrollment

The DMHA approval letter directs the eligible provider applicant to complete an IHCP provider application. See the *Provider Enrollment* provider module at indianamedicaid.com for information about the IHCP provider enrollment process. The applicant must submit the DMHA CMHW service provider approval letter with the IHCP provider enrollment application for processing.

Providers will not appear on the pick lists nor be eligible to submit a claim for CMHW services until they successfully complete the IHCP provider enrollment process and have acquired IHCP authorization as a CMHW service provider.

Regardless of the possible status of an applicant's existing enrollment as an IHCP provider of one or more of the Medicaid HCBS programs, each provider must be specifically approved by the DMHA and enrolled as a provider of the CMHW services to be reimbursed for services under the CMHW program.

> *Note: To provide and bill for CMHW services, the provider must:*
> *• Be approved by the DMHA to deliver one or more of the CMHW services*
> *• Be approved by the IHCP as a CMHW service provider*

It is the applicant's responsibility to follow the IHCP provider enrollment process as mandated by the IHCP:

- CMHW providers must be enrolled as provider type 11 − *Mental Health Provider* and provider specialty 611 − *1915(i) CMHW service provider*. See the *IHCP Provider Enrollment Type and Specialty Matrix* at indianamedicaid.com for provider enrollment documentation requirements.

- Providers that are already enrolled as provider type 11 − *Mental Health Provider* must add provider specialty 611 − *1915(i) CMHW service provider* to their provider profiles. To add provider specialty 611, complete the *IHCP Provider Specialty Maintenance Form* at indianamedicaid.com.

- Providers must obtain rendering National Provider Identifiers (NPIs) for each authorized staff member to be eligible for reimbursement of services.

For detailed information, see the *Provider Enrollment* module.

Provider Activation after Successful IHCP (Medicaid) Enrollment as a CMHW Service Provider

When the applicant has successfully enrolled with the IHCP as a CMHW service provider, IHCP Provider Enrollment notifies the applicant. The applicant, now an approved provider, should notify the DMHA via scanned copy of the IHCP approval letter (including all pages) so that the DMHA can activate the provider in the CMHW service provider database (Tobi). Activation in the database means that the provider begins to appear on pick lists and is eligible to be placed on a Plan of Care (POC) and to bill for services.

> *Note: Providers must retain copies or originals of all documentation required for CMHW service providers. It is the responsibility of the provider to maintain this documentation and keep it updated at all times. Failure to do so will result in corrective action up to and including revocation of provider approval.*

It is important for providers at all levels to retain copies or originals of all required documentation and to keep their documentation updated at all times. Failure to do so will result in corrective action up to and including revocation of provider approval. For example, car insurance is required for some providers. Providers must not only have documentation of car insurance current at the time of application, but must keep the insurance current and retain documentation of continual coverage. If proof of continual coverage cannot be supported by documentation as part of an audit, the provider may be sanctioned (up to and including revocation of approval as a CMHW service provider). Once approved, the date of approval from the IHCP will correspond to the DMHA provider approval date.

CMHW Provider Reauthorization with DMHA

All DMHA-authorized CMHW Providers (agencies and individuals) are expected to submit an application to the DMHA for reauthorization as a CMHW provider, according to the established provider type schedule:

- *Accredited agency*: At least every 3 years

- *Nonaccredited agency*: At least every 2 years

- *Individual provider*: At least every 2 years

Reauthorization Process and Provider Responsibilities

It is the responsibility of the service provider to track the due date of their reauthorization. The following applies to all providers regarding reauthorization:

- The reauthorization process is the same as the initial provider approval process and uses the same forms with the following exceptions:
    - The applicant indicates on the *Application Cover Sheet* that the application is for Reauthorization. Providers are expected to complete and submit all required forms, updated *DMHA Youth Home and Community-Based Services Provider Agreement,* and all required collateral documents to ensure that the DMHA's records reflect the most up-to-date information.

    > *Note:*   *CMHW provider and reauthorization application forms are available by visiting the [Provider Information](#) page.*

- The provider must submit documentation showing completion of the required 10 hours of ongoing professional development training per year. See the *[Continuing Education and Reauthorization Requirements](#)* section for additional information.

- Providers must submit their application for reauthorization to the DMHA at least **60 days** before the end of their current authorization period to allow time for application processing.

    > *Note:*   *It is the responsibility of the CMHW provider to track the due date of their reauthorization. The DMHA issues Formal Notice letters to notify delinquent providers of suspension and need to comply with the reauthorization requirement.*

- After the reauthorization application is approved, the provider receives a dated letter on FSSA letterhead, which contains an official DMHA signature. Once issued, the reauthorization is complete. The reauthorization letter does not need to be submitted to the IHCP.

    > *Note:*   *The IHCP has its own revalidation process and timetable. The IHCP notifies the provider when it is time for IHCP revalidation and outlines the IHCP revalidation process.*

- Failure to comply with the provider reauthorization requirement in a timely manner will result in the provider being issued a Formal Notice letter informing them that the provider has been suspended pending compliance with the provider reauthorization requirement.

- After the provider successfully completes the reauthorization application, and if the DMHA approves the reauthorization, the provider's status is updated to active.

- Continued failure to comply with provider reauthorization requirements will result in the DMHA's de-authorization of the provider as a CMHW service provider.

Library Reference Number: PRPR10019   *53*
Published: July 10, 2018
Policies and procedures as of July 1, 2018
Version: 3.0

- In compliance with *405 IAC 1-1-6*, the FSSA may impose one or more of the following sanctions if a provider has violated any rule established under *IC 12-15*:
  - Deny payment
  - Revoke authorization as a CMHW service provider
  - Assess a fine
  - Assess an interest charge
  - Require corrective action against the provider
  - Require prepayment review process

If a provider does not wish to reauthorize, the provider may request to voluntarily close by submitting the request in writing to the DMHA at DMHAYouthServices@fssa.in.gov, or by mail to:

Youth Provider Coordinator
Division of Mental Health and Addiction
Family and Social Services Administration
402 W. Washington St., W353
Indianapolis, IN 46204

Providers who voluntarily close rather than reauthorize will not be eligible to apply for any DMHA Youth Services program for a period of no less than 3 years from the date of closure.

Providers wishing to voluntarily close must notify the IHCP as well as the DMHA.

Provider Suspended Status

Suspended status is defined by the DMHA as the following:

- The provider no longer appears on the provider pick list as a qualified 1915(i) CMHW service provider in any county.

- The provider may continue work with participants already receiving services from the suspended provider prior to suspension; however, the provider is prohibited from accepting any new participants.

- Where there has been an allegation of abuse, neglect, and/or exploitation, the staff member accused must be placed on suspended status pending the outcome of an investigation. The staff member may not continue to provide services to any participants until the investigation has been completed, a determination made, and the provider notified.

Deauthorization of a Provider

Providers must adhere to all policy, procedures, standards, and qualifications contained in the *DMHA CMHW Services* module and other CMHW-related bulletins, or documentation published by the DMHA and Office of Medicaid Policy and Planning (OMPP). For more information, see the DMHA System of Care web pages at in.gov/fssa/dmha.

Provider authorization may be revoked under the following conditions (not an inclusive list):

- Failure to adhere to and follow all CMHW policies and expectations for behavior, documentation, billing, and service delivery, as defined in this document and all other relevant IHCP provider reference modules, the DMHA website at in.gov/fssa/dmha, and the IHCP website at indianamedicaid.com

- Failure to respond to or resolve a corrective action imposed on a provider by the DMHA or the OMPP for noncompliance with CMHW policies and procedures

- Substantiated allegation of abuse or neglect, as determined by the DCS, Adult Protective Services, or findings by DMHA investigation

- Failure to maintain clinical qualifications, DMHA-required training and certifications, and standards required for delivering CMHW services that the provider or agency is DMHA-authorized to provide

- Failure to apply for CMHW provider reauthorization, as defined in the *this* module

- Any conviction for a misdemeanor related to the health and safety of a child

- Any felony conviction

- Any pending criminal charges

- The applicant has been convicted of four or more misdemeanors (that are not related to the health and safety of a child).

- The applicant is currently on probation or parole.

- The applicant has been identified as a perpetrator of child abuse or neglect.

- Failure to report to the DMHA in a timely manner a provider's conviction of any crime or finding that would affect the provider's eligibility for CMHW authorization

- The provider tests positive for any of the drugs tested for in the five-panel drug test described in the *Drug Screen Requirements* section.

- The provider is found to have falsified or omitted information as part of the application, reauthorization, or monitoring process that would impact the provider's qualifications or eligibility for authorization.

- The provider has an open corrective action or has been terminated by any division within the FSSA.

- Any other condition that is in direct violation of the CMHW program requirements

Continuing Education and Reauthorization Requirements

All CMHW service providers are required to engage in ongoing professional development. Reauthorization requires the successful completion of no less than 10 hours of professional development training per approval year. The DMHA expects providers to obtain the 10 required hours of training per year within the parameters of the associated approval year. For example, a provider approved on September 1 is expected to obtain 10 hours of training and professional development before September 1 of the following year.

Approved training is defined as any training sponsored by one of the following entities:

- Division of Mental Health and Addiction (DMHA)

- Department of Education (DOE)

- Office of Medicaid Policy and Planning (OMPP)

- National Alliance on Mental Illness (NAMI)

- Mental Health America (MHA)

- Department of Child Services (DCS)

- A private, secure facility licensed by the DCS

- Affiliated Service Providers of Indiana (ASPIN)

- Essential Learning

- Any other entity using State or federal funds to conduct training or a conference whose subject matter is related to mental health and addiction

Any training for which the trainee is eligible to receive continuing education units (CEUs), such as training for psychologists, social workers, licensed marriage and family therapists (LMFTs), counselors, licensed professional clinical counselors (LPCCs), marriage and family therapy (MFT) interns, or licensed clinical social workers (LCSWs), would be eligible for credit. The DMHA reserves the right to make the final determination of the training's eligibility. There is no requirement for providers to have trainings or conferences approved before attending; however, providers may submit requests for DMHA to approve a conference or training for this purpose before providers attend.

Staff hired subsequent to the start of the authorization period must have documentation of 10 hours professional development training per complete hire year. DMHA no longer requires the submission of prorated professional development hours. Providers have the entire employment year to complete required professional development training for submission at the next reauthorization.

> *Note:*   *Agency staff hired subsequent to the start of the authorization period must have documentation of 10 hours professional development training **per complete hire year**. The DMHA no longer requires the submission of **prorated** professional development hours. Agency staff have the entire employment year to complete required professional development training for submission at the next reauthorization.*

Possible Topics and Examples of Approved Trainings and Conferences

The following list shows examples of DMHA-approved trainings and conferences:

- Indiana System of Care Annual Conference

- Cultural competency

- Leadership

- Time management

- Topics related to Wraparound Service delivery

- Facilitation of teams

- Family-driven care

- Youth-guided care

- Suicide prevention/intervention

- Topics related to special populations

- 40 Developmental Assets

- System of Care (SOC)

- Topics related to mental health – diagnosis, serious emotional disturbance (SED), serious mental illness (SMI)

- Trauma-informed care

- Evidence-based practices

- Substance abuse or addiction

- DMHA Indiana System of Care Provider Seminar

The entity facilitating the training must give each attendee documentation that includes the total number of training hours. Training may be in person or web-based. Without documentation of the training and the total number of hours credited, the training will not be accepted for reauthorization purposes.

Wraparound Facilitator Training Requirements

Wraparound Facilitators and their supervisors have specific training requirements they are to complete for all State-funded wraparound programs, as follows:

- Complete training for and certification as a Child and Adolescent Needs and Strengths (CANS) Assessment SuperUser. For information regarding the CANS assessment, provider training, and certification, see the *Training and Support* page at the Data Assessment Registry Mental Health and Addiction (DARMHA) website.

- Successful completion of the *Wraparound Facilitator Certification Training Program*, which includes 6 days of training (Introduction, Engagement, and Intermediate). Participants complete certification by demonstrating competency and fidelity, as measured by the Coaching Observation Measure for Effective Teams (COMET).

- Supervisors must complete an additional day of training, *Supervisor Training*, which is an introduction to training and coaching tools.

- Supervisors must complete *Advanced Supervisor Training* on an annual basis

- Wraparound Facilitators and their supervisors must attend a yearly wraparound booster training.

All required trainings for Wraparound Facilitators and Wraparound Facilitator Supervisors are eligible as ongoing professional development training for the purposes of reauthorization.

Indiana Requirements for Wraparound Facilitator Agency Policy

The purpose of this policy is to define agency requirements for providing HFW through State-funded initiatives.

Initial Wraparound Facilitator Agency Requirements

Wraparound Facilitator agencies will be expected to follow the requirements in this section to employ Wraparound Facilitators. Wraparound Facilitators will be enrolled in first cohort available after hire date, or within 4 months of employment as a Wraparound Facilitator. The DMHA can make one exception for up to 6 months regarding time frame for enrollment into cohort.

1. Staff Training: Brief descriptions of core training courses are presented in the *Core Training Course Descriptions* section)
   a. 100% of Wraparound Facilitators and Wraparound Facilitator Supervisors participate in the online training courses, including Indiana *System of Care Overview*.
   b. 100% of staff serving as Wraparound Facilitators and Supervisors have participated in *Introduction to Wraparound* within 4 months of hiring or taking this role.

     c.   100% of staff serving as a Wraparound Facilitator and Supervisors have participated in *Engagement in the Wraparound Process* within 2 months of participating in *Introduction to Wraparound*.

     d.   100% of staff serving as a Wraparound Facilitator and Supervisor have participated in *Intermediate Wraparound* within 1 year of participating in *Introduction to Wraparound* or 1 year of their previous *Intermediate Wraparound* training.

     e.   100% of Supervisors will participate in Wraparound Facilitator training and *Introduction to Training and Coaching Tools* (CREST, COMET, STEPS Wheel] within 12 months.

     f.   Participate in local DMHA coaching quarterly at minimum.

2.   Organizational Structures in Support of Quality Implementation:

     a.   Supervisor-to-staff ratio does not exceed one to 10 (1:10) regardless of funding source.

     b.   Wraparound Facilitator-to-family ratios at best practice are one to 10, but do not exceed one to 12 (1:12) regardless of funding source.

     c.   Supervisors must provide skill-based supervision to Wraparound Facilitators a minimum of twice a month.

     d.   Wraparound Facilitator must offer or link families participating in wraparound with access to parent/and or peer support (for example, Training and Support for Unpaid Caregivers).

3.   Competency and Fidelity Measures:

     a.   95% of Wraparound Facilitators with 2 or more years of wraparound experience demonstrate 80% skill attainment as measured by the COMET as provided by the DMHA coach, with no key element below 70% (based on external review of documents, observation of Child and Family Team (CFT) meetings, and observation of supervisory sessions).

     b.   Average scores on the Wraparound Fidelity Index (WFI) meet or exceed 75%. Data collection and reporting time frames to be determined by the DMHA contractor but will occur minimally twice a year.

Ongoing Requirements for Wraparound Facilitator Agencies

The following expectations are ongoing requirements for all Wraparound Facilitator Agencies:

1.   Provide ongoing training of new staff as outlined above.

2.   Participate in local DMHA coaching at least quarterly.

3.   Wraparound Facilitators will complete certification within 24 months of hire date.

4.   100% of wraparound staff (includes Wraparound Facilitators and Supervisors) must attend a yearly wraparound booster training.

5.   Continue ongoing participation in the fidelity and outcomes monitoring, as outlined in the initial certification criteria in the *General Provider Requirements* section.

6.   Notify DMHA local coach when there has been a change with a Wraparound Facilitator and/or Supervisor.

Core Training Course Descriptions

The following describes the required State-sponsored core trainings:

- **Child and Adolescent Needs and Strengths Survey (CANS) Training**: This training is designed to educate participants on using the CANS instrument in their work with families. Through attendance at this training, participants will be able to:
  - Define the components and the rating system of the CANS

- – Complete a sample CANS
- – Identify how to use CANS in Plans of Care (POCs)
- – Identify when a more in-depth assessment is appropriate
- – Complete the CANS certification test
- – Complete and maintain Indiana CANS SuperUser certification

- **System of Care Overview**: This training is to model and provide leadership, guidance, technical assistance, policy, and change at the state level to ensure that local SOCs are available for every child, youth, young adult, and their families. The local and regional community takes responsibility for building a comprehensive system that leads to sustainable success for youth and families. The system is characterized by all of the following:
  - – Respect, compassion, and values throughout the system
  - – Efforts to be responsive and tailor effective services and supports to the unique, whole person
  - – Services and supports created and maintained based upon community data by multiple, varied stakeholders who work in committed, visible partnerships characterized by honest communication, a shared philosophy and approach, and shared resources
  - – Community recognition that stakeholders responsible for the creation and maintenance of the system include youth and families
  - – A community-based infrastructure that plans, coordinates, implements, and sustains the system through accountability, evaluation, and quality assurance

- **Introduction to Wraparound:** This course is the first training of the series for frontline Wraparound Facilitators, Supervisors, and Directors. Through attendance at this training, participants will be able to:
  - – Gain an understanding of the critical components of the wraparound process to provide HFW practice.
  - – Practice these steps of the process to include:
    - ➢ Eliciting the family story from multiple perspectives
    - ➢ Reframing the family story from a strengths perspective
    - ➢ Identifying functional strengths
    - ➢ Developing vision statements and team missions
    - ➢ Identifying needs
    - ➢ Establishing outcomes
    - ➢ Brainstorming strategies
    - ➢ Creating a Plan of Care and Crisis Plan that represents the work of the team
  - – Learn basic facilitation skills for running a wraparound team meeting.

- **Engagement in the Wraparound Process:** This course is the second training in the series for frontline Wraparound Facilitators, Supervisors, and Directors. Through attendance at this training, participants will be able to:
  - – Identify barriers to engagement.
  - – Develop skills around engaging team members and the family.
  - – Utilize research-based strategies of engagement for increased positive outcomes for youth and their families.

- **Intermediate Wraparound Practice-Improving Wraparound Practice**: This course is the third training in the series for frontline Wraparound Facilitators, Supervisors, and Directors to enhance their skills and move toward higher quality practice. Common implementation challenges are addressed in this training; however, topics can be adjusted based on individual, organizational, or state need. Through attendance at this training, participants will be able to:
  - – Practice and utilize tools in telling and reframing the family story.

–   Pull out specific and individualized functional strengths for use in the planning process.

–   Identify underlying needs of the youth and caregiver.

–   Practice developing outcome statements and strategies that tie back to the reason for referral and address underlying needs moving the family closer to attaining their vision.

- **Introduction to Training and Coaching Tools**: This training is provided for supervisors in wraparound. Through attendance at this training, participants will be able to:

    –   Identify the tools necessary to support quality wraparound implementation.

    –   Develop an increased understanding of the role of the supervisor.

    –   Learn how and when to use coaching tools to support quality Wraparound Facilitators, individualized and strength-based service plans, and team processes.

Skill-Based Supervision for Wraparound Practice

Wraparound is a process requiring many skills to be developed to ensure quality practice is occurring. Wraparound Facilitators are typically task-oriented and the supervisors must work to move staff from this task-orientation approach to building the skills necessary for staff to consistently and reliably practice inside a quality wraparound process. In Wraparound Skill Based Supervision, two tools are used to assist in guiding this process:

- Coaching Response for Effective Skills Transfer (CREST)

- Supportive Transfer of Essential Practice Skills (STEPS Wheel)

The CREST is a five-step method that provides supervisors a clear pathway for communication around not only the task to be performed but also the rationale for why things should be done that way. Supporting Wraparound Facilitators or a Wraparound workforce is a shift to implementing high quality wraparound process and is more effective and efficient by breaking specific job duties into small chunks and ensuring staffs understand the expectations. The CREST can assist supervisors in attaining the level of practice implementation needed to ensure fidelity and quality practice are occurring. CREST: This model was adapted from *The Direct Supervision Training Model* developed by Patricia Miles.

The STEPS Wheel is a tool for supervisors to keep the individual components of Wraparound aligned when discussing and reviewing Wraparound Staff experience with families. Following this process allows Supervisors to stay on track with wraparound inputs as well as creating a simple one-page diagram that allows staff to consider all of the pieces of the wraparound process as a whole when considering an individual family. This process also keeps Supervision grounded in the process of Wraparound. The point of Wraparound supervision is not to discuss families but to discuss how the process is being delivered with integrity with individual families. Effective Wraparound supervision should avoid too much digging about family detail but instead get Wraparound staff to relate the family detail that is necessary for quality implementation of Wraparound. This tool was designed to assist supervisors with staying on track about the necessary Wraparound elements. This method reflects a guided approach to supervising staff in all eight quadrants embedded in the wheel. STEPS Wheel: This model was designed to assist supervisors employed and hired in Wraparound. This design was informed by work originally completed by John Franz and Patricia Miles.

Training for New Wraparound Facilitators

This policy pertains only to agencies with at least one staff member who has completed the Wraparound Facilitator Certification training (not necessarily certified yet), or to agencies that have access to an individual with this qualification from a neighboring community. This policy is for situations where the next state-sponsored cohort training will take place more than 30 days from the hire date of the new Wraparound Facilitator.

Training Components for Wraparound Practitioner Certification

The DMHA will oversee and provide training components for the Wraparound Practitioner Certification Training.

Requirements for Wraparound Facilitator Agencies

Based on needs of the Wraparound Facilitator, access to the following supports will be available for a minimum of 4 weeks, with the expectation that additional supervision will be provided by the agency through completion of Wraparound Practitioner Certification.

The new Wraparound Facilitator will:

1. Complete the *Indiana SOC Overview* training course.

2. Shadow a team leader or agency lead. The agency can rotate seasoned staff as lead for training new facilitators.

3. Be accompanied to team meetings.

4. Shadow a team leader or agency lead in the field for at least 1 week without a case.

5. Complete a minimum of two CFT observations.

6. Daily access to team leader or lead support, and at least one face-to-face contact with a Certified Wraparound Facilitator or agency lead per week.

7. Have all case notes reviewed, as demonstrated by sign-off on notes and paperwork pertaining to a case.

8. Have a STEPS Wheel and CREST used for supervisory purposes.

9. For agencies with offices in multiple counties, it would be ideal for new facilitator to shadow in different county.

Requirements for Wraparound Facilitator Shadowing

The individual providing shadowing for the new Wraparound Facilitator must have completed one of the following:

- Wraparound Practitioner Certification

- *Introduction and Engagement Training for Wraparound Practitioner Certification*

Agencies without qualified staff to shadow a new Wraparound Facilitator must contact a local coach through DMHA for assistance in providing the support.

Criteria for Assignment of Initial Wraparound Facilitator Cases

Prior to taking a Wraparound Facilitation case, the new Wraparound Facilitator must complete the following as documented by their agency:

1. Minimum of two CFT observations of an HFW case

2. Development of an "elevator speech" that describes System of Care and the wraparound process

3. Review of and demonstrated understanding of the four phases of wraparound process

4. Review of and demonstrated understanding of the crisis planning process

5. Review of and demonstrated understanding of the four key elements of wraparound process

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61

Section 14: DMHA and IHCP Provider Agreements

Division of Mental Health and Addiction (DMHA)-approved Child Mental Health Wraparound (CMHW) service providers must be authorized by DMHA, enrolled in the Indiana Health Coverage Programs (IHCP) and must have executed the Indiana Family and Social Services Administration (FSSA) DMHA Provider Agreement and an IHCP Provider Agreement. These agreements stipulate that the provider will comply, on a continuing basis, with all federal and State statutes and regulations pertaining to the DMHA and IHCP, as well as the standards and requirements of the 1915(i) CMHW Services Program.

By signing the IHCP and DMHA provider agreements, the provider agrees to the policies and expectations provided in the *IHCP Provider Modules* and the *DMHA CMHW Services* module, as amended periodically, as well as all related provider bulletins and notices.

All amendments to the *IHCP Provider Reference Modules* and the *DMHA CMHW Services* module, all applicable Indiana Administrative Codes (IACs), and federal rules and regulations pertaining to CMHW services and service provider policy and procedures are binding on publication.

> *Note: All information pertaining to CMHW services and service provider policy and procedures are binding on publication. Receipt of all information is presumed when the information is emailed to the provider's current email address on file with DMHA, and when mailed to the provider's current "mail-to address" on file with the DMHA and IHCP. Failure to update the DMHA and IHCP with current information does not relieve the provider of the responsibility for adhering to CMHW program and policy changes.*

Receipt of all information is presumed when the information is mailed to the provider's current *mail-to* address on file with the DMHA and IHCP. This same expectation applies to information pertaining to CMHW services, DMHA-approved providers, and home and community-based services (HCBS) policy and procedures, which is distributed via electronic mail and posted on the DMHA Indiana System of Care website. Providers are expected to adhere to the DMHA communications expectations, which include the following:

- It is the responsibility of the CMHW provider to enroll in the DMHA System of Care email database, available at in.gov/fssa/dmha/2747.htm.

- Providers will make sure the DMHA Indiana System of Care and the IHCP maintain current contact information at all times with DMHA Indiana System of Care and Medicaid (Office of Medicaid Policy and Planning) for all avenues of contact, including but not limited to, electronic mail address and physical mail-to address, as well as telephone and fax numbers.

- Providers must accept and respond to certified mail. It is the responsibility of providers to keep their mail-to address information current in the DMHA and IHCP provider databases. If the provider refuses to accept delivery of certified mail, or if mail is undeliverable due to the failure of the provider to maintain accurate delivery information with the State or its agents, the provider will be in violation of the Provider Agreement.

- Providers' failure to adhere to the FSSA/DMHA communication expectations may result in the DMHA's termination of authorization as a CMHW service provider.

Provider Record Updates

Provider information is stored in two systems: Core Medicaid Management Information System (*Core*MMIS) and the DMHA database, Tobi. *Core*MMIS is maintained by the Office of Medicaid Policy and Planning (OMPP). The DMHA maintains Tobi. It is the provider's responsibility to ensure that the information on file with the DMHA and the OMPP is accurate and current.

> *Note:*   *Providers must notify the DMHA **and** the IHCP of any and all provider changes requiring notification. DMHA and IHCP do not share updated demographic information.*

- Maintenance of *Core*MMIS requires that the IHCP has accurate *pay-to*, *mail-to*, and *service location* information on file for all providers. It is the provider's responsibility to ensure that the information is on file with the IHCP (the DMHA system does not interface with the IHCP system).

- The DMHA database, Tobi, is the State's system. Providers are responsible for ensuring that the information on file with the DMHA is up-to-date. Tobi stores the following CMHW Services and provider information:
    – Participant demographic, Level of Need (LON) and eligibility information
    – Participant's Plan of Care (POC) and other participant-related documentation pertaining to CMHW services
    – Notices of Action (NOAs) that are used to communicate DMHA authorization for CMHW services to the Wraparound Facilitator
    – The CMHW provider database that is maintained by the DMHA Youth Provider team and is intended to provide up-to-date information about the approval status of potential service providers, as well as which services the provider is approved to provide. Provider selection profiles (pick lists) are generated from the DMHA database.

Due to the importance of accurate database information, service providers are responsible for making timely updates of the following information:

- Change in telephone number

- Change in Home Office address

- Change in email address

- Banking information changes (notify the IHCP only)

- Name changes (personnel and DBA)

- Additional service locations

- Tax identification changes

- Changes in ownership (CHOW)

- Changes in mail-to, pay-to, and home office information/address

- Changes in primary contact information

- Changes in staff approved to provide services (terminations)

It is the responsibility of the provider to ensure that the updates and change requests are made in accordance with the following processes.

IHCP Notification of Provider Updates

The IHCP requires providers to make certain updates to provider information via paper form or online updates. See Update Your Provider Profile at indianamedicaid.com for additional information.

DMHA Notification of Provider Demographic Updates and Requests

Providers changing demographic information (for example, an address) or identifying provider information (for example, addition of staff, request to provide additional CMHW services, and so on) that is maintained in the DMHA database must submit the changes to the DMHA by completing a *Provider Demographic Form,* which is available on the DMHA Indiana System of Care website at in.gov/fssa/dmha. After the form is completed and any required collateral documentation related to the provider/applicant request are attached, such as legal change of name, the packet is submitted to the DMHA for processing.

Provider and Service Addition Requests

Providers must be authorized by the DMHA to provide any CMHW service. Authorized, enrolled providers wishing to add a new CMHW service to their existing enrollment must apply to the DMHA for authorization before providing the service. If the provider is adding a staff person to provide this new service, the new staff member must also be included in the application. The DMHA will not authorize any agency to provide a service for which that agency does not have qualified and authorized staff to provide the service. The authorization of the agency to provide a service does not extend to its employees by default. Each individual in an agency must be DMHA-authorized to provide any CMHW service the agency wishes to employ that staff to provide. The provider must complete and send the following information to the DMHA Youth Provider team (required forms may be accessed on the CMHW *Provider Information* page at in.gov/fssa/dmha.):

- *Application Cover Sheet*: All applicants must complete this form to indicate the purpose of the application.

- *Provider Demographic Form*: Only required when providers are requesting initial authorization or reauthorization as CMHW service providers, or when updating demographic information. If provider is only adding new staff or new services to an existing enrollment, this form is not required.

- *Rendering Provider Application Form*: This form is used to request DMHA authorization as a rendering provider for CMHW services, including Wraparound Facilitation, Habilitation, Respite Care, and Training and Support for the Unpaid Caregiver.

- *Facility Based Respite Application Form*: This form is only used to request DMHA authorization as a facility-based Respite Care provider.

- All other required collateral documentation: For each applicant, collateral documentation verifying the qualifications of the applicant are required and are listed on the *Rendering Provider Application Forms*, the *Application Cover Sheet, Facility Based Respite Application* form, and/or the *Provider Demographic Form*.

After the provider request is received, the DMHA will review the submitted information to ensure that the provider meets criteria for services/service delivery. If approved, the DMHA will send a signed provider approval letter on FSSA letterhead to the applicant to verify that the change has been approved by the DMHA. The DMHA provider system will be updated accordingly. Changes are effective on the date of the approval of the letter and are not retroactive.

Solicitation of CMHW Services

The CMHW Services Program adheres to State regulation regarding solicitation of CMHW services. Title 405 of the *Indiana Administrative Code 5-1-4*, solicitation of services, states the following:

> Sec. 4 (a) *Solicitation, or a fraudulent, misleading, or coercive offer by a provider to provide a service to a Medicaid recipient, is prohibited. Examples of solicitation include, but are not limited to, the following:*
>
> 1) *Door-to-door solicitation.*
> 2) *Screenings of large or entire inpatient populations of long-term facilities, hospitals, institutions for mental disease, ICFs/IID, or CRGs/DD except where such screenings are specifically mandated by law.*
> 3) *The use of any advertisement prohibited by federal or state statute or regulation.*
> 4) *Any other type of inducement or solicitation to cause a recipient to receive a service that the recipient either does not want or does not need.*

Quid pro quo: Promising service(s) if participant selects the provider, completing an initial evaluation for CMHW services as the provider of choice.

The following are guidelines regarding advertising the provision of CMHW services:

- *Brochures and bios*: An agency or individual provider may develop a brochure or a bio about themselves, their agency, and their staff. The following applies to the brochure or bio developed:
  – Information in the brochure or bio may include education, hobbies, interest, areas of specialty, and so on.
  – The brochure or bio must only be given to the Access Site or Wraparound Facilitation agency of each county in which the agency or individual provider is approved to conduct business.
  – If a family member is interested in interviewing the agency or provider, the Access Site or Wraparound Facilitator will provide the brochure or bio about the agency or provider to the family for review.
  – The Access Site and/or Wraparound Facilitation agency may only share the brochure or bio with the family after the family has selected the provider from the pick list.

- *Marketing during conferences (or setting up a booth for display)*: Service providers may set up informational booths at conferences or outreach events and distribute materials with basic information about CMHW services.
  – This material may include information about the provider, what services the provider provides under the CMHW Services Program, and where the provider is located.
  – Contact at the event must be initiated by the participant, his or her family, or his or her authorized representative.

- *Social media and websites*: The DMHA recognizes that social media is becoming the fastest-growing way to communicate and distribute information. Service providers may have a Facebook page and a website. Providers must abide by all policies and regulations related to the CMHW Services Program and this policy.
  – Potential clients may contact you to request information about the CMHW Services Program through these media.
  – Service providers may not initiate contact with former, current, or potential clients for the purpose of securing additional business through the CMHW program.
  – Service providers may not display any material on a social media platform or website that could be harmful or damaging to the integrity of the CMHW Services Program, or that may reasonably be interpreted as solicitation.

- The DMHA reserves the right to make the final determination as to whether a document or activity is deemed solicitation and in violation of the State regulations.

- Questions regarding an activity or marketing document should be submitted to the DMHA for review.

- Failure to follow this policy could result in corrective action up to and including revocation of DMHA authorization as a CMHW service provider.

Professional Code of Conduct and CMHW Services Delivery

These guidelines are intended to clarify service delivery standards expected of all DMHA-approved service providers. All services and methods of service delivery must honor the family's values and culture, and protect their right to privacy.

- *In-home activities*: When a service provider is providing services that he or she typically provides to others in the home (such as piano lessons, pottery lessons, and so on), an unpaid responsible adult who has been designated by the guardian must accompany the participant to the home and be available during the lesson.

- *Information sharing*: Providers must have a *Consent to Release Information* form signed by the parent/guardian in order to share participant/family information.

- *Activity funds*: Providers are not to request funds for activities from the participant/family outside the Child and Family Team (CFT) meetings.

- *Rewards*: Deciding to provide a reward to a CMHW Services Program participant for POC accomplishments is the CFT's decision.
  – The team decides an appropriate reward for a specific accomplishment, and the activity is noted in the participant's POC.
  – If the team determines it is appropriate for the provider to participate in the reward, this decision is also noted in the POC.
  – Providers cannot bill their time to the CMHW Services Program while participating in the reward activity.

- *Activities not allowed*: The following activities are not allowed with CMHW Services Program participants:
  – Taking the participant to your private or personal residence for any reason other than those activities and under those circumstances specifically detailed in the service definition
  – Buying gifts for the participant
  – Allowing the participant to participate in your own family outings
  – Any activity that the parent is responsible for and capable of doing

- *Family friends who become service providers*: Individuals who are friends with or provide services to a participant/family before becoming a CMHW service provider for the family must differentiate between the personal relationship with the participant/family and CMHW service delivery. Activities engaged in with the participant before becoming a provider may not be eligible for reimbursement under the CMHW Services Program. Activities during services must meet all requirements and standards of the CMHW services being provided.

- *Healthy boundaries*: The following are suggestions to help providers increase awareness and management of boundary concerns:
  – A provider's role in the context of the participant's care should be clear to the provider and to the family. Make sure expectations are clear at the CFT meeting.

    – Specific CMHW services to be provided to the participant must address a need (or encourage a strength) identified by the CFT and be DMHA-approved.

    – If the participant/family asks a provider to do something more, less, or differently than the activity identified by the CFT on the POC, contact the Wraparound Facilitator.

    – Adhere to all CMHW service delivery requirements and limitations as documented in this provider module and the 1915(i) CMHW Services Program.

    – When uncertain about how to respond to a participant/family's behavior, consult the Wraparound Facilitator and review the concerns during the required face-to-face supervision with a qualified mental health provider, as required.

    – Address boundary issues as they arise with the participant/family; emphasize the importance of maintaining objectivity and that rejecting an activity requested by the participant/family does not imply lack of caring on the part of the provider.

    – Do not discuss issues regarding claims and billing with the participant/family. This increases the family's stress. Request assistance with billing issues from the Wraparound Facilitator or the Medicaid fiscal agent (DXC Technology).

    – Remember that you are an individual brought to the team and to the family's life to accomplish a defined task. Your role is not permanent, and the goal should always be to transition the family to a state of independence, not reliance on providers.

- *Professional boundaries*: It is not uncommon for strong emotional bonds to form between program participants and providers, particularly when providers deliver services to children in need. However, the limits of a provider's relationships with participants/families must be established and maintained to ensure mutual respect, a sense of control for the provider and the participant/family, and therapeutic rapport.

If a provider fails to follow these guidelines while serving in the capacity of an identified CMHW service provider on the POC, the DMHA will implement corrective action. Failing to meet the requirements of the plan of correction will lead to termination of DMHA authorization as a CMHW service provider and/or the provider's agency.

Section 15: Documentation Standards and Guidelines

All documentation must adhere to the documentation content requirements for Child Mental Health Wraparound (CMHW) services, which are listed in this section. Documentation standards specific to each CMHW service are detailed, along with the service definition, scope, limitations, and exclusions, in subsequent sections of this module. Providers are responsible for understanding the service scope and documentation requirements for each service they are approved to provide. Questions about a service and its requirements may be directed to the Quality Improvement Specialist assigned to the provider's service area.

> *Note:* *Providers are responsible for understanding the service scope and documentation requirements for each service they are approved to provide. Questions about a service may be directed to the DMHA.*

The format for clinical documentation maintained for the provider is up to the individual provider or agency; however, the State expects the provider to understand the following standards that are required for each CMHW service that is billed for reimbursement:

- All clinical documentation must adhere to IHCP standards. For additional information regarding requirements, see the *IHCP Provider Reference Modules* on the *Provider Reference Materials* page at indianamedicaid.com.

- All documentation for CMHW services is subject to review by the Centers for Medicare & Medicaid Services (CMS), the Family and Social Services Administration (FSSA), including the Division of Mental Health and Addiction (DMHA) and the Office of Medicaid Policy and Planning (OMPP), or their designees. The provider agency must submit the requested documentation to the State, the CMS, or designee within 24 hours of the request. The CMS, the DMHA, the OMPP, or designees also reserve the right to request immediate access to documentation relating to a CMHW participant via an on-site visit.

- The provider is subject to denial of payment or recoupment for paid claims for services if the provider does not have adequate documentation to support the CMHW service billed.

Content Requirements for the Participant Record

Providers are required to maintain a CMHW participant file that includes, but is not limited to, copies of the following:

- *Plan of Care (POC)*: An individualized treatment plan that integrates all components and aspects of care that are deemed medically necessary/clinically indicated for a CMHW participant including the Intervention Plan, the Care Plan, and the Crisis Plan. The DMHA-approved POC must be signed by the participant/caregiver. The participant/family's signature on the proposed POC created with the family and Child and Family Team (CFT) is not sufficient, as the POC may change some during the review and authorization process. (See *Section 7* in this module for additional information and requirements).

- *Notice of Action (NOA) statements*: Documentation of the DMHA-approved Intervention Plan authorizing CMHW services, units of service, and the providers of the services (See *Section 7* in this module for additional information about service authorization.)

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- *Service notes*: The daily contact log or progress note that is completed to document contact between the participant and provider and provision of a CMHW service

  – Service notes must be signed by the provider of the service and maintained in the participant record.

  – All provider service notes are subject to review by the Wraparound Facilitator, who has the responsibility for oversight of the participant's POC and provision of services.

  – These notes may be submitted to the Wraparound Facilitator monthly, or more frequently, *if agreed on by the CFT or required by the Wraparound Facilitation agency*.

- *Monthly Summary Reports*: A brief summary (by service type) of all incidents of services provided in the preceding month, the participant's reaction to services delivered, and the participant's movement toward achieving the desired outcomes documented on the POC

- *Child and Adolescent Needs and Strength Assessment (CANS)*: The DMHA-approved assessment tool that is used to assess the applicant's/participant's strengths, needs, and level of functioning

- *All other documentation* pertaining to the participant's enrollment in CMHW services, CFT meetings, referral, evaluation, reassessment, service delivery, monthly summaries, Crisis Plan, and incidents, as required by the FSSA's DMHA and the OMPP.

Documentation of Supervision

Supervision is required for some providers of services as detailed in the services sections of the provider module. Previously, providers have been advised to maintain this documentation in the participant file. It has been determined that documentation of supervision of the service provider is not an appropriate component of the participant file. Providers are advised to maintain documentation of supervision in a secure, separate location.

Supervision must be adequately documented and meet the following standards:

- Supervision must be documented in a "supervision summary note format" agreed upon by the CMHW service provider and supervisor.

- The note must be signed by the supervisor, including the date of supervision and credentials of the supervisor. In signing the note, the supervisor is verifying that the supervision occurred on a given date and time frame.

- Challenges the CMHW service provider has faced must be documented and supervisory suggestions for his or her improvement must be made.

- The supervisory role is not intended for clinical direction on a participant's case. It is intended to provide coaching and supervision for the CMHW service provider only, and his or her ability to maintain quality outcomes with the participant on the CMHW.

The DMHA may request this documentation at any time. Wraparound Facilitators are required to receive individual, process-based supervision two times a month. For documentation purposes, Wraparound Supervisors must maintain proof of process-based supervision by completion of the CREST.

Content Standards for Service Notes

The following content must be documented in each CMHW services progress note:

- Participant's name – nicknames are insufficient

- Member identification number (RID)

- CMHW service provided (Habilitation, Training and Support for the Unpaid Caregiver, Respite, Wraparound Facilitation)

- All locations where services were provided

- Date and exact time of the service, including a.m. and p.m. (these must match the date on claim and units billed)

- Provider rendering the service, including the last name, first initial, and credentials (if applicable) of the person providing the service

- Legible signature of person completing the documentation

- Need identified on the POC that is being met through provision of the service

- Strategy identified on the POC that is being employed

- Participant's response to service provided

- Any other specific documentation required for the CMHW service provided

Monthly Summary Reports

Communication is key to the success of the High Fidelity Wraparound (HFW) service delivery system. Submission of clinical information to the Wraparound Facilitator is required of all CMHW service providers. The *Monthly Summary Report* is a brief summary (by service type) of all incidents of services provided in the preceding month and is one of the communication methods used by the CFT to summarize the participant's reaction to services delivered and the participant's movement toward achieving the desired outcomes documented on the POC. The following is required by all service providers:

- The *Monthly Summary Report* must include the following:
  – Dates of service and total hours provided during that month
  – Information regarding strategies/activities during sessions
  – Content individualized for that participant for the month
  – Some information may be similar month to month, but most of the report should be new information each month.
  – Statements about how client responded to strategies
  – Strengths and successes
  – A discussion of progress being made, as well as areas that continue to be needs or new needs.

- The *Monthly Summary Report* must be completed, dated, signed, and sent to Wraparound Facilitator by the fifth business day of the month following the month services were provided (for example: the December report must be sent to the Wraparound Facilitator by the fifth business day of January)

- If the CFT agrees or the Wraparound Facilitator Agency requires, submission of notes and service documentation may be required.

- If a provider provides more than one service to a participant/family, a separate monthly summary must be sent for each service.

Section 16: Service Claim and Billing Overview

This section summarizes the general claim and billing procedures for Child Mental Health Wraparound (CMHW) service providers. Additional billing information and requirements specific to the service being billed are provided in service definition sections of this module. (See *Sections 20–23* for additional information.)

For providers to be reimbursed, the CMHW service provided to a participant must be:

- Supported by the participant's Level of Need (LON) and documented on the Plan of Care (POC)

- Approved by the Division of Mental Health and Addiction (DMHA) and documented on the Notice of Action (NOA)

- Provided by a DMHA-approved service provider selected by the family

- Provided within the scope, duration, and frequency defined on the participant's POC and the NOA

- Billed according to Indiana Health Coverage Programs (IHCP) CMHW service billing procedures

> *Note:* *The provision of a CMHW service must be compliant with the Centers for Medicare & Medicaid Services (CMS) service definition, allowed and non-allowed activities, and all applicable service limitations. Services provided outside the CMS-approved service scope and related requirements will not be reimbursed.*

CMHW service providers are responsible for understanding and following the policy and procedures associated with the provision of and billing for CMHW services. CMHW service claims not meeting the preceding requirements may be denied for payment. The following eligibility factors affect the processing and payment of CMHW service claims:

- *Participant eligibility*: All CMHW participants must be enrolled in the IHCP and CMHW services.
  - Participant's IHCP eligibility must be current. The provider is responsible for verifying the participant's Medicaid eligibility before providing CMHW services, as explained in the *Member Eligibility and Benefit Coverage* module.
  - The approved CMHW participant's LON and DMHA-approved services, including the service frequency and start date, are entered into *Core*MMIS (the Indiana Medicaid Management Information System)*,* which allows reimbursement of the service if it is provided on or after the CMHW service's authorized start date.
  - CMHW participants may be enrolled in *both* the CMHW Services Program and Hoosier Healthwise, the IHCP's risk-based managed care program.

- *Service provider eligibility*: All service providers submitting a claim must be:
  - Enrolled in the IHCP as an IHCP provider of CMHW services
  - DMHA-approved as a CMHW service provider
  - Documented on the NOA as the DMHA-approved provider of the service

- *CMHW service eligibility*: The service being billed must be an eligible CMHW service for the participant.

CMHW Services Authorization

When the DMHA approves CMHW services on a submitted POC, the NOA is generated and provided to the Wraparound Facilitator (who provides it to the participant, family, and service providers on the POC). The NOA documents a decision that affects the participant's authorization of benefits for the CMHW Services Program. The NOA includes the following information:

- All DMHA-approved CMHW services for the participant, including:
    – Service type
    – Dates of service authorization
    – Number of units to be provided
    – Name of the DMHA-approved provider of the service
    – Approved billing code with the appropriate modifier for the service

- Subsequent changes to increase, reduce, or terminate any or all CMHW services

- The effective dates

- The participant's appeal and fair hearing rights (and procedural information)

Common Reasons for Claims to Be Denied

Claims may be denied for the following reasons:

- The service billed for is not an approved service on the NOA.

- The service provider is not authorized to provide the billed service.

- The date of service being billed does not match the date range for the DMHA-approved service.

- The units of service billed exceed the authorized amount.

- The code/modifier on the claim is not the approved code/modifier on the NOA.

When the Wraparound Facilitator receives the NOA, he or she is responsible for ensuring the participant/family receives and signs the POC, and all service providers on the Child and Family Team (CFT) receive the POC and NOA information. The DMHA database communicates this information to *Core*MMIS, where it is stored in the prior authorization database and used during claims processing. It is each service provider's responsibility to understand the service scope and limitations for each CMHW service that the DMHA approved on the POC, and to deliver to the participant those services within the scope and limitations. The service provider is further responsible for notifying the Wraparound Facilitator if the participant's LON is no longer consistent with the approved services documented on the NOA.

Billing Guidelines

When billing for a CMHW service, the provider must use the service procedure code, modifier, and units of service associated with an approved service, as documented on the NOA. All CMHW service claims are billed through the IHCP on the professional claim (*CMS-1500* claim form, 837P electronic transaction, or Provider Healthcare Portal professional claim).

See *Sections 20–23* of this module for the CMHW service definitions, billing codes (Healthcare Common Procedure Coding System codes and modifiers), service rates, and units of service information. It is the provider's responsibility to seek the most up-to-date billing information regarding the IHCP's procedures for claims and billing. IHCP billing information, provider bulletins, forms, and instructions are available at indianamedicaid.com.

Units of Service

The following is general information regarding the IHCP's expectations for billing units of a service. Questions regarding IHCP billing procedures, regulations, and expectations should be directed to IHCP Customer Assistance at 1-800-457-4584 or to your [Provider Relations field consultant](#).

Billing 15-Minute Units for a CMHW Service Provided on a Single Date

To bill one 15-minute unit of service, a minimum of 8 minutes of service must be provided.

Units of service activity time for 1 day are totaled to submit one claim. Remaining units that are less than 8 minutes may not be billed or added to partial units on other days of service:

- Round partial units of service for a single visit on a date of service as follows:
  - A partial unit of service totaling 8 minutes or more is rounded up to a 15-minute unit of service.
  - A partial unit of service totaling 7 minutes or less must not be rounded up and cannot be billed or added to partial units on other days of service.

- Round partial units of service for multiple visits on same date of service as follows:
  - Activities requiring 7 minutes or less may be accrued to the end of that date of service. In this situation, the preceding guidelines regarding rounding of any remaining partial minutes will apply.
  - Multiple visits on the same date of service must be billed on the same claim form and on one detail with the total number of units of service provided.

> *Note:*   *Multiple visits are totaled by the sum of the minutes spent providing the service (for all the visits that day). For example: If a provider has three contacts at 8 minutes each, units billed will equal two units of service (as 24 minutes of the service was provided on that day).*

> *Note:*   *Respite Care service being provided to two or more participants in the same home, at the same time, by the same provider, must total units of service for that date of service, and the provider must divide the units accordingly. The Respite Care service for each participant is billed separately. Billing total hours to each participant is considered duplicate billing and is not allowed. (Doing so may constitute fraud.)*

Billing on separate lines for the same date of service causes claims to be denied as exact duplicates.

Billing Daily Units of Service

Daily units of service (for example, Respite Care service) may be billed daily or totaled weekly or monthly:

- *Respite – Routine Daily*: One unit of service provided is 7–24 hours on a date of service.

- *Respite – Crisis Daily*: One unit of service provided is 8–24 hours on a date of service.

- *Respite – In PRTF*: One unit of service for the date of service is established by the current IHCP-approved PRTF billing policy in effect at the time of the service. The current policy is based on the individual census taken at midnight on the date of service.

Billing Services That Do Not Have Defined Billing Rates

Not all CMHW services have a defined billing rate; and DMHA-approved items and services vary widely, according to the individual needs of the participant. The non-hourly training and support for unpaid care givers service is not billed in time increments, and the DMHA approves items purchased as a result of the authorized service based on the participant's needs and the POC. (See *Section 23* in this module for a service description and limitations associated with the non-hourly training and support service).

The following general billing information applies to the non-hourly training and support for unpaid caregiver service:

- The service is billed in $1.00 units of service. Cents of $0.50 or more are rounded up to $1.00 (and down for $0.49 cents or less).
  - Single item example: $20.00 for a given item of service (for example, a workbook purchased at an educational seminar) is billed as twenty $1.00 units of service.
  - Multiple items example: If multiple services are provided on the same date of service (for example, a workshop registration fee of $80.00 and a workshop book for $20.00), they must be added together and billed as one complete unit of service. In the example provided, the workshop registration and workshop book would be billed at one hundred $1.00 units of service.

- The Wraparound Facilitator is responsible for maintaining documentation to support claims for all items and services purchased via the non-hourly training and support for unpaid caregiver services.

- The Wraparound Facilitator must have documented authorization for the specific items or services purchased and maintain receipts to support the items billed by date of service. Additional required information for billing includes:
  - Items purchased
  - The cost of items
  - Where the items were purchased or services were provided

- Families should be instructed to keep purchase receipts for items purchased by CMHW funds separate from non-CMHW funded items purchased.

  Example: The identified unpaid caregiver (who was DMHA-approved on the CMHW participant's POC) to attend a workshop and be reimbursed for a workshop registration and a workbook under the approved non-hourly training and support for unpaid caregiver service) purchased a book, in addition to the approved workbook, while attending the workshop. The caregiver must obtain a separate receipt for the unauthorized book purchase (and not combine DMHA-approved and non-approved purchases on the same receipt).

- If there are multiple participants in the same household, the family must be able to provide separate expenditure receipts for each individual participant. Federal regulations do not allow for mixing funds between two or more participants.

- Failure to provide separate receipt documentation for DMHA-approved CMHW/non-CMHW purchases or for each individual participant for which the expenses were approved will result in denial of the entire expenditure.

Medicaid Claim Tips and Reminders

When billing Medicaid CMHW service claims, the provider must consider the following:

- Medicaid does not reimburse for time spent by office staff preparing the billing claims.

- A claim may include dates of service within the same month. Do not submit a claim with dates that span more than 1 month on the same claim.

76   *Library Reference Number: PRPR10019*
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- The units of service as billed to the IHCP must be substantiated by documentation in the participant's case file. The documentation must be in accordance with the appropriate *Indiana Administrative Code* (IAC) regulations and the CMHW Services Program documentation standards.

- Services billed to the IHCP must meet the service definitions and parameters as published in the 1915(i) CMHW Services Program, rule, and this provider module.

- Updated IHCP billing and policy information is disseminated through IHCP provider bulletins (see the *Bulletins* page at indianamedicaid.com) and DMHA bulletins (sent through email and posted on the DMHA website). Each provider is responsible for obtaining the information and implementing new or revised policies and procedures as outlined in these notices.

The Office of Medicaid Policy and Planning (OMPP) and DMHA recommend submitting claims electronically using the IHCP Provider Healthcare Portal at portal.indianamedicaid.com or the appropriate 837 electronic transaction. See the *Provider Healthcare Portal* module for information on completing a professional claim on the Portal. See the *Electronic Data Interchange* module for information about the 837P transaction. See the *Claim Submission and Processing* module for instructions on completing the *CMS-1500* paper claim form.

Child Mental Health Wraparound (CMHW) service providers have access to several resources to assist and support them in the delivery of CMHW services. The CMHW quality improvement team engage in the following activities meant to ensure quality program outcomes and provision of support to CMHW service providers, agencies, participants, and families:

- Ensure that training, coaching, and support are provided to Wraparound Facilitators, Wraparound Facilitator Supervisors, service providers, and Access Sites

- Conduct quality reviews of clinical documentation and provider records to ensure that the CMHW service provider is adhering to federal and State statutes associated with the 1915(i) CMHW Service program

- Review each participant's Plan of Care (POC) and make determinations for approval or denial of services requested

- Ensure that all providers are qualified initially and continually to be CMHW service providers

The site coaches (also known as Quality Improvement Specialists) are assigned to Wraparound Facilitation Agencies to provide oversight and support, and are the point of contact for CMHW program-related questions or concerns. The provider specialist, provider coordinator, and clinical QI Specialist offer support and oversight for all CMHW providers and ensures that all providers are qualified to provide CMHW services.

The INSOC Website and Mailing List

The *DMHA Indiana System of Care* web page at in.gov/fssa/dmha is intended to educate and assist the public, service providers, Access Sites, participants, and families about Indiana's home and community-based services programs for youth with serious emotional disturbances (SED), events, and the Indiana System of Care (INSOC) expansion initiatives. It also serves as a resource for providers regarding training opportunities, policies and procedures, program updates, and public announcements about new and revised service programs.

All service providers are required to sign up for the Division of Mental Health and Addiction System of Care (DMHA) website mailing list to receive CMHW Services Program email announcements Providers can sign up for the emailing on the *Announcements* page at in.gov/fssa/dmha.

DMHA also maintains a general email account to which CMHW providers may submit questions and concerns, DMHAYouthServices@fssa.in.gov.

IHCP Provider Support

The Indiana Health Coverage Programs (IHCP) offers resources, education, and updates regarding service delivery and billing on its website. Providers are responsible for being familiar with any IHCP policy or procedure changes that would impact how they provide, document, or bill for CMHW services. For more information, visit indianamedicaid.com.

Quality assurance for the Child Mental Health Wraparound (CMHW) Services Program includes monitoring, discovery, and remediation processes to ensure that:

- CMHW services are provided to eligible participants by Division of Mental Health and Addiction (DMHA)-authorized providers in accordance with federal and state requirements.

- The participant's health and welfare are monitored.

- The participant's needs, desired outcomes, and preferences are part of the person-centered planning process

- Opportunities for ongoing quality improvement are identified and pursued.

Quality-assurance processes are implemented in the following ways:

- Qualified provider enrollment function

- Surveillance Utilization Review (SUR)

- Quality assurance review

- Financial integrity audits

- Quality Improvement Strategic Planning

All services are provided according to the federal and state regulations and mandates set forth by the State Plan Amendment (SPA) and Medicaid. For additional information, go to the *Operating Policy & Procedures* page at in.gov/fssa.

Qualified Provider Enrollment Function

The Office of Medicaid Policy and Planning (OMPP) utilizes fiscal agent contractor DXC Technology to assist in processing approved Indiana Health Coverage Programs (IHCP) Provider Agreements. DXC Technology enrolls DMHA- authorized, eligible providers in the Medicaid Management Information System (MMIS) for claim processing. The fiscal contractor also conducts training and provides technical assistance concerning claim processing.

Surveillance Utilization Review

The CMHW program auditing function is incorporated into the Surveillance Utilization Review (SUR) functions of the contract between the Family and Social Services Administration (FSSA) and SUR contractor. The FSSA has expanded its program integrity activities by using a multipronged approach to SUR activity that includes provider self-audits, contractor desk audits, and full on-site audits. The SUR contractor sifts and analyzes claims data and identifies providers and claims that indicate aberrant billing patterns or other risk factors, such as correcting claims.

The FSSA/OMPP or any other legally authorized governmental entity (or their agents) may, at any time during the term of the service agreement and in accordance with Indiana Administrative Regulation, conduct audits to ensure the appropriate administration and expenditure of the monies provided to the provider through this service agreement. Additionally, the FSSA/DMHA may at any time conduct audits to ensure appropriate administration and delivery of services under the service agreement.

The following program integrity and SUR activities describe post-payment financial audits to ensure the integrity of IHCP payments. Detailed information on SUR policy and procedures is available in the *Provider and Member Utilization Review* module.

The State of Indiana employs a hybrid program integrity (PI) approach to overseeing waiver programs, incorporating oversight and coordination by a dedicated waiver specialist position within the SUR Unit, as well as engaging the full array of technology and analytic tools available through the Fraud and Abuse Detection System (FADS) contractor arrangements.

Quality Assurance Review

The DMHA has a quality improvement team that is responsible for conducting quality assurance reviews and improvement activities. This team works closely with the IHCP, providers, and the local community to affirm all participants are receiving services based on CMHW Services Program policies, procedures, High Fidelity Wraparound (HFW), and a System of Care philosophy.

The purpose of the quality assurance review is to routinely monitor provider files and documentation and, if necessary, assist the provider to become compliant with all policies, practices, and procedures of the CMHW program. The review gives providers the opportunity to enhance and/or modify their business practices to align more closely with policies, procedures, and philosophies of the CMHW program. In addition, providers have the opportunity to receive individualized training and support and DMHA is able to identify areas to focus quality improvement efforts, as it specifically relates to the administration of the CMHW program. These reviews can be conducted on-site or electronically and may also be conducted as the result of a complaint or concern.

- Quality assurance reviews and improvement activities include but are not limited to: Announced and unannounced reviews of provider client files and documentation for all CMHW approved services

- Announced and unannounced reviews of provider eligibility requirements as well as employee personnel files

- Observation of Child and Family Team (CFT) meetings

- Communication with families and participants regarding their treatment and satisfaction with services

- Review of participant Level of Need (LON), Plan of Care (POC), and any other CMHW-related services documentation

Quality assurance reviews, as well as any corrective action, are formally documented in the DMHA provider file. Review outcomes are also included in the file and are used to evaluate program compliance and effectiveness for the participants and families being served.

Medicaid Fraud Control Unit – Audit Overview

The Indiana Medicaid Fraud Control Unit (MFCU) is an investigative branch of the Attorney General's Office. MFCU conducts investigations in the following areas:

- Medicaid provider fraud

- Misuse of Medicaid members' funds

- Abuse or neglect of patients in Medicaid facilities

When the MFCU identifies a provider that has committed one of these violations, the provider's case is presented to the State or federal prosecutors for appropriate action. Access information about MFCU at the *Medicaid Fraud* page at in.gov.

Financial Integrity Audits

In accordance with their service agreement, providers must maintain an accounting system of procedures and practices that conforms to Generally Accepted Accounting Principles (GAAP).

In accordance with Indiana Administrative Regulations, the OMPP or any other legally authorized governmental entity (or its agents) may at any time during the term of the service agreement conduct audits for the purpose of ensuring the appropriate administration and expenditure of the monies paid to the provider through this service agreement. Additionally, the DMHA may at any time conduct audits for the purpose of ensuring appropriate administration and delivery of services under the service agreement. The *Provider and Member Utilization Review* module covers utilization review.

Under the provisions of the *Single Audit Act*, as amended by the *Single Audit Act Amendments of 1996*, the State of Indiana uses the Indiana State Board of Accounts (SBOA) to conduct the independent audit of State agencies, including the Office of Medicaid Policy and Planning. The FSSA routinely monitors audit resolution and provides annual status updates to SBOA.

Quality Improvement Strategic Planning Process

The purpose of the DMHA Quality Improvement Strategic Planning process is to systematically review and analyze collected data and develop plans for ongoing quality improvement. Data is collected from multiple sources; including but not limited to the following:

- CMHW participants and families

- Providers

- Wraparound Facilitators

- General public

- Indiana System of Care (INSOC) Board

- INSOC Youth and Family Subcommittee

- Other FSSA's divisions

The DMHA team meets biannually to synthesize this data into meaningful constructs as it relates to provider enrollment, participant outcomes, participant health and well-being, provider program compliance and other functions and responsibilities of the CMHW program. Data analysis, reports and other findings are then shared with CMHW internal and external stakeholders. Input and commentary is sought.

Utilizing all data and other information gathered, the DMHA team develops a quality improvement strategic plan to address pertinent issues that impact program effectiveness and integrity. The plan is reviewed and progress is updated at each subsequent bi-annual meeting.

Section 19: Tobi (the DMHA Case Record Management System)

The Division of Mental Health and Addiction (DMHA) operates the Child Mental Health Wraparound (CMHW) Services Program using an electronic case records management system (database) called *Tobi*. Tobi processes and tracks the CMHW Services Program and stores the following CMHW participant, services, and provider information:

- Participant demographic, level of need (LON), eligibility, plans of care (POCs), and other participant-related documentation pertaining to CMHW services

- Notices of action (NOAs) that are used to communicate DMHA authorization for CMHW services to the Wraparound Facilitators and providers on the POC. Tobi transmits DMHA authorization for services to the Indiana Health Coverage Programs (IHCP) database (the Medicaid Management Information System) that processes claims for payment.

- Provider selection profiles (pick lists) are generated to inform families about the DMHA-approved CMHW service providers in their county.

The following information is maintained, reviewed, and/or accessed by Tobi:

- *Participant Plans of Care – The* Plan of Care (POC) is a single document created in three parts: the Intervention Plan, the Care Plan, and the Crisis Plan.

- The *NOA* is generated after the DMHA reviews and approves or denies the Intervention Plan.

- *Participant LON from the Child and Adolescent Needs and Strengths (CANS)* assessment reflects increases or decreases in the participant's level of functioning and needs-based eligibility for CMHW services. (PDF files of annual CANS assessment ratings are saved as part of the eligibility determination.)

- *Freedom of choice*: Confirmation affirms that the participant and family have determined the CMHW POC and associated services and supports.

- *Choice of service providers*: Confirmation affirms that the participant and family were provided the provider pick list to assist them in selecting the Wraparound Facilitator and CMHW service providers.

- *Change in placement*: Documentation is provided of any participant's change in placement that impacts the delivery of CMHW services.

- *Submission of CMHW Participant Eligibility and Re-Evaluation of Eligibility Applications*: Tobi is the conduit for submission of the eligibility and renewal applications for the CMHW applicant.

- *Minimum Data Set Questionnaire*: Additional evaluation questions are completed at the beginning of services, and are updated every 6 months and at the end of an episode of CMHW services (disenrollment from CMHW).

User Roles and Security Rights

Access Sites, Wraparound Facilitators, and Wraparound Facilitators' supervisors are granted user rights for the Tobi system by the DMHA. A license is approved for release by the State to an approved user at the time of approval. Tobi users are required to sign a user agreement before the release of a license.

Only those with licenses are permitted to access the Tobi database. All work done through Tobi must be done by the approved user, and not a designee or trainee. Classroom training for use of the Tobi system is provided by the State. Training may also be supported by the user's supervisor/trainer after the trainee has been approved and had a license released to him or her. Training modules and videos for using Tobi can be found under the Announcements section of Tobi.

Section 20: Wraparound Facilitation Service

Service Definition

Wraparound Facilitation is a comprehensive service that comprises a variety of specific tasks and activities designed to carry out the wraparound process. Wraparound Facilitation is an important and required component of the Child Mental Health Wraparound (CMHW) Services Program. Wraparound is a planning process that follows a series of steps and is provided through the Child and Family Team (CFT). The wraparound team, with oversight and direction provided from the Wraparound Facilitator, is responsible for assuring that the participant's needs and the entities responsible for addressing them are identified in a written Plan of Care (POC), which is composed of the Intervention Plan, the Care Plan, and the Crisis Plan. The Wraparound Facilitator facilitates and supervises this process. Each CMHW Services Program participant/family selects a Wraparound Facilitator to help them through the wraparound service delivery process.

> *Note:*   *The Wraparound Facilitator manages the entire wraparound process and*
> *ensures that the participant and family's voice, preferences, and needs are*
> *central in developing the POC and throughout service delivery.*

The Wraparound Facilitator ensures that care is delivered in a manner consistent with strength-based, family-driven, and culturally competent values. The Wraparound Facilitator manages the entire wraparound process and ensures that the participant and family's voice, preferences, and needs are central in the POC development, throughout service delivery and into the child and family transition into a less intensive level of service delivery, when appropriate.

The Wraparound Facilitator is responsible for guiding the participant, family, and team through the four phases of wraparound (*The Wraparound Process User's Guide: A Handbook for Families,* Miles, Bruns, Osher, and Walker, 2006). See *Section 4: High Fidelity Wraparound* for more information about the wraparound principles and process for service delivery.

See the *Billing Information* section for service code, billing, and reimbursement information for Wraparound Facilitation services.

Service-Specific Provider Qualifications and Standards

All providers must be approved by the Division of Mental Health and Addiction (DMHA) to deliver CMHW services. See *Section 13* in this module for additional information about applying for DMHA approval as a CMHW service provider. See Table 3 for Wraparound Facilitator-specific provider qualifications and standards.

Table 3 – Qualifications and Standards for Wraparound Facilitators

	Accredited Agency	**Nonaccredited Agency**	**Individual Service Provider**
Provider type eligible to bill for service (yes or no)	Yes (**Note:** The staff member providing the service must meet additional standards shown later.)	No	No
License	The individual providing the Wraparound Facilitation services must qualify as an Other Behavioral Health Professional (OBHP), as defined in *405 IAC 5-21.5-1*, who has a bachelor's degree or a master's degree with 2 or more years of one or a combination of the following experience: • Clinical • Case management • Skills building • Child welfare • Juvenile justice • Education in a K-12 school setting	NA	NA
Certificate	Must demonstrate one of the following: • Be approved as a community mental health center by the DMHA (*440 IAC 4.1-2-1*) • Be accredited by a DMHA-approved national accrediting entity (AAAHC, COA, URAC, CARF, ACA, JCAHO, or NCQA – For definitions of accrediting entities, see *Section 24.*) Agencies must participate in and have been endorsed as a Wraparound Facilitation provider by the local System of Care (SOC), which includes a governing coalition and service-delivery system that endorses the values and principles of wraparound; or if the area of the state does not have an organized SOC, the provider is a part of a DMHA-approved/designated Access Site for services.	NA	NA

	Accredited Agency	**Nonaccredited Agency**	**Individual Service Provider**

Other standards	Individual staff members providing Wraparound Facilitation services must be affiliated with an accredited agency that has been DMHA-authorized to provide Wraparound Facilitation services. In addition to qualifications listed above, the agency providing Wraparound Facilitation services must:
	
	• Maintain proof of the following screens (see *Section 13* in this module for additional information about screens), which were completed prior to authorization on each individual authorized for Wraparound Facilitation services:
	  – Fingerprint-based national and State criminal history background screen
	  – Local law enforcement screen
	  – State and local Department of Child Services abuse registry screen
	  – Five-panel drug screen, or agency meets the same requirements specified under the *Federal Drug Free Workplace Act 41, U.S.C. 10 Section 702(a)(1)*
	• Successfully complete the DMHA and Office of Medicaid Policy and Planning (OMPP)-approved training and certifications for CMHW services. Must be a certified Child and Adolescent Needs and Strengths (CANS) SuperUser
	• Have acquired or be working toward acquiring Wraparound Practitioner Certification, according to DMHA policy
		NA	NA

Eligible Activities

The following activities are eligible for reimbursement when provided by a Wraparound Facilitator, according to the Wraparound Facilitation service scope and limitations:

• Comprehensively assess the participant, including administering the CANS assessment tool

• Guide the family engagement process by exploring and assessing strengths and needs through documentation of the family story

• Guide the POC development process by informing the team of the family's vision and ensuring that the family's voice, preferences, and vision are central to all service planning and delivery

• Coordinate with team members to ensure that the POC is developed, written, and approved by the DMHA

• Develop, implement, and monitor the Crisis Plan and intervene during a crisis situation, if needed

• Assist participant/family in gaining access to a full continuum of services (that is, medical, social, educational, and/or other needed services and supports in addition to CMHW services)

• Ensure that all work that needs to be done to assist the participant and family in obtaining the desired outcomes on the POC is identified and assigned to a team member

Library Reference Number: PRPR10019   *89*
Published: July 10, 2018
Policies and procedures as of July 1, 2018
Version: 3.0

- Oversee implementation of the POC:
  – Monitor service delivery of all DMHA-approved services documented on the participant's POC
  – Monitor participant's progress toward treatment desired outcomes
  – Reassess, amend, and secure ongoing approval of the POC
  – Ensures that care is delivered in a manner consistent with strength-based, family driven, and culturally competent values

- Facilitate, coordinate, and attend monthly team meetings

- Offer consultation and education to all team members regarding the values and principles of the wraparound model

- Ensure that all CMHW assessment and service-related documentation is gathered and reported to the DMHA, as mandated

- Complete the annual CMHW Services Level of Need (LON) Redetermination evaluation, with active involvement of the participant, family, and team members

- Communicate and coordinate with local Division of Family Resources (DFR) regarding continued Indiana Health Coverage Programs (IHCP) eligibility status

- Guide the transition of the participant and family from CMHW services to State Plan or other community-based services, when indicated.

Activities Not Allowed

Wraparound Facilitation does not duplicate any other CMHW or State Plan Medicaid service. The following activities are not eligible for reimbursement under the Wraparound Facilitation service:

- Duplicative services covered under the Medicaid State Plan

- Any CMHW service other than Wraparound Facilitation

- Services provided in a setting that is not home and community-based, in compliance with HCBS Settings Final Rule

Service Delivery Standards

The following list shows the service delivery standards for Wraparound Facilitation:

- The Wraparound Facilitator is responsible for ensuring that the CMHW services are provided within the wraparound principles, guided by a SOC philosophy, and meet all standards and regulations for the Medicaid-approved 1915(i) CMHW Services State Plan Amendment, as supported by *405 IAC 5-21.7*. The Wraparound Facilitator adheres to the following service delivery standards:
  – The Wraparound Facilitator maintains a caseload of no more than 12 youth, regardless of sources of funding (insurance, Medicaid, and so on). Wraparound Facilitation may be provided in the participant's home or community, according to participant and family preferences.
  – The Wraparound Facilitator is responsible for facilitating, coordinating, and participating in the monthly team meetings.
  – The Wraparound Facilitator ensures that the participant, family, and members of the team received notification of the DMHA-approved POC and Notice of Action (NOA).
  – The Wraparound Facilitator makes sure that Wraparound Facilitation does not duplicate any other CMHW or State Plan Medicaid service.

Documentation Requirements

The Wraparound Facilitator is responsible for adhering to all general documentation requirements described in this provider module and according to IHCP rules and regulations. The additional Wraparound Facilitation service documentation requirements also apply to the Wraparound Facilitator:

- Wraparound Facilitators bear the largest portion of documentation requirements, including distribution of the POC and CFT meeting minutes to providers and family members, as well as the responsibility for maintaining records of service documentation (excluding daily service notes) from all providers on the team.

- The Wraparound Facilitator must document each contact with, or activity on behalf of, the participant.

- Wraparound Facilitator documentation can be categorized into the four following primary groups:
    - Electronic and case file (Tobi)
    - CFT meeting minutes
    - CANS assessment
    - Agency-related documentation

Electronic and Case File Documentation and Requirements (Tobi)

The Wraparound Facilitator is responsible for ensuring that all DMHA-required documentation is entered and maintained in the DMHA electronic database, Tobi. The following information is maintained in the Tobi system (see *Section 19* in this module for additional information):

- *POC documentation and updates* reflecting the participant's needs, desired outcomes, and strategies are entered into the Tobi system. Additionally, the Wraparound Facilitator is required to ensure that the participant and family sign a printed copy of the DMHA-approved POC. The signed POC must be maintained in the participant's case file. The POC is a single document in three parts: the Intervention Plan, the Care Plan and the Crisis Plan.

- *DMHA-approved CMHW services* are entered into the DMHA database and monitored monthly, or more often, as required.

- *Notice of Action (NOA)* is generated after the DMHA reviews and approves/denies POC updates entered into the DMHA database. The Wraparound Facilitator is responsible for sharing the information with the participant, family, and team members and maintaining a printed copy of the NOA in the participant's case file with a copy of the DMHA-approved POC signed by the participant/family.

- *Crisis Plan* and associated updates that reflect the participant's likely crises and the planned interventions are updated as needed and maintained in Tobi and the participant's case file.

- *Level of Need (LON)* is maintained in the DMHA database to reflect increases or decreases in the participant's level of functioning and needs-based eligibility for CMHW services.

- *Freedom of choice* is documented in Tobi. The Wraparound Facilitator maintains a signed and dated copy of the freedom of choice form in the participant case file.

- *Choice of service providers*: The participant/family are provided with the provider pick list when determining which Wraparound Facilitator and CMHW service providers will deliver CMHW services on the POC. The participant/family's choice of providers is documented in the Tobi system. The Wraparound Facilitator maintains a signed copy of the pick list in the participant's case file, documenting that the participant/family received a choice of providers.

- *Change in placement* is clearly documented in Tobi. See *Section 19* in this module for additional information.

- *CMHW Services Level of Need Re-determination* application is submitted electronically to the DMHA (via Tobi) for review and approval of eligibility for CMHW services. The Wraparound Facilitator is responsible for ensuring the application is submitted to the DMHA before the participant's eligibility for CMHW services expires.

Child and Family Team Meeting Documentation

The Wraparound Facilitator is responsible for maintaining CFT meeting documentation.

- The Wraparound Facilitator contacts each CFT member weekly to gather information needed to track progress toward meeting underlying needs, progress made around outcome statements, and development of newly found functional strengths, along with assigned task completion. The Wraparound Facilitator may make contact with team members in person or by telephone, email, or text message. All contacts made must be documented in the agencies electronic health record in the participant file. It is the responsibility of the Wraparound Facilitator to share these updates with the CFT members through the CFT meeting process and provide updates to the team.

- *CFT meeting minutes* are a required practice and includes preparing a report or minutes to document the progress discussed toward the family vision, team mission, underlying needs, outcomes, addition of functional strengths, changes made to strategies, and plans reached through the team meeting. This report documents specific actions to be taken by each team member before the next team meeting. If services outlined on the POC were not provided, the Wraparound Facilitator must note in the meeting minutes the reason they were not provided and the strategy for correction. Copies of the meeting minutes should be distributed within 5 business days of the CFT meeting to all team members, and maintained in the participant's case file and uploaded into Tobi.

Any other documentation related to the progress or functioning of the team should be included in the participant's case file, maintained by the Wraparound Facilitator, and entered into the Tobi system.

CANS Assessment Documentation

The Wraparound Facilitator will complete and enter CANS assessments and reassessments in the Data Assessment Registry Mental Health and Addiction (DARMHA); and copies of the assessments should be part of the participant's case file. Results from the CANS assessment are included in the CMHW application, which is entered into the Tobi system.

Agency Documentation Requirements

Each service agency may have additional documentation requirements for the participant's case file and/or clinical record, in addition to what is required by the DMHA and the IHCP. Wraparound Facilitators are responsible for maintaining the documentation requirements for the service agencies they are employed by, in addition to the Wraparound Facilitator documentation requirements.

> *Note:*   *The provider is subject to denial of payment or recoupment for paid claims for services if the provider does not have adequate documentation to support the service billed.*

Billing Information

See Table 4 for Healthcare Common Procedure Coding System (HCPCS) code, code modifier, code description, billing unit, and unit rate information.

92   *Library Reference Number: PRPR10019*
Published: July 10, 2018
Policies and procedures as of July 1, 2018
Version: 3.0

Table 4 – Service Code and Billing Information for Wraparound Facilitation

Service	HCPCS Code and Modifier	HCPCS Code Description	Unit and Rate	Service Ratio	Limitations (Amount/Duration/ Frequency)
Wraparound Facilitation	T2022 HA	Case Management; per month; child mental health wraparound services	$965.49 per unit 1 unit = 1 month	One-to-one	NA

Providers cannot bill for any activity listed in the *Activities Not Allowed* section for this service. See *Section 16* in this module for detailed claims and billing instructions. See the *IHCP Provider Reference Modules* on the *Provider Reference Materials* page at indianamedicaid.com for additional documentation, billing, and service delivery requirements.

> *Note:*   *The provider will provide only those services in the amounts and time frames that have been authorized by the Wraparound Facilitator in the youth's Intervention Plan and approved by the DMHA for the provider identified on the NOA.*

Service Definition

The goal of Habilitation services is to enhance the participant's level of functioning, quality of life, and use of social skills, as well as build the participant's and family's strengths, resilience, and positive outcomes. The Habilitation service provider helps the participant accomplish these goals through development of the following skills:

- Identification of feelings

- Managing anger and emotions

- Giving and receiving feedback, criticism, or praise

- Problem-solving and decision making

- Learning to resist negative peer pressure and develop pro-social peer interactions

- Improving communication skills

- Building and promoting positive coping skills

- Learning how to have positive interactions with peers and adults

See the *Billing Information* section for service code, billing, and reimbursement information for Habilitation services.

Service-Specific Provider Qualifications and Standards

All providers must be Division of Mental Health and Addiction (DMHA)-approved to deliver Child Mental Health Wraparound (CMHW) services. See *Section 13* in this module for additional information about applying for DMHA approval as a CMHW service provider.

Table 5 on the following page shows service-specific qualifications and standards for CMHW Habilitation service providers.

Table 5 – Qualifications and Standards for CMHW Habilitation Service Providers

	Accredited Agency	**Nonaccredited Agency**	**Individual Service Provider**
Provider type eligible to bill for service (yes or no)	Yes **Note:** Accredited agencies must receive approval from the DMHA for an individual to provide this service, based on the qualifications of the individual.	Yes **Note:** Nonaccredited agencies must receive approval from the DMHA for an individual to provide this service, based on the qualifications of the individual.	Yes
License	NA	NA	NA

	Accredited Agency	**Nonaccredited Agency**	**Individual Service Provider**
Certificate	Must demonstrate one of the following: • Approved as a community mental health center by the DMHA (*440 IAC 4.1-2-1*) or • Accredited by a DMHA-approved national accrediting entity (AAAHC, COA, URAC, CARF, ACA, JCAHO, or NCQA – For definitions of accrediting entities, see *Section 24.*)	NA	NA

Other standards	The following standards are required for a DMHA-approved Habilitation provider. (**Note:** Agencies must maintain documentation that the individual providing the service meets service standards and requirements): The individual:
	• Is at least 21 years of age
	• Possesses a high school diploma or equivalent
	• Has 2 years of qualifying experience working with or caring for children and youth with serious emotional disturbance (SED), as defined by the DMHA. See *Section 13* in this module for additional information about SED experience requirements.
	• Has completed and submitted proof of the following screens:
	   – Fingerprint-based national and State criminal history background screen
	   – Local law enforcement screen
	   – State and local Department of Child Services abuse registry screen
	   – Five-panel drug screen, or agency meets same requirements specified under the *Federal Drug Free Workplace Act 41*, *U.S.C. 10 Section 702(a)(1)*.
	• Provide documentation of the following:
	   – Current driver's license
	   – Proof of motor vehicle insurance coverage
	   – Proof of vehicle registration
	All approved providers must complete the DMHA- and Office of Medicaid Policy and Planning (OMPP)-approved training and certifications for CMHW services.		

Provider Supervision Requirements

Habilitation providers are required to obtain one hour of face-to-face, one-to-one supervision with an approved health service provider for every 30 hours of Habilitation services provided. The following supervision standards and requirements apply:

• Supervision time is not billable to CMHW services.

• The supervision time does not need to be completed in a single block of time but can be split up over the month, as long as the one hour of supervision occurs within 14 days of completing 30 hours of Habilitation services.

96

Library Reference Number: PRPR10019
Published: July 10, 2018
Policies and procedures as of July 1, 2018
Version: 3.0

- Supervision must be obtained from a health service provider in psychology (HSPP), as defined by one of the following:
    – *IC 25-33-1*: Licensed marriage and family therapist (LMFT) or licensed clinical social worker (LCSW)
    – *IC 25-23.6*: Licensed mental health counselor (LMHC)
    – *IC 12-15-5-14(d)*: Advanced practice nurse (APN)

- It is the responsibility of the Habilitation provider to ensure that the supervision is completed, as required.

- The supervisor must not be a member of the participant's Child and Family Team (CFT).

- Supervision must include the following:
    – Review of all participant documentation, such as monthly summaries, progress notes, CFT meeting minutes, participant/family's desired treatment outcomes and progress made toward those outcomes
    – Discussion about any significant change to or event with the participant's behavior/affect or within the family

- Supervision must be adequately documented and meet the following standards:
    – Supervision must be documented in a "supervision summary note format" agreed on by the Habilitation provider and supervisor.
    – The note must be signed by the supervisor, including the date of supervision and credentials of the supervisor. In signing the note, the supervisor is verifying that the supervision occurred on a given date and time frame.
    – Documentation of challenges the Habilitation provider has faced and supervisory suggestions for his or her improvement
    – The supervisory role is not intended for CMHW clinical direction on a participant's case. It is intended to provide coaching and supervision for the Habilitation provider only, and his or her ability to maintain quality outcomes with the participant on the CMHW. Because the intent of supervision is to provide coaching and supervision for the provider only, documentation of supervision should be maintained in a separate, secure location. The DMHA may request this documentation at any time.

Eligible Activities

The following activities are eligible for reimbursement under the Habilitation service:

- Activities intended to assist the participant in meeting his or her treatment outcomes through the following:
    – Acquisition, retention, or improvement in self-help, socialization, and adaptive skills necessary to support the participant's needs
    – Acquiring skills that enable the participant to exercise self-control and responsibility over services and supports received or needed

> Note: While the caregiver may "get a break" in the period during which Habilitation services are provided to the participant, the purpose of the service is habilitation and is based on the outcomes and strategies approved on the Plan of Care (POC). Scheduling the Habilitation service solely to provide a break for the caretaker is not acceptable or reimbursable. Respite Care services may be requested on the POC to provide the caregiver needed relief.

- Habilitation services may include, but are not limited to, training and psycho-education in self-direction designed to help the participant achieve one or more of the following outcomes:
  - Develop self-advocacy skills
  - Exercise civil rights
  - Acquire skills that enable the participant to become more independent, integrated, or productive in the community (including skills to stay on task, follow instructions, and manage his or her time)

- Supervision, monitoring, psycho-education, demonstration, mentoring, or support to assist the participant with the acquisition and retention of skills in the following areas:
  - Psycho-educational activities
  - Hobbies
  - Unpaid work experiences (for example, volunteer opportunities)
  - Leisure activities and hobbies related to functional strengths-building and community/public events to encourage positive community connections
  - Assist in developing nonpaid, natural supports for participant and family

Activities Not Allowed

The following activities are not eligible for reimbursement under the Habilitation service:

- Services not identified on the individual POC

- Services provided to anyone other than the participant when the activity occurs in a group setting

- Services not provided face-to-face with the youth

- Service provided to participant's family members

- Service provided to give the family or caregiver respite

- Service provided that is strictly vocational or educational in nature, such as tutoring or any other activity available to the participant through the local educational agency under the *Individuals with Disabilities Education Improvement Act of 2004*; or covered under the *Rehabilitation Act of 1973*

- Activities provided in the service provider's residence

- Leisure activities that provide a diversion rather than work toward a therapeutic objective

- Duplicative services covered under the Medicaid State Plan

- Attending the CFT meetings or completing the *Monthly Summary Report*

- Services furnished to a minor by parents, step-parents, or spouse

- Family therapy

- Interventions provided in a camp setting

- Services provided in a setting that is not home and community-based

Service Delivery Standards

The following list shows service delivery standards for Habilitation services:

- Habilitation services are provided face to face in the participant's home or other community-based setting, based on the preferences of the participant/family and as defined in the POC.

- Need for service must address a need identified through the Child and Adolescent Needs and Strengths (CANS) assessment and CFT's development of the POC.

- Each service/strategy must address an identified desired outcome on the participant's POC.

- The service provider is responsible for participating in the CFT meetings.

- In a group situation, the Habilitation provider's services must be provided only to the participant. The participant may take part in an activity with one or more other children while receiving Habilitation services from the Habilitation provider, as long as the provider is responsible for only that participant.

- No activity fund or incentives may be requested or provided outside those agreed on at the CFT meetings and must be documented appropriately.

- Providers are responsible for the health and welfare of the child during the provision of services and until the child is returned to care of another responsible caregiver.

    Example: Habilitation may be provided to monitor the participant's behavior during a martial arts lesson, but another person or instructor must be responsible for all other individuals in that class.

Documentation Requirements

The provider is responsible for service notes and the monthly summary report. Providers must adhere to all general documentation requirements as described in *Section 15* in this provider module, referenced in service-specific *Sections 20-23*, and according to Medicaid rules and regulations.

Agency Documentation Requirements

Each service agency may have additional documentation requirements for the participant case file and/or clinical record, in addition to what is required by the DMHA and the Indiana Health Coverage Programs (IHCP). Providers are responsible for maintaining the documentation requirements for the service agencies they are employed by, in addition to the Habilitation documentation requirements.

> *Note:* *The provider is subject to denial of payment or recoupment for paid claims for services if the provider does not have adequate documentation to support the service billed.*

Billing Information

See Table 6 for Healthcare Common Procedure Coding System (HCPCS) code, code modifier, code description, billing unit, and unit rate information.

Table 6 – Service Code and Billing Information for Habilitation Services

Service	HCPCS Code and Modifier	HCPCS Code Description	Unit and Rate	Service Ratio	Limitations (Amount/ Duration/ Frequency)
Habilitation Services	H2014 HA	Skills training and development, per 15 minutes; child mental health wraparound services	$19.26 per unit 1 unit = 15 minutes	One-to-one	Limited to 12 units (3 hours) per day and 120 units (30 hours) per month

Providers cannot bill for any activity listed in the *Activities Not Allowed* section for this service. See *Section 16* in this module for detailed claim and billing instructions. See the *IHCP Provider Reference Modules* on the *Provider Reference Materials* page at indianamedicaid.com for general claims and billing information.

> *Note:*   *The provider will provide only those services in the amounts and time frames that have been authorized by the Wraparound Facilitator in the youth's POC and approved by the DMHA for the provider identified on the Notice of Action (NOA).*

100

Library Reference Number: PRPR10019
Published: July 10, 2018
Policies and procedures as of July 1, 2018
Version: 3.0

Section 22: Respite Care Services

Service Definition

Respite Care services are provided to participants unable to care for themselves and are furnished on a short-term basis because of the absence or need for relief of persons who normally provide care for the participant.

The Respite Care service may be provided in the following manner for planned or routine time frames when the caregiver is aware of needing relief or assistance through the Respite Care service:

- On an hourly basis, billed less than 10 hours in the same day

- On a daily basis, as follows:
  - Billed for service provided 10 to 24 hours in the same day
  - Respite Care provided as a daily service cannot exceed 14 consecutive days at one time

Crisis Respite Care service may be provided on an unplanned basis, as an emergency response to a crisis situation in the family, when a caregiver has an unexpected situation requiring assistance in caring for the participant:

- A crisis situation is one where the participant's health and welfare would be seriously impacted without the crisis respite care.

- Crisis Respite Care is provided on a daily basis, billed 8 to 24 hours in the same day.

- Crisis Respite Care is not meant to be scheduled to relieve the family when the participant is in crisis.

- Crisis Respite Care cannot exceed 14 consecutive days at one time.

> *Note: Respite Care may not be provided as a substitute for regular child care to allow the parent/guardian to hold a job.*

Respite Care services may be provided in the following locations:

- Participant's home or private place of residence

- Any Division of Mental Health and Addiction (DMHA)-approved facility licensed by the Indiana Family and Social Services Administration (FSSA), Division of Family Resources (DFR), or by the Indiana Department of Child Services (DCS). (See Table 7.)

Respite Care services must be provided in the least restrictive environment available and ensure the health and welfare of the participant. A participant who needs consistent 24-hour supervision with regular monitoring of medications or behavioral symptoms should be placed in a facility under the supervision of a psychologist, psychiatrist, physician, or nurse who meets respective licensing or certification requirements of his or her profession in the state of Indiana.

See the *Billing Information* section for service codes, billing, and reimbursement information for Respite Care services.

Service-Specific Provider Qualifications and Standards

All providers must be approved by the DMHA to deliver Child Mental Health Wraparound (CMHW) services. See *Section 13* in this module for additional information about applying for DMHA approval as a CMHW service provider.

Library Reference Number: PRPR10019   *101*
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Table 7 shows service-specific qualifications and standards for CMHW Respite Care providers.

Table 7 – Qualifications and Standards for CMHW Respite Care Providers

	Accredited Agency	Nonaccredited Agency	Individual Service Provider
Provider type eligible to bill for service (yes or no)	Yes	Yes **Note:** Nonaccredited community service agencies must receive approval from the DMHA, based on licensure of individuals providing services.	Yes **Note:** Respite Care services may be provided by any relative related by blood, marriage, or adoption who is not the legal guardian and who does not live in the home with the child. Respite Care providers who are relatives must meet all the following: • Approved by the DMHA as a CMHW service provider • Determined by the Child and Family Team (CFT) that use of family or relative is in participant's best interests • Selected by the family/child to provide the service • Maintains the qualifications required for Respite Care service for an individual service provider (see *Other Standards* later in this table)

	Accredited Agency	**Nonaccredited Agency**	**Individual Service Provider**
License	• Emergency shelters licensed under *465 IAC 2-10* • Special needs foster homes licensed under *IC 31-27-4* • Therapeutic foster homes licensed under *IC 31-27-4*, including special needs and therapeutic foster homes only when the licensed child placing agency (LCPA) is the DMHA-approved CMHW services agency provider. The DMHA will have the authority to request a copy of the home study that was conducted on the foster parent providing CMHW Respite Care services • Other child caring institutions licensed under *IC 31-27-3* • Child care centers licensed under *IC 12-17.2-4* or child care homes, licensed under *IC 12-17.2-5*-1 or school-age child care project licensed under *IC 12-17-12* • Medicaid-approved PRTF under *405 IAC 5-20-3.1* and licensed under *465 IAC 2-11-1* as private secure residential facility Agencies must maintain documentation that the individual providing the service meets service standards and requirements listed in Other Standards section later in this table.	• Emergency shelters licensed under *465 IAC 2-10* • Special needs foster homes licensed under *IC 31-27-4* • Therapeutic foster homes licensed under *IC 31-27-4*, including special needs and therapeutic foster homes only when the licensed child placing agency (LCPA) is the DMHA-approved CMHW services agency provider. The DMHA will have the authority to request a copy of the home study that was conducted on the foster parent providing CMHW Respite Care services • Other child caring institutions licensed under *IC 31-27-3* • Child care centers licensed under *IC 12-17.2-4* or child care homes, licensed under *IC 12-17.2-5*-1 or school age child care project licensed under *IC 12-17-12* • Medicaid-approved PRTF under *405 IAC 5-20-3.1* and licensed under *465 IAC 2-11-1* as private secure residential facility Agencies must maintain documentation that individual providing the service meets service standards and requirements listed in Other Standards section later in this section	NA

	Accredited Agency	**Nonaccredited Agency**	**Individual Service Provider**
Certificate	• Community mental health centers approved as a community mental health center by the DMHA (*440 IAC 4.1-2-1*) • Community service agencies accredited by AAAHC, COA, URAC, CARF, ACA, JCAHO, or NCQA (For definitions of accrediting entities, see *Section 24.*)	NA	NA

Other Standards	The DMHA-approved individual providing the service must adhere to the following requirements and standards (agencies must maintain documentation that the individual providing the service meets the following requirements and standards):
	
	• The individual is at least 21 years of age and has a high school diploma, or equivalent.
	• The individual has 1 year of qualifying experience working with or caring for serious emotional disturbance (SED) youth (see *Section 13* in this module for additional information).
	• The individual has completed and submitted proof of the following screens:
	  – Fingerprint-based national and State criminal history background screen
	  – Local law enforcement screen
	  – State and local Department of Child Services abuse registry screen
	  – Five-panel drug screen, or agency meets same requirements specified under the *Federal Drug Free Workplace Act 41, U.S.C. 10 Section 702(a)(1)*
	• Provide documentation of the following:
	  – Current driver's license
	  – Proof of current vehicle registration
	  – Proof of motor vehicle insurance coverage
	• All approved providers must complete the DMHA- and Office of Medicaid Policy and Planning (OMPP)-approved training for CMHW services.		

Family Member as Respite Care Provider

Respite Care services may be provided by any relative related by blood, marriage, or adoption who is not the legal guardian and who does not live in the home with the child. Respite Care providers who are relatives must meet the following criteria:

• Approved by the DMHA as a Respite Care service provider

• Child and Family Team (CFT) determines use of family or relative is in participant's best interests.

• Selected by the family/participant to provide the service

• Maintains the qualifications required for Respite Care service (see Table 7)

Respite Care services may not be provided by parents for a participant who is a minor child, or by any relative who is the primary caregiver of the participant.

104

Library Reference Number: PRPR10019
Published: July 10, 2018
Policies and procedures as of July 1, 2018
Version: 3.0

The DMHA monitors any Respite Care services provided by a relative approved to provide the service to ensure that the service is being provided as specified by the CMHW Services Program policy and procedure, which may include, but is not limited to, an unannounced visit in the home by a CMHW service provider during the period the Respite Care service is DMHA-approved.

Eligible Activities

The following activities are eligible for reimbursement under the CMHW Respite Care service:

- Assistance with daily living skills, including assistance with accessing and/or transporting to and from community activities

- Assistance with grooming and personal hygiene

- Meal preparation, serving, and cleanup

- Administration of medications

- Supervision

Activities Not Allowed

The following activities are **not** eligible for reimbursement under the CMHW Respite Care service:

- Respite care provided by:
    - Parents of a participant who is a minor child
    - Any relative who is the primary caregiver of the participant
    - Anyone living in the participant's residence

- Respite services provided as a substitute for regular child care to allow the parent/caregiver to hold a job, engage in job-related or job search activities, or attend school

- Respite care provided in the residence of any respite service provider unless the provider is authorized as a facility-based Respite Care service provider

- Services not provided face-to-face

- Respite care while the participant is attending school

- Duplicative of any service covered under the Medicaid State Plan

- Crisis respite care that is provided or scheduled when the participant is in crisis

- Billing for time spent attending the CFT meetings or completing the *Monthly Report*

- Daily 24-hour service that exceeds 14 consecutive days at any one time

- Respite provided in a PRTF as a replacement for the participant's need for admission to a PRTF for treatment. Admission to a PRTF for respite must be provided within the service definition for respite.

Service Delivery Standards

The following list shows service delivery standards for Respite Care:

- The service must address a need identified through the Child and Adolescent Needs and Strengths (CANS) assessment and the CFT process, be documented in the Plan of Care (POC), and authorized by the DMHA with a current Notice of Action (NOA).

- Service may be provided in the participant's home, community-based setting, or in a facility authorized by DMHA based on the preferences of the participant/family and documented on the POC.

- The service provider may be responsible for participating in the CFT meetings.

- Crisis respite care must be reported by the service provider to the Wraparound Facilitator within 48 hours of the crisis; and the Wraparound Facilitator will determine the need for continued crisis respite care provision. The Wraparound Facilitator must request additional crisis respite and include justification for the service. Additionally, the Wraparound Facilitator must ensure that the crisis respite was actually used.

- Respite Care service being provided by the same provider to two or more CMHW participants residing in the same home at the same time must adhere to the following:
  – Total units of service for that date of service must be divided by the number of participants receiving the care.
  – Respite Care services for each participant are billed separately.
  – Billing total hours to each participant is considered duplicate billing and is not allowed. Doing so may constitute fraud.

- For Respite Care services provided in a facility-based setting authorized by DMHA, the provider must follow the same ratio requirements as indicated by their licensure. In these settings, there is not a requirement to divide the billing.

Documentation Requirements

The provider is responsible for service notes and the monthly summary report. Providers must adhere to all general documentation requirements as described in *Section 15* in this provider module and according to Medicaid rules and regulations.

Agency Documentation Requirements

Each service agency may have additional documentation requirements for the participant case file and/or clinical record, in addition to what is required by the DMHA and IHCP. Providers are responsible for maintaining the documentation requirements for the service agencies they are employed by, in addition to the Respite Care service documentation requirements.

> *Note: The provider is subject to denial of payment or recoupment for paid claims for services if the provider does not have adequate documentation to support the service billed.*

Billing Information

See Table 8 for Healthcare Common Procedure Coding System (HCPCS) codes, code modifiers, code descriptions, and billing unit and unit rate information.

Table 8 – Service Codes and Billing Information for Respite Care Services

Service	HCPCS Code and Modifier	HCPCS Code Description	Unit and Rate	Service Ratio	Limitations (Amount/ Duration/ Frequency)
Respite routine hourly	T1005 HA	Respite Care services, up to 15 minutes; child mental health wraparound services	$6.09 per unit 1 unit = 15 minutes	One-to-one; or multiple persons: Excluding facility-based respite services, when Respite Care service is being provided by the same provider to two or more participants who reside in the same home at the same time, (both/all of whom are enrolled in the CMHW Services Program), the total units of service for that date of service must be divided accordingly and billed separately for each participant. Billing total hours to each participant is considered as duplicate billing and is not allowed (doing so may constitute fraud). For Respite Care services provided in a facility-based setting authorized by DMHA, the provider must follow the same ratio requirements as indicated by their licensure. In these settings, there is no requirement to divide the billing.	Billed for service less than 10 hours per day.
Respite routine daily	S5151 HA	Unskilled respite care, not hospice; per diem; child mental health wraparound services	$243.77 per unit 1 unit = day		Billed for 10–24 hours per day service Service not to exceed 14 consecutive days at any one time
Respite crisis daily	S5151 HA U1	Unskilled respite care, not hospice; per diem; child mental health wraparound services; respite crisis daily	$292.53 per unit 1 unit = day		Billed for 8–24 hours per day service Service not to exceed 14 consecutive days at any one time
Respite daily in Medicaid Psychiatric Rehabilitation Treatment Facility (PRTF)	S5151 HA U2	Unskilled respite care, not hospice; per diem; child mental health wraparound services; respite daily in Medicaid certified PRTF	$321.52** per unit (**Same as Medicaid PRTF per diem rate) 1 unit = day		Billing day is same policy as Medicaid PRTFs; census at midnight Service not to exceed 14 consecutive days at any one time

Providers cannot bill for any activity listed in the *Activities Not Allowed* section for this service. See *Section 16* in this module for detailed claims and billing instructions. See the *IHCP Provider Reference Modules* on the *Provider Reference Materials* page at indianamedicaid.com for general claims and billing information.

> *Note:*   *The provider will provide only those services in the amounts and time frames*
> *that have been authorized by the Wraparound Facilitator in the youth's POC*
> *and approved by the DMHA for the provider identified on the NOA.*

Section 23: Training and Support for Unpaid Caregiver

Service Definition

Training and Support for the Unpaid Caregiver, commonly referred to as Family Support and Training (FST), is a service provided for an individual who is providing unpaid support, training, companionship, or supervision for the youth. The intent of the service is to provide education and supports to the caregiver that preserves the family unit and increases confidence, stamina, and empowerment. Training and support activities, and the providers selected for these activities, are based on the family/caregiver's unique needs and are identified in the Plan of Care (POC).

> *Note: Non-hourly fees for Training and Support for the Unpaid Caregiver services are reimbursed only to accredited facilities billing for the Division of Mental Health and Addiction (DMHA)-approved service.*

The provision of the Training and Support for the Unpaid Caregiver service is:

- Available for non-hourly Training and Support for the Unpaid Caregiver services, for the costs of registration/ conference training fees, books, and supplies associated with the training and support needs. The non-hourly service may be provided by the following types of DMHA-approved community resources:
    - Nonprofit, civic, faith-based, professional, commercial, or government agencies and organizations
    - Community colleges, vocational schools, or universities
    - Lecture series, workshops, conferences, and seminars
    - Online training programs
    - Community mental health centers
    - Other qualified community service agencies

- Provided on an hourly schedule for face-to-face training by a DMHA-approved Child Mental Health Wraparound (CMHW) service provider (see the following section, *Service-Specific Provider Qualifications and Standards*).

See the *Billing Information* section for service code and billing information for the Training and Support for Unpaid Caregiver service.

Service-Specific Provider Qualifications and Standards

All providers must be approved by the DMHA to deliver CMHW services. See *Section 13* in this module for additional information about applying for DMHA approval as a CMHW service provider.

Table 9 shows service-specific qualifications and standards for CMHW Training and Support for Unpaid Caregiver providers.

Library Reference Number: PRPR10019   *109*
Published: July 10, 2018
Policies and procedures as of July 1, 2018
Version: 3.0

Table 9 – Qualifications and Standards for CMHW Training and Support for Unpaid
Caregiver (FST) Providers

	Accredited Agency	**Nonaccredited Agency**	**Individual Service Provider**
Provider type eligible to bill for service (yes or no)	Yes	Yes	Yes
License	NA	NA	NA
Certificate	• Community mental health centers approved as a community mental health center by the DMHA (*440 IAC 4.1-2-1*), or • Community service agencies accredited by AAAHC, COA, URAC, CARF, ACA, JCAHO, or NCQA – For definitions of accrediting entities see *Section 24.*	NA	NA

Other Standards	The individuals providing the service must meet the following service provider qualifications (agencies must maintain documentation that the individual providing the service meets the following requirements and standards):
	• Is at least 21 years of age
	• Possesses a high school diploma, or equivalent
	• Has 2 years of paid, qualifying experience working with or caring for serious emotional disturbance (SED) youth (see *Section 4* in this module for additional information) or caregivers of children or youth with SED, or certification as a Parent Support Provider through National Alliance on Mental Illness Indiana
	• Can complete and submit proof of the following screens for the individual providing the service:
	  – Fingerprint-based national and State criminal history background screen
	  – Local law enforcement screen
	  – State and local Department of Child Services abuse registry screen
	  – Five-panel drug screen, or agency meets the same requirements specified under the *Federal Drug Free Workplace Act 41, U.S.C. 10 Section 702(a)(1)*
	  – Complete the DMHA- and Office of Medicaid Policy and Planning (OMPP)-approved training and certifications		

Provider Supervision Requirements

Training and Support for the Unpaid Caregiver (FST) providers are required to obtain 1 hour of face-to-face, one-to-one supervision with an approved health service provider for every 30 hours of FST services provided. The following supervision standards and requirements apply:

- Supervision time is not billable to CMHW services.

- The supervision time does not need to be completed in a single block of time but can be split up over the month, as long as the 1 hour of supervision occurs within 14 days of completing 30 hours of FST services.

110

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- Supervision must be obtained from one of the following:
  – Health service provider in psychology (HSPP), as defined by *IC 25-33-1*
  – Licensed marriage and family therapist (LMFT)
  – Licensed clinical social worker (LCSW)
  – Licensed mental health counselor (LMHC) under *IC 25-23.6*
  – Advanced practice nurse (APN) under *IC 12-15-5-14(d)*

- It is the responsibility of the FST provider to ensure that the supervision is completed, as required.

- The supervisor must not be a member of the participant's Child and Family Team (CFT).

- Supervision must include the following:
  – Review of all participant documentation, such as monthly summaries, progress notes, CFT meeting minutes, participant/family's desired treatment outcomes and progress made toward those outcomes
  – Discussion about any significant change to or event with the participant's behavior/affect or within the family

- Supervision must be adequately documented and meet the following standards:
  – Supervision must be documented in a "supervision summary note format" agreed on by the FST provider and supervisor.
  – The note must be signed by the supervisor, including the date of supervision and credentials of the supervisor. In signing the note, the supervisor is verifying that the supervision occurred on a given date and time frame.
  – Challenges the FST provider has faced must be documented, and supervisory suggestions for his or her improvement be provided.
  – The supervisory role is not intended for CMHW clinical direction on a participant's case. It is intended to provide coaching and supervision for the Habilitation provider only, and his or her ability to maintain quality outcomes with the participant on the CMHW. Because the intent of supervision is to provide coaching and supervision for the provider only, documentation of supervision should be maintained in a separate, secure location. The DMHA may request this documentation at any time.

Eligible Activities

Training and Support for the Unpaid Caregiver services allowed activities may include, but are not limited to the following:

- Practical living and decision-making skills

- Child development parenting skills

- Home management skills

- Use of community resources and development of informal supports

- Conflict resolution

- Coping skills

- Gaining an understanding of the participant's mental health needs

- Learning communication and crisis de-escalation skills geared for working with participant's mental health and behavioral needs

Activities Not Allowed

The following activities are not eligible for reimbursement under the Training and Support for the Unpaid Caregiver services:

- Duplicative services covered under the Medicaid State Plan

- Billing for time spent attending the CFT meetings or completing the *Monthly Summary Report*

- Reimbursement is not available for the costs of travel, meals, and overnight lodging.

Service Delivery Standards

The following list shows service delivery standards for Training and Support for the Unpaid Caregiver:

- The service must address a need identified through the Child and Adolescent Needs and Strengths (CANS) assessment and the CFT process, be documented in the Plan of Care (POC), and be authorized by the DMHA with a current Notice of Action (NOA).

- The service provider providing the training and support services must be documented in the POC and authorized by the DMHA with a current NOA.

- Services may be provided in the participant's home, school, or community, as described in the POC.

- Hourly services must be provided face-to-face.

- The service provider (hourly service provider) is required to participate in the CFT meetings.

Documentation Requirements

The provider is responsible for service notes, documentation of supervision, and the monthly summary report. Providers must adhere to all general documentation requirements as described in *Section 15* in this provider module and according to Medicaid rules and regulations.

In addition to general documentation requirements, the non-hourly training and support service provider is required to retain receipt of payment for the activity (class/conference registration, fees, supplies, and so on).

See indianamedicaid.com for additional documentation and service delivery requirements.

Agency Documentation Requirements

Each service agency may have additional documentation requirements for the participant's case file or clinical record, in addition to what is required by the DMHA and the IHCP. Providers are responsible for maintaining the documentation requirements for the service agencies they are employed by, in addition to the documentation requirements for Training and Support for the Unpaid Caregiver.

> *Note:* *The provider is subject to denial of payment or recoupment for paid claims for services if the provider does not have adequate documentation to support the service billed.*

Billing Instructions

See Table 10 for Healthcare Common Procedure Coding System (HCPCS) codes, code modifiers, code descriptions, and billing units and unit rate information.

Table 10 – Service Code and Billing Information for Training and Support for the Unpaid Caregiver Services

Service	HCPCS Code and Modifier	HCPCS Code Description	Unit and Rate	Service Ratio	Limitations (Amount/ Duration/ Frequency)
Training and support for unpaid caregiver – hourly	H2015 HA	Comprehensive community support services, per 15 minutes; child mental health wraparound services	$15.00 per unit 1 unit = 15 minutes	One-to-one; or multiple persons if they are all caregivers for the same CMHW participant	Limited to 8 units/per day (2 hours) No annual limit
Training and support for unpaid caregiver – non-hourly/family	S5111 HA	Home care training, family; per session; child mental health wraparound services	1 unit = registration, fees and/or supplies	Group activities (conference, classes, and so on) are based on the cost of the activity	$500 max/per unit Total of this service, plus S5116, limited to $500 per year **Note:** FST non-hourly fees are only reimbursed to accredited facilities billing for the DMHA-approved service Reimbursement is not available for the costs of travel, meals, and overnight lodging
Training and support for unpaid caregiver – non-hourly/non-family	S5116 HA	Home care training, nonfamily; per session; child mental health wraparound services	1 unit = registration, fees and/or supplies	Group activities (conference, classes, and so on) are based on the cost of the activity	$500 max/per unit Total of this service, plus S5111, limited to $500 per year. **Note:** FST non-hourly fees are only reimbursed to accredited facilities billing for the DMHA-approved service. Reimbursement is not available for the costs of travel, meals, and overnight lodging.

Providers cannot bill for any activity listed in the *Activities Not Allowed* section for this service. See *Section 16* in this module for detailed claims and billing instructions. See the *IHCP Provider Reference Modules* on the *Provider Reference Materials* page at indianamedicaid.com for general claims and billing information.

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Note: *The provider will provide only those services in the amounts and time frames that have been authorized by the Wraparound Facilitator in the youth's POC and approved by the DMHA for the provider identified on the NOA.*

Section 24: Glossary of Terms and Acronyms

1915(i) CMHW Services: *Child Mental Health Wraparound* (CMHW) services provides eligible youth with serious emotional disturbances (SED) with intensive, home and community-based wraparound services that are provided within a System of Care (SOC) philosophy and consistent with wraparound principles. Services are intended to augment the youth's existing or recommended behavioral health treatment plan (Medicaid Rehabilitation Option, managed care, and so on) and address the following:

- The unique needs of the CMHW youth

- A treatment plan built on the youth's and family's strengths

- Services and strategies that assist the youth and family in achieving more positive outcomes in their lives

AAAHC: *Accreditation Association for Ambulatory Health Care*

ACAC: *American Council for Accredited Certification*

Accredited Agency: Must be accredited by a nationally recognized accrediting body (AAAHC, COA, URAC, CARF, ACAC, JCAHO, or NCQA)

ADA: The *American Disabilities Act of 1964* is a wide-ranging civil rights law that prohibits, under certain circumstances, discrimination based on disability.

ANSA: The *Adult Needs and Strengths Assessment Tool* is the Division of Mental Health and Addiction (DMHA)-approved behavioral health assessment tool administered by a qualified individual who is trained and DMHA-certified to administer the tool to determine the individual's strengths, needs, and functional impairment. The tool is administered to individuals who are 18 years of age or older.

Applicant: Refers to an individual applying for a DMHA Youth home and community-bases services (HCBS) program by inquiring about HCBS or completing the HCBS application process.

CANS: *Child and Adolescent Needs and Strengths* assessment tool used to assess the child/youth's and the caregiver's needs and strengths. The CANS assessment ratings are submitted to the DMHA through the DARMHA electronic system. Ratings from the assessment assist in determining an appropriate intensity of needed services. (For additional information about the tool, see the Praed Foundation website at praedfoundation.org).

CA-PRTF Grant: *Community Alternatives to Psychiatric Residential Treatment Facilities Grant*, which was Indiana's 5-year Demonstration Grant from October 1, 2007, through September 30, 2012

Care Plan: One of three components of the Plan of Care (POC). The Care Plan is developed by the Child and Family Team (CFT). It includes the Family Vision Statement, Team Mission Statement, and Functional Strengths for all team members, identification of underlying needs that drive behavior putting the participant at risk for out of home care, and identification of outcomes that are linked to the reasons for referral.

CARF: *Commission on Accreditation of Rehabilitation Facilities*

CFT: The *Child and Family Team* is developed by the participant and family to provide the support and resources needed to assist in developing and implementing an individualized Plan of Care (POC). Individuals selected for the team include the participant, family, Wraparound Facilitator, service providers, non-service providers that support the participant and family, and anyone else the participant and family feel will benefit the treatment process.

CMHC: *Community Mental Health Centers* are approved as such by the DMHA under *440 IAC 4.1-2-1*. The centers offer communities access to a full continuum of behavioral health services.

CMHI: *Children's Mental Health Initiative* is a program administered by the Indiana Division of Child Services (DCS) and provides intensive home and community-based wraparound services to youth with no payer source.

CMHW: The *Children's Mental Health Wraparound* Services Program is a CMS-approved 1915(i) HBCS program adopted by Indiana via *405 IAC 5-21.7.*

CMS: The federal *Centers for Medicare & Medicaid Services* has authority over the 1915(i) State plan amendments in each state. CMS must approve the State's requests to implement the federally funded State Plan Amendment and all subsequent program amendments and funding.

CMS-1500: The CMS-authorized professional claim form used to submit paper claims to the Medicaid fiscal contractor for reimbursement of rendered, DMHA-approved HCBS

COA: *Council on Accreditation*

Crisis Plan: One of three components of the Plan of Care (POC). The Crisis Plan is developed by the Child and Family Team (CFT). It is a comprehensive plan that addresses reasons for referral and risks for the participant and others through utilization of services and natural supports.

CRM: *Customer Record Management*

CSA: *Community Service Agency*, for purposes of HCBS services, may be either accredited or nonaccredited. Both types of agencies must be approved by the DMHA to be enrolled as HCBS providers.

CSL: Indiana's *Consumer Service Line* is a toll-free line for consumers to share compliments, questions, and concerns about services, treatments, procedures, rights, and policies. The line is open Monday-Friday from 8:30 a.m. to 5 p.m. The DMHA contractor processes calls and informs the DMHA. The toll-free number is 1-800-901-1133. Deaf, hard-of-hearing, or speech-impaired individuals can dial 7-1-1 to access the Consumer Service Line.

DA: Indiana *Division of Aging*

DARMHA: The *Data Assessment Registry Mental Health and Addiction* electronic system is accessed to report CANS assessment ratings to the DMHA. The interactive website analyzes the ratings and recommends the appropriate intensity of services, based on the child and family's strengths and needs. This Behavioral Health Decision Model (algorithms that are based on patterns of CANS ratings) is used to make decisions about appropriate intensity of needed services. The Decision Model determines Level of Need (LON) for eligibility for HCBS.

DBA: *Doing Business As*

DCS: The *Department of Child Services* protects children from abuse and neglect by partnering with families and communities to provide safe, nurturing, and stable homes. DCS includes Child Protective Services, Child Support, Foster Care, and Adoption services.

DFR: The *Division of Family Resources*, a division within the Family and Social Services Administration (FSSA), is responsible for processing applications and approving eligibility for Medicaid, Temporary Aid for Needy Families (TANF, or cash assistance), child care assistance, Supplemental Nutrition Assistance Program (SNAP, or food stamps), and employment and training services for low-income clients.

DMHA: The Indiana *Division of Mental Health and Addiction*, within the Family and Social Services Administration, has responsibility for the daily operation of the HCBS program, including provider enrollment, eligibility determinations, and service authorizations.

DXC: *DXC Technology*, the Indiana Medicaid fiscal agent responsible for maintaining the Core Medicaid Management Information System (*Core*MMIS) database for all Medicaid participants, provider enrollment, authorized Indiana Health Coverage Programs (IHCP) services, IHCP claim processing, and reimbursement for eligible IHCP providers. This includes all approved HCBS participants, DMHA-approved services, and enrolled providers of HCBS. DXC assigns all IHCP Provider IDs (see later entry) required for reimbursement of all IHCP claims. DXC also maintains the *IHCP Provider Reference Modules* for all IHCP providers.

FSSA: The Indiana *Family and Social Services Administration* is the single State Medicaid agency. It was established by the General Assembly in 1991 to consolidate and better integrate the delivery of human services by State government. The FSSA includes the Division of Aging (DA), Division of Disability and Rehabilitation Services (DDRS), Division of Family Resources (DFR), Division of Mental Health and Addiction (DMHA), and Office of Medicaid Policy and Planning (OMPP).

FST: *Family Support and Training* is a common term for family training. This service has been renamed **Training and Support for the Unpaid Caregiver** for the CMHW program. See *Training and Support for the Unpaid Caregiver.*

Habilitation: Services to enhance the participant's level of functioning, quality of life, and use of social skills, as well as build the participant's and family's strengths, resilience, and positive outcomes.

HCBS: *Home and Community-Based Services* is a system of services provided to someone residing in a community setting, as opposed to an institutional or residential setting. For Medicaid purposes, *HCBS* generally refers to home and community-based services programs authorized by CMS under Section 1915(c) of the *Social Security Act.*

HFW: *High Fidelity Wraparound* is a process of delivering services that is usually reserved for youth at risk for out-of-home placement.

HIPAA: *Health Insurance Portability and Accountability Act of 1996* refers to mandated requirements for the adoption of national standards for healthcare, including the protection of health information and standard unique identifiers for all healthcare providers, as well as coding healthcare services for approving, billing, reimbursing, and tracking.

HSPP: *Health Service Provider in Psychology*, as defined by *IC 25-33-1*

IAC: *Indiana Administrative Code* refers to the Indiana State policy and procedures

IC: *Indiana Code* consists of Indiana State statutes that govern the IAC

IDEA: *Individuals with Disabilities Education Act* (1997) under the U.S. Department of Education law ensures services to eligible children with disabilities throughout the nation. IDEA governs how states and public agencies provide early intervention, special education, and related services. IDEA Part B includes special education and related services to children and youth ages 3 to 21.

IDEIA: *Individuals with Disabilities Improvement Education Act* (in 2004, IDEA was reauthored and renamed to amend the 1997 act)

IHCP: *Indiana Health Coverage Programs* within the OMPP

INSOC: *Indiana Strengthening Our Communities – Supporting Our Youth in their Communities* is Indiana's System of Care name for the State-level system.

Individual Provider: Provider that practices privately and not under an agency

Intervention Plan: One of three components of the Plan of Care (POC). The Intervention Plan authorizes services and generates a Notice of Action (NOA) for providers.

JCAHO: The *Joint Commission on the Accreditation of Healthcare Organizations*

LCSW: *Licensed clinical social worker*

LMFT: *Licensed marriage and family therapist*

LMHC: *Licensed mental health counselor*, as defined by *IC 25-23.6*

LOC: *Level of Care* is one of the federal eligibility requirements for the CA-PRTF grant and the PRTF Transition Waiver.

LON: *Level of Need* is one of the federal eligibility requirements for the HCBS program. CMS requires that a participant must meet defined requirements for LON and eligibility to enroll in the 1915(i) HCBS services State Plan Amendment.

LPI: *Legacy Provider Identifier*. See *Provider ID.*

MCE: A *managed care entity* is contracted to provide and manage benefits for members enrolled in a managed care program, such as the Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise. In a full-risk contract, the MCE agrees to provide all benefits on a per-member per-month basis, known as full capitation.

Member ID: *Member identification number*, also known as RID, used to identify individuals eligible for Indiana Health Coverage Programs (IHCP) services, including tracking and claim processing for eligible services. This includes the HCBS program.

MRO: *Medicaid Rehabilitation Option* refers to any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of a member to his or her best possible functional level.

NCQA: *National Committee for Quality Assurance*

NOA: *Notice of Action* (*State Form-HCBS Form 5*) is a written notice given to each HCBS applicant and participant for any action that will affect his or her HCBS benefits. The NOA includes actions to approve or deny an applicant's eligibility for HCBS; all DMHA-approved CMHW benefits; all subsequent changes to increase, reduce, or terminate any or all HCBS; the effective dates and reasons for the actions taken; and the individual's appeal rights. The designated service providers also receive a copy of the NOA for prior authorization to provide and bill the IHCP for the DMHA-approved services. The IHCP will deny reimbursement for any service that is not listed on the NOA or exceeds the DMHA-approved amount of each service.

Nonaccredited Agency: A community service agency that does not have a national accreditation

NPI: *National Provider Identifier* is the 1996 HIPAA-mandated standard unique identifier for all healthcare providers. Unique NPIs are assigned by application to the National Plan and Provider Enumeration System that collects identifying information on healthcare providers. (**Note:** An assigned NPI is not needed for CMHW service providers who do not perform healthcare services. HCBS providers may submit claims using their Provider ID.)

NWIC: The *National Wraparound Implementation Center* is a partnership among the University of Washington School of Medicine, Portland State University School of Social Work, and the University of Maryland School of Social Work. These universities collaborate to support communities to implement High Fidelity Wraparound (HFW) that is effective and sustainable for children and youth with behavioral health needs and their families.

OBHP: Qualifies as an *Other Behavioral Health Professional*, as defined in *405 IAC 5-21.5-1(d)*

OMPP: The *Office of Medicaid Policy and Planning* is a division within the Family and Social Services Administration. The OMPP administers the Indiana Health Coverage Programs in accordance with federal and State requirements, which includes responsibility for financial oversight of the HCBS program.

Outpatient mental health services: Services defined under *405 IAC 5-20-8,* formerly referred to as "Medicaid Clinic Option" services.

Participant: Refers to an individual who has been deemed eligible for HCBS services by the DMHA

POC: The *Plan of Care* is the individualized plan of treatment that guides the HCBS delivery and includes the Intervention Plan, Care Plan, and Crisis Plan.

Provider Agency: A DMHA-approved agency provider of HBCS

Provider Agency Staff Member: Refers to a staff member providing HBCS under the direction and supervision of a DMHA-approved provider agency

Provider Healthcare Portal (Portal) is a secure, web-based tool where CMHW providers may view CMHW authorization, claim, and other information. Provider enrollment, provider profile updates, and claims (including claims for DMHA-approved CMHW services rendered) may also be submitted via the Portal. The Portal is available at portal.indianamedicaid.com. For more information about using the Portal, see the *Provider Healthcare Portal* module.

Provider ID: A unique identifier, formerly referred to as the Legacy Provider Identifier (LPI), assigned to IHCP-enrolled providers, including service providers, for submission of all claims for IHCP reimbursement. This number is assigned by the Medicaid fiscal agent during the provider enrollment process.

PRTF: *Psychiatric Residential Treatment Facilities* were implemented in January 1, 2004. PRTFs in Indiana are licensed under *465 Indiana Administrative Code 2-11* as private, secure care institutions and must be accredited by either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); American Osteopathic Association (AOA); or the Council on Accreditation of Services for Families and Children (COA). PRTFs receive reimbursement to provide prior authorized institutional care to children with serious emotional disturbance (SED) who are under the age of 21 (or continued services to children under age 22 who were in the PRTF immediately prior to their 21st birthday).

PRTF Transition Waiver: *Psychiatric Rehabilitation Treatment Facility Transition Waiver* was a program administered by the Indiana Division of Mental Health and Addiction (DMHA) that provided intensive home and community-based wraparound services for youth who were enrolled in the CA-PRTF Demonstration Grant when the grant expired in September 2012. The waiver continued to provide access to the services until the youth who were enrolled achieved treatment goals and transitioned to a less intensive mode of service (or aged out of the program). This waiver is not accepting any new participants.

Rendering Provider/Rendering NPI: A provider that renders Children's Mental Health Wraparound (CMHW) services. These providers must complete a *Rendering Provider Application Form* to request DMHA authorization. Providers must obtain rendering National Provider Identifiers (NPIs) for each authorized staff member to be eligible for reimbursement of services.

Respite Care: Services provided to participants who are unable to care for themselves. These services are furnished on a short-term basis because of the absence or need for relief of persons who normally provide care for the participant.

RID: See *Member ID.*

SED: *Serious Emotional Disturbance*, as defined in *440 IAC 8-2-4* (individuals from age of 6 through 17)

SMI: *Serious Mental Illness* refers to persons (18 years of age or older) with serious and long-term mental disorders that impair their capacity for self-care, interpersonal relationships, work, and schooling.

Tobi: The FSSA's electronic management system that processes and tracks the HCBS program. The database stores all applications, demographic information, the CANS information, documentation of choice, grant providers, pick lists, POCs, costs, and approvals and denials, and is used by the Wraparound Facilitator to manage the POC and generate and store the NOAs. After the Wraparound Facilitator enters the approved POC in the DMHA database, the DMHA database interfaces with the Medicaid Management Information System to authorize the services for Medicaid reimbursement as those services are provided and billed.

Training and Support for the Unpaid Caregiver: A service provided for an individual who is providing unpaid support, training, companionship, or supervision for the youth This service was formerly called *Family Support and Training (FST).*

Unpaid Caregiver: Refers to any individual who does not receive compensation for providing care or services to a Medicaid member.

URAC: *Utilization Review Accreditation Commission*

WFI 4.0: Wraparound Fidelity Index measures fidelity to the wraparound process, as established by the NWIC.

Wraparound: An ecologically based process and approach to care planning that builds on the collective action of a committed group of family, friends, community, professional, and cross-system supports, mobilizing resources and talents from a variety of sources and resulting in the creation of a POC that is the best fit between the family vision and story, team mission, and youth and family's strengths, needs, and strategies. Wraparound provides youth and their families with *access, voice, and ownership* in the development and implementation of their POC.

Wraparound Facilitation: A CMHW service. Children and youth who participate in the HCBS program must receive Wraparound Facilitation. The individual who facilitates and supervises this process is the Wraparound Facilitator.

YSS: *Youth Satisfaction Survey*, used for evaluation purposes, is a consumer satisfaction survey used for monitoring participant satisfaction with HCBS.

YSSF: *Youth Satisfaction Survey for Families* is a consumer satisfaction survey used for CMHW evaluation purposes to monitor family members' satisfaction with HCBS.