Statement of Work
High Fidelity Wraparound
Care Management Entity
State of Wyoming

PROGRAM NAME: Magellan Wyoming Care Management Entity

PROVIDER TYPE: Family Care Coordinator
Wyoming High Fidelity Wraparound

SERVICE DESCRIPTION:
A Family Care Coordinator is responsible for comprehensive, strength-based, and culturally responsive support to families with complex needs. Their role is to bring together the family and a team (such as teachers, counselors, and other supporters) to create and follow a personalized plan that meets the family's needs and goals.

The main responsibilities include:

1. Team Building and Planning: The coordinator helps build a supportive team around the family, ensuring that everyone involved understands the family's strengths, culture, and challenges. Together, they set achievable goals and develop a plan tailored to the family's needs. The Family Care Coordinator should work to prepare the family for each step of the Wraparound process to build an individualized plan that meets that family's needs. If needed the Family Care Coordinator should connect the family to the auxiliary roles within High Fidelity Wraparound to aid the process.
2. Goal Setting and Outcome Monitoring: They guide the family through identifying specific goals for obtaining the youth and family's vision, whether related to education, mental health, housing, or other life areas. They keep track of progress, adjusting the plan as needed. The Family Care Coordinator tracks each piece of the family's documentation through the Electronic Health Record for outcome management.
3. Connecting with Resources: Family Care Coordinators help families access community resources and services, such as financial support, mental health services, educational assistance, and job training.
4. Ongoing Support and Advocacy: They provide regular check-ins, ensuring the family stays on track and has the support they need. The coordinator also coordinates services with the family within systems like schools, social services, and health care to ensure their voices are heard and their rights respected.

In High Fidelity Wraparound, the Family Care Coordinator is committed to empowering families, respecting their values, and helping them build a sustainable support network that will continue even after the formal services end. Their goal is to improve the family and youth's overall stability and well-being.

The Family Care Coordinator is the mandatory service for all youth enrolled in High Fidelity Wraparound. A Family Care Coordinator will not exceed a capacity of 1:15 enrolled youth for their caseload. The Team will coordinate development of a wraparound plan for all enrolled individuals in accordance with requirements under the State's 1915(b) and 1915(c) Waivers. This plan should include the following interventions: behavioral health, Early Periodic Screening and Diagnostic Treatment (EPSDT) and who the primary care physician is for the youth. It does not substitute for the service planning requirements of the behavioral health providers involved with the youth and family. It coordinates services and supports across multiple plans through the Team and as the Plan of Care develops.

SUMMARY OF PRINCIPLES

The values of wraparound match the system of care framework. At its core, wraparound focuses on listening to families and respecting their choices. This approach, called "voice and choice," ensures that the family's perspective (including the youth's) is the most important part of planning and decision-making.

Wraparound values emphasize creating plans and services that are personalized, family-led, culturally respectful, and connected to the community. It also aims to build a family's natural and community support system by strengthening relationships and using resources within their network. Wraparound focuses on strengths, helping families and teams recognize and build on their talents and abilities.

In the High Fidelity Wraparound model, all roles—Family Care Coordinators, Family Support Partners, Youth Support Partners, respite providers, and as applicable their supervisors—must follow the 10 principles supported by the National Wraparound Initiative (http://www.nwi.pdx.edu) and the Substance Abuse and Mental Health Services Administration (SAMHSA). These principles are:

1. **Family voice and choice:** The family's input is key.
2. **Team-based:** A supportive team works together.
3. **Natural supports:** Uses resources like friends and community connections.
4. **Collaboration:** Everyone works as a team.
5. **Community-based:** Services are rooted in the family's community.
6. **Culturally competent:** Plans respect the family's culture.
7. **Individualized:** Tailored to each family's unique needs.
8. **Strengths-based:** Focuses on talents and abilities.
9. **Unconditional:** Committed to helping the family, no matter what.
10. **Outcome-based:** Focused on achieving positive results.

REQUIREMENTS AND PERFORMANCE OUTCOMES OF A FAMILY CARE COORDINATOR

1. Timely Engagement and Coordination
   - Outcome: The FCC will engage with families promptly and efficiently to ensure a smooth enrollment into High Fidelity Wraparound.
     - Performance Metrics:

        - Contact the family within 72 hours of notification of application authorization.
        - Ensure timely and successful enrollment into the High Fidelity Wraparound program, with full documentation of choice of provider along with other required intake forms.
        - If the family chooses to initiate respite services, the Family Care Coordinator will complete a parent information exchange document for authorization.
    - Target: 100% of families contacted within 72 hours, with documentation of provider choice for all enrollees.

2. Assessment and Family Story Development
   - Outcome: The FCC will complete comprehensive assessments within the first 60 days of enrollment, including the Family Story, CANS (Child and Adolescent Needs and Strengths) assessment, and ACE (Adverse Childhood Experiences) screening.
     - Performance Metrics:
       - Complete Family Story, CANS, and ACE screening within 60 days.
       - Document readiness for transition and initial needs assessment.
     - Target: 100% completion within 60 days.
3. Family Preparation and Safety Planning
   - Outcome: The FCC will help families prepare for team involvement, safety planning, and behavioral crisis management.
     - Performance Metrics:
       - Development of an individualized safety plan within the first 60 days.
       - Ensure that all behavioral exploration and crisis team preparations are made with the family.
     - Target: 100% of families prepared with a safety plan within the first 60 days.
4. Team Formation and Support
   - Outcome: The FCC will support the creation of a team-based process, helping families identify natural and formal supports.
     - Performance Metrics:
       - Facilitate the creation of a comprehensive team with formal and natural supports.
       - Schedule regular Child and Family Team (CFT) meetings and emergency meetings, ensuring the family has control over location unless safety concerns arise.
     - Target: 100% team formation and meetings scheduled within the first 30 days, with family input on location.
5. Individualized Care Plan Development
   - Outcome: The FCC will develop a person-centered, individualized care plan based on the family's unique needs, utilizing assessments and the Family Story.
     - Performance Metrics:
       - Creation of an individualized care plan within the first 60 days of enrollment.
       - Ensure that every plan is reviewed regularly (best practice every 45 days), and adjustments are made as necessary.

        - Ensure full sign-off by the youth, family, and legal guardian on every plan of care.
    - Target: 100% creation of care plans within 60 days, with reviews occurring every 45 days.

6. Goal Setting and Objective Development
- Outcome: The FCC will assist the family in setting clear, measurable goals and objectives for improvement.
    - Performance Metrics:
        - Work with the family to set measurable objectives based on identified needs and strengths.
        - Review goals during each plan of care meeting, and adjust as necessary.
    - Target: 100% families will have measurable objectives set within 60 days and reviewed every 45 days at Child and Family Team Meetings

7. Service Coordination and Appointment Scheduling
- Outcome: The FCC will ensure timely access to services, including scheduling appointments and coordinating with providers.
    - Performance Metrics:
        - Assist the family in scheduling and attending appointments with appropriate service providers.
        - Ensure that families are referred to necessary services (e.g., healthcare, education, housing) and those services are implemented in a timely manner.
    - Target: 100% of CME network providers will be available during their defined business hours, ensuring that families can access services as needed within the established timeframes.
    - Target: 100% of families are connected to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services (example: Primary Care Physician, dentist, etc.) as documented in the Electronic Health Record.

8. Regular Family Check-ins and Monitoring
- Outcome: The FCC will regularly check in with families to monitor progress and reassess their needs.
    - Performance Metrics:
        - Meet with the youth (as age appropriate) and caregiver at least two times every 30 days.
        - Conduct regular follow-ups to monitor progress and adjust the care plan.
    - Target: 100% of families will have bi-monthly check-ins and progress monitoring.

9. Resource Connection and Advocacy
- Outcome: The FCC will assist the family in accessing community and healthcare resources, as well as advocating for their needs.
    - Performance Metrics:
        - Connect families with appropriate resources, such as healthcare, housing, or education.
        - Educate families on available services, financial eligibility applications, and self-advocacy.

- Target: 90% of families will be successfully connected with at least one documented community resource in the electronic health record.

10. Crisis Management and Support
    - Outcome: The FCC will ensure families have effective crisis management plans and are supported during emergencies.
        - Performance Metrics:
            - Develop and document crisis plans for every family, with clear roles and contacts.
            - Track and manage any incidents of crisis, including out-of-home placements.
        - Target: 100% of families will have a crisis plan, and critical incidents (e.g., out-of-home placements) will be documented within 24 hours of notification of the incident and reviewed promptly.
11. Documentation and Record-Keeping
    - Outcome: The FCC will ensure all interactions, assessments, care plans, and progress are documented according to regulatory requirements.
        - Performance Metrics:
            - Ensure that all documentation (e.g., care plans, meeting notes) are entered into the approved Electronic Health Record system within defined timelines.
        - Target: 100% of required documentation entered within 3 business days of interactions or events.
12. Tracking and Reporting on Youth's Care
    - Outcome: The FCC will track critical milestones for each enrolled youth, including the following:
        - Out of Home Placements
        - Changes to timelines for return to home
        - Lengths of stay beyond 18 months
        - Youth who are turning 18 years old
        - Any time additional support is needed.
        - Performance Metrics:
            - Document and track out-of-home placements within the custody status while enrolled in High Fidelity Wraparound.
            - Request a case review to report any changes.
        - Target: 100% tracking and documentation of any of the above situations and case reviews requested.
13. Compliance with Privacy Regulations
    - Outcome: The FCC will ensure all care coordination activities comply with privacy laws and regulations (e.g., HIPAA).
        - Performance Metrics:
            - Ensure that all interactions and documentation adhere to privacy requirements (45 CFR, parts 160 and 164).
        - Target: 100% compliance with privacy requirements.
14. Evaluating Service Effectiveness
    - Outcome: The FCC will evaluate the effectiveness of services and adjust care plans as necessary.

- Performance Metrics:
  - Regular evaluation of whether goals have been met and if the care plan needs revisions.
  - Document progress and outcomes at least 90 days.
- Target: 100% evaluation of care plans with necessary adjustments.

The responsibility to continuously demonstrate quality service delivery to youth and families enrolled in High Fidelity Wraparound is the responsibility of each Family Care Coordinator. The Care Management Entity will monitor all provider performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the Care Management Entity and the State, consistent with industry standards or State laws and regulations. The Care Management Entity will identify strengths and areas for improvement, and the provider will be asked for performance improvement and/or corrective action or be terminated if substantial progress toward corrective action is not taken to meet the defined deficiencies. All Family Care Coordinators are required to provide to the Care Management Entity within defined timelines outlined in detail in Magellan's Provider Handbook.

FREQUENCY/DURATION:

The Care Management Entity, via prior authorization of the plan of care, will administer a prior authorization for the requested frequency and duration of services (units requested) on a 90 day cycle dependent on the needs of the youth/family. This is based on the following documentation:

- Family Story and Culture
- CANS
- CASII/ECSII
- Level of Care
- Intake Documents
- The Needs as identified by the Child and Family Team.

The Family Care Coordinator shall ensure that each enrolled youth receives no more than 4 hours of Care Coordinator per day. Per Medicaid policy, do not submit a claim for payment that is not fully documented in Magellan's electronic health record.

REPORTING REQUIREMENTS

High Fidelity Wraparound providers adhere to financial, quality, and other reporting requirements at the request of Wyoming Magellan Care Management Entity.

NON-REIMBURSEABLE ACTIVITIES

The following activities by Wraparound Family Care Coordinators are not reimbursable:

- Activities that are not delivered to a specific enrolled child or the family of that child in support of the child's Plan of Care.
- The High Fidelity Wraparound provider must ensure that only specifically documented coordination and delivery of High Fidelity Wraparound services and supports are reimbursed by the Care Management Entity. Activities that are the responsibility of another State agency and are excluded from Medicaid coverage (such as child welfare permanency planning or behavioral health services) are not to be billed as High Fidelity Wraparound.
- Participation by other Medicaid providers in the planning process should be reimbursed separately only if appropriate and in accordance with the guidelines for service delivery for that provider and is not covered by this Statement of Work.
- Providers adhere to noncovered services per the CMS 1500.
- Non covered services also include but are not limited to:
    - Consultation to other persons and agencies about non-Members, public education, public relations activities, speaking engagements and education
    - Services not provided through face-to-face contact with the Member, other than collateral contacts necessary to develop or implement the Plan of Care or aid in the High Fidelity Wraparound process.
    - Residential room, board, and care
    - Substance abuse programs or curriculum
    - Individual recreation and socialization services
    - Vocational services and training
    - Cancelled or missed appointments
    - Day care
    - Remedial or other formal education
    - Travel time
    - Transportation
    - Record keeping time
    - Time spent writing progress notes, assessments or Plan of Care without the member or family.
    - Legal Services
    - Substance Abuse Treatment Programs
    - Alternative Therapies
    - Spiritual Support
    - Fundraising
    - Renovation
    - Tutoring
    - Driving lessons

STAFFING REQUIREMENTS

Provider qualifications required in order to contract with the Care Management Entity for the provision of High Fidelity Wraparound services are stipulated below.

Family Care Coordinator: The High Fidelity Wraparound Family Care Coordinator must meet the following prerequisites:

- Bachelor's-level degree in a human services (or related) field or Bachelor's-level degree in any field with a minimum of two years of full-time experience working in relevant family, children/youth or community service capacity; or
  Two years of work/personnel experience in providing direct service or linking of services for youth experiencing serious emotional disturbance.
- At least 21 years of age.
- Possess a valid driver's license, appropriate auto insurance and reliable transportation.
- CPR and First Aid Certification.
- Completion of the required Care Management Entity and State training for provider.
- Completion of the required Care Management Entity and State training and credentialing processes High Fidelity Wraparound Family Care Coordinators.
- Enrolled as a Wyoming Medicaid Provider through the State's Fiscal Agent.
- Successful completion of all Central Registry and FBI/DCI background screenings.
- Demonstration of high fidelity to National Wraparound Initiative standards through ongoing participation in wraparound fidelity monitoring using the Wraparound Fidelity Assessment System.
- Initial Training is a prerequisite as well as participation in annual recertification.

TRAINING REQUIREMENTS

Please refer to the Provider Certification Guide for specific training requirements for the Family Care Coordinator. This can be found at www.magellanofwyoming.com.

FIDELITY MONITORING

To maintain a contracting relationship with the Care Management Entity, all providers must complete initial training and be either in the process of certification or certified. Re-certification is due annually. Documentation of annual staff re-certification will be provided to the Care Management Entity for each High Fidelity Wraparound provider to demonstrate continued adherence to the fidelity standards. The Care Management Entity certification of a High Fidelity Wraparound provider will be withdrawn if current requirements, training and documentation are not maintained. Please refer to the Provider Handbook. The Magellan standards include requirements for cultural competency, and other National Wraparound Initiative standards that every High Fidelity Wraparound provider is expected to adhere to and demonstrate for quality and excellence.

WFI-EZ is a tool Magellan uses in monitoring High Fidelity Wraparound. Using the Wraparound Fidelity Assessment System tools (i.e. WFI-EZ) is essential in establishing and maintaining fidelity to the wraparound model. High Fidelity Wraparound providers are expected to participate in completing the WFI-EZ and support caretakers and youth to complete it too. The FCC shall prompt the enrollee and their family thirty (30) calendar days before the WFI-EZ assessment date. Participation and review of fidelity monitoring and quality improvement activities to improve fidelity and meet additional minimum fidelity requirements established by the Care Management Entity is an essential part of improving wraparound for families.

ENROLLED POPULATIONS TO BE SERVED BY WRAPAROUND

Individuals found eligible for the High Fidelity Wraparound program will be enrolled in the Care Management Entity and the Children's Health Insurance Program Reauthorization Act, the federal grant that allows for the Care Management Entity. The following individuals will be eligible for Medicaid reimbursement under the Care Management Entity program:

- Children eligible for Medicaid; and
- Children eligible for Medicaid through the 1915(c) Waiver services

Children identified as meeting the criteria for the High Fidelity Wraparound as determined by the CASII, ECSII and Level of Care must be:

- Youth ages 6 to 20 years old must have a minimum CASII composite score of 20, and youth ages 4 and 5 years old must have an ECSII score of 18 to 30 OR the appropriate social and emotional assessment information provided to illustrate level of service needs; and
- Must have a DSM Axis 1 or ICD diagnosis that meets the State's diagnostic criteria.

And may include:

- Medicaid youth ages 4 to 21 at risk of out-of-home placement (defined and identified as youth with 200 days or more of behavioral health services within one State fiscal year).
- Medicaid youth ages 4 to 21 who currently meet Psychiatric Residential Treatment Facility level of care or are placed in a Psychiatric Residential Treatment Facility.
- Medicaid youth ages 4 to 21 who currently meet acute psychiatric stabilization hospital level of care; had an acute hospital stay for mental or behavioral health conditions in the last 365 days; or are currently placed in an acute hospital stay for mental or behavioral health conditions.
- Youth on the Children's Mental Health Waiver (1915(c); or
- Medicaid youth ages 4 to 21 referred to the Care Management Entity (who meet defined eligibility, including clinical eligibility and SED criteria).

DOCUMENTS BY REFERENCE

In addition to this contract and statement of work, all providers are required to adhere to the stipulations, regulations, performance guidelines and reporting as fully described in the following documents.

- 1915 (c) HCBS Waiver
- 1915 (b) Waiver: Wyoming Medicaid's Youth Initiative – A High Fidelity Wraparound Community-based Alternative for Youth with Serious Emotional/Behavioral Challenges
- Direct billing and Wyoming Rules