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:

Wraparound is a family-driven, youth guided process that uses the family's strengths as well as their supports to create a plan to meet the family's needs and create hope. The High Fidelity Wraparound model aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. Additionally, wraparound plans are more holistic than traditional care plans in that they address the needs of the youth within the context of the broader family unit and are also designed to address a range of life areas. Through the team-supported planning and implementation process, wraparound also aims to increase the problem-solving skills, coping skills, self-efficacy and a social support network of young people and their family. The ultimate goal is to help youth develop and maintain positive connections within their communities, achieve in school, enjoy health and wellbeing, have friends, and successfully live with families.

The provider will facilitate High Fidelity Wraparound using Child and Family Teams to carry out specific activities as part of the network of the Care Management Entity. 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. The Family Care Coordinator is the mandatory service for all youth enrolled in High Fidelity Wraparound. This plan is referred to as a Plan of Care. Although this plan includes 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. Instead, it coordinates services and supports across multiple plans through the Team and the Plan of Care it develops.

SUMMARY OF PRINCIPLES

The values of wraparound, as expressed in its core principles, are fully consistent with the system of care framework. Our philosophy of care begins with an open, non-judgmental mindset and allows for the principle of "voice and choice", which stipulates that the perspectives of the family – including the youth –must be given primary importance during all phases and activities of wraparound. The values associated with wraparound further require that the planning process itself, as well as the services and supports provided, should be individualized, family driven,

culturally competent, and community based. Additionally, the wraparound process should increase the "natural and community support" available to a family by supporting the strengthening of interpersonal relationships and utilizing other resources that are available in the family's network of social and community relationships. Finally, the wraparound process should be "strengths based", including activities that purposefully help the team, child and family to recognize, utilize, and build talents, assets, and positive capacities.

All functions within the High Fidelity Wraparound model – The Family Care Coordinators, Family Support Partners, Youth Support Partners, Respite providers and supervisors are expected to adhere to the ten principles outlined and supported by the National Wraparound Initiative (http://www.nwi.pdx.edu/) and the Substance Abuse and Mental Health Services Administration (SAMHSA). Those principles are:

1. Family voice and choice
2. Team based (supported)
3. Natural supports
4. Collaboration
5. Community based
6. Culturally competent
7. Individualized
8. Strengths based
9. Unconditional
10. Outcome based

Specialized Wraparound Service Requirements include:

- Make initial contact with the family within 72 hours upon receipt of the prior authorization of an application.
- Carry out intake activities for qualifying High Fidelity Wraparound referrals from the Care Management Entity, including coordinating with other High Fidelity Wraparound providers and respite providers.
- Completion of the Strengths, Needs, Culture Discovery, CANS, ACE Survey, Crisis Team, Child and Family Team and Plan of Care (including a crisis plan) within the first 46 days of enrollment.
- Completion of the Child and Adolescent Needs and Strengths (CANS) assessment and the Transition Assets continues every 180 days after the initial one.
- Facilitate the child and family team process, through intensive care management with the following maximum ratio:
    - Family Care Coordinator to child ratio of 1:15
- Input individual data into a management information system capable of tracking and monitoring functions and integrated with the Care Management Entity's electronic health record, Fidelity EHR and any other tools identified by the Care Management Entity.
- Develop plans of care consistent with federal requirements in conjunction with the Care Management Entity under the State's Medicaid 1915(b) and 1915(c) waivers.
- Work with families to expand access to federal funding when available (i.e., help them complete Medicaid applications).

- The Team, which includes professional, community and natural supports, will take the lead in the development of the Plan of Care and documented by the Family Care Coordinator.
- Needs and goal development are based on family needs and informed by the CANS. Goals are established based upon the child/youth's prioritized needs with interventions built upon team, youth and family's identified strengths.

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 CHPR, 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).

PERFORMANCE OUTCOMES

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 at a minimum the following:

1. The Family Care Coordinator must document that each Plan of Care receives full signoff by attending members of the Team including the youth, family, and legal guardian (when applicable).
2. Each Plan of Care has an identified crisis and safety plan section that identifies potential crisis scenarios, what action steps or strategies need to be implemented, and lists the persons responsible.
3. The Family Care Coordinator must document the Child and Family Team and all attempts to coordinate with the child's primary care physician in the development of the Individualized Plan of Care. If the child's primary care physician wishes to take part in the development of the Individualized Plan of Care, the Family Care Coordinator must ensure that the primary care physician is involved to the extent he or she desires.
4. The Family Care Coordinator must demonstrate all coordination of care activities protect each enrollee's privacy in accordance with the privacy requirements at 45 CFR, parts 160 and 164, subparts A and E, to the extent that they are applicable.
5. The Family Care Coordinator must ensure the legal guardian was given freedom of choice to choose a Family Care Coordinator. The Care Management Entity will provide the family Freedom of Choice to select a Family Care Coordinator at referral. If the family selects a Family Care Coordinator directly, the Freedom of Choice form needs to be submitted by the Family Care Coordinator to the Care Management Entity prior to enrollment.
6. The Family Care Coordinator must request, through defined processes, a prior authorization to complete a High Fidelity Wraparound application for youth referred to the Care Management Entity. The Care Management Entity will authorize the qualification and enrollment into High Fidelity Wraparound and provide a prior authorization for the application of seven days, and the initial enrollment for a maximum period up to 46 days, only upon completion of all required documents submitted by the Family Care Coordinator.
7. The Family Care Coordinator will communicate within defined timelines for any inpatient or other out-of-home placements, which must be pre-authorized by the Wyoming Department of Health. The Family Care Coordinator must coordinate with the Care Management Entity for the continuation or initiation of High Fidelity Wraparound and all discharge planning from any higher level of care returning to the community.
8. The Family Care Coordinator shall document adherence all requirements for processes related to intake/initial application for enrollment, engagement, wraparound implementation, planning, and transition/discharge activities, including at a minimum:
    a. The Family Care Coordinator shall initiate the engagement process within 72 hours from receipt of the Prior Authorization for enrollment from the Care Management Entity and document how and the date that contact was made within three working days.

b. The Family Care Coordinator will work with the family to complete an application for enrollment into the Care Management Entity and whenever necessary, to gain access to federal funding when necessary and available (i.e., help them complete a Medicaid application).
c. Upon enrollment, the Family Care Coordinator facilitates and documents processes to:
    i. Support the family to enroll in High Fidelity Wraparound,
    ii. Identifies the individual needs and strengths of the child and family (SNCD) and other assessments,
    iii. Supports the family to identify the Crisis Team members and Child and Family Team members
    iv. Holds a Crisis Team meeting to develop the Crisis and Safety plan,
    v. Facilitates Team meetings and
    vi. Develops a customized wraparound approach and Plan of Care with adherence to National Wraparound Initiative standards and treatment planning requirements consistent with 42 CFR 438.208(c)(3).
d. The Family Care Coordinator will document that the youth and family's support network comprises a team of natural and professional supports chosen by the youth and family. The Team, with the assistance of the Family Care Coordinator, develops a sustainable Plan of Care consistent with the family's needs or goals, is informed by the Transition Assets Tool, CANS results, Care Management Entity utilization management guidelines, and evidence based High Fidelity Wraparound practices. Through the Plan of Care, Family Care Coordinator will document the mandatory use of family care coordination and along with other chosen waiver provider types and use of informal and other professional supports whenever possible.
e. The Family Care Coordinator must meet with both the youth, dependent upon age, and caregiver at least two times every 30 days, based on the family's preferred contact type and more as needed and determined by the Plan of Care.
f. The Family Care Coordinator, upon request of the family, shall add family and youth support, and respite providers to integrate all types of support needed to achieve goals in the plan of care
    i. It is mandated that all youth enrolled as 1915 C waiver eligible, will have either a Family Support Partner or a Youth Support Partner assigned and chosen by the legal guardian to provide all required quarterly youth and family training. The Family Care Coordinator will document how and when this training occurs for every quarter C Wavier youth are enrolled.
g. The Family Care Coordinator shall work closely with the child welfare, juvenile justice, and local education agencies to the extent necessary and possible, to integrate plans and support for youth and families. It is expected that personnel from all the child-serving State agencies, the juvenile justice system, and local education agencies will be invited to the Child and Family Team as appropriate.
h. The Family Care Coordinator must submit Plan of Care individualized for every youth and family including a crisis plan, to the Care Management Entity for review prior to the end of the initial 46-day authorization period and within 30 days of the Team meeting.

i. It is the responsibility of the Family Care Coordinator to verify the Care Management Entity program eligibility at least monthly with the legal guardian to ensure services provided can be billed to Medicaid.
ii. The Plan of Care must include the High Fidelity Wraparound services chosen by the family (Family Care Coordinator, Family Support Partner, Youth Support Partner, Respite and Youth and Family Training) and outline the interventions brainstormed by the team and chosen by the family. All waiver required services and supports must be documented in the Plan of Care for prior authorization.
iii. The Care Management Entity reviews the Plan of Care for timeliness, and consistency with the child and family's strengths and needs and utilization guidelines. If the Plan of Care meets these criteria, the Care Management Entity provides a prior authorization for a period of up to 90 days. Authorization shall be documented in the youth's file.

9. Best practice is to update the Plan of Care every 30-45 days and review for authorization at every 90 days. However, a Team meeting can be convened at any time in which needs or circumstances have changed or the child/youth and parents or caregivers of the child/youth feel it is warranted, or the needs of the child require the Team to meet on a more frequent basis.
10. The Family Care Coordinator shall work with the family to schedule and document all Team meetings and invite the entire team. The family will select meeting locations unless the Family Care Coordinator is unwilling to attend due to safety concerns.
    a. In the case of safety concerns, the Family Care Coordinator will report to the Care Management Entity and communicate how this will be address through the process.
11. Documentation, Plan of Care. and progress notes must demonstrate throughout the wraparound process a focus on planning for a purposeful transition out of formal wraparound to a mix of formal and natural supports in the community (and, if appropriate, to services and supports in the regular Medicaid or behavioral health system). The focus on purposeful transition is continual during the wraparound process, and the preparation for transition is apparent even during the initial engagement activities. Documentation must be maintained and available upon request.
12. The Family Care Coordinator will track, document and review with the Clinical Team anytime a youth experiences:
    a. Out of Home Placement.
    b. Change to timelines for return home.
    c. Lengths of Stay in High Fidelity Wraparound beyond 18 months.
    d. Before youth turns 18 years old.
    e. Any time as necessary when additional support is needed.
13. A family has the right to change providers at any time. If the Family Care Coordinator chooses to leave a team, Medicaid rules state they must give 30 days' notice and provide the family with a list of other providers to choose from.

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.

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.
- Transportation of the client is not a reimbursable component of High Fidelity Wraparound. The provider will coordinate with local Medicaid transportation supports and also help children and families connect with natural supports to provide needed transportation as part of the Team process.
- 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.

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/vendor.
- 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

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 one also. 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

REPORTING REQUIREMENTS

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

DOCUMENTS BY REFERENCE

In addition to this contract and statement of work, all provider/vendors 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