



The Indiana Family and Social Services Administration

Child Mental Health Wraparound Services

Introduction to the 1915(i) State Plan Amendment
and Provider Orientation

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Introductions

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Home and Community Based Services

- History
 - 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. 47 States and DC are operating at least one 1915(c) waiver



Home & Community Based Services

- Provide opportunities for Medicaid beneficiaries to receive services in their own home or community.
- Serve a variety of targeted populations groups, such as people with mental illnesses, intellectual disabilities, and/or physical disabilities.



Types of HCBS

State Medicaid agencies have several Home and Community-Based Service (HCBS) options, two of which include:

- 1915 (c) Home and Community-Based Waivers, such as Indiana's PRTF (Psychiatric Residential Treatment Facility) Transition Waiver
- 1915 (i) State Plan Home and Community-Based Services, such as Indiana's Child Mental Health Wraparound (CMHW) Services



1915 (i) State Plan HCBS

State Options

- Target one or more specific populations
- Establish needs-based criteria
- Can have new Medicaid eligibility group for people who get State plan HCBS
- Define the HCBS included in the benefit, including State- defined and CMS-approved “other services” applicable to the population
- Option to allow any or all HCBS to be self-directed

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1915 (i) State plan HCBS

1915(i) State plan HCBS Guidelines

- States can develop the HCBS benefit(s) to meet the specific needs of a population(s) 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 will be 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
 - Establish a quality assurance, monitoring and improvement strategy for the benefit. See HCBS Quality information.



CMHW Services in Indiana

- Indiana received approval from Centers for Medicare & Medicaid Services (CMS) for Community Alternative to Psychiatric Residential Treatment Facility (CA-PRTF) October 4, 2007
- Enrolled first client January 31, 2008
- Served over 1,600 youth



CMHW Services in Indiana

- PRTF Transition Waiver began October 1, 2012 to sustain services to those enrolled in CA-PRTF
- Money Follows the Person-PRTF (MFP) began December 2012
 - Available after 90-day placement in PRTF
 - 365 Days
 - Administered by Division of Aging
 - Division of Aging administers all MFP Grants
 - Providers approved by DMHA Youth Provider Specialist



CMHW Services in Indiana

- Wraparound Practitioner Certification Program: Over 120 Wraparound Facilitators started the certification process (began February 2012)
- 1915(i) Child Mental Health Wraparound Services State Plan Amendment approved 2013 by CMS
- The State of Indiana promulgated 405 IAC 5-21 which was approved in January 2014



Who's Who in Oversight

Division of Mental Health and Addiction

- Operating agency
- Develops program policies and procedures
- Approves providers
- Final determination of eligibility for CMHW Services
- Creates initial plan of care
- Monitors implementation of services
- Quality Improvement Reviews
- Incident Reports and Complaints



Who's Who in Oversight

OMPP

- Administers Medicaid programs
- Serves more than 450,000 children and pregnant women under Hoosier Health Wise
- Healthy Indiana Plan—State sponsored insurance for low income Hoosiers
- Helps our most vulnerable Medicaid Recipients through The Indiana Chronic Disease Management Program
- Hoosier Rx helps thousands of low-income seniors to buy the prescription drugs needed to stay healthy
- Administers Home and Community Based Services (HCBS) programs that help people with mental, intellectual, and physical disabilities to live, work and become active members in their communities by providing alternative supports and services to institutional care



Who's Who in Oversight

- **Family and Social Services Administrations (FSSA)**—the Agency umbrella under which is OMPP, DMHA, Division of Aging, and DFR, among others.
- **Division of Family Resources (DFR)** —determines eligibility for Medicaid
- **Surveillance Utilization Review (SUR)**—the program integrity division of OMPP responsible for billing and payment concerns
- **CMS**—Federal oversight and fiscal partner



Child Mental Health Wraparound Services

- Child Mental Health Wraparound Services (CMHW) provides youth, with serious emotional disturbances (SED) with intensive, home and community-based wraparound services
- CMHW services will be provided within a System of Care 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, etc.)



Eligibility

Target Group Criteria

- Ages 6-17
- Meets Criteria of **two or more** DSM IV diagnoses not excluded below
- Borderline, level of intellectual functioning, or above

Exclusionary Diagnoses

- Primary Substance Abuse Disorder
- Primary or Secondary Pervasive Developmental Disorder (Autism Spectrum Disorder)
- Primary Attention Deficit Hyperactivity Disorder
- Intellectual Disabilities
- Dual diagnoses of serious emotional disturbances and intellectual disabilities

The algorithm for the CMHW is a combination of ratings from the CANS that have been implemented as a CMS requirement to reduce the risk of subjectivity



Eligibility Criteria

The following needs-based eligibility criteria:

- Youth is experiencing significant emotional and/or functional impairments that impact his/her level of functioning at home or in the community, as a result of a mental illness. A behavioral recommendation of a 4, 5, or 6 is required



Eligibility Criteria (Cont'd)

- The Applicant, who meets a 4, 5, or 6 behavioral recommendation on the CANS, must also meet the following needs-based criteria

Dysfunctional patterns of behavior due to one or more of the following behavioral/emotional need(s), as identified on the CANS assessment tool

- Adjustment to Trauma
- Psychosis
- Debilitating anxiety
- Conduct problems
- Sexual aggression
- Fire-setting



Eligibility Criteria (Cont'd)

- Demonstrates significant needs in at least one of the following **Family/caregiver** area(s), as indicated on the CANS assessment tool, that results in a negative impact on the child's mental illness and may indicate a higher level of need:
 - Mental Health
 - Supervision issues
 - Family Stress
 - Substance abuse



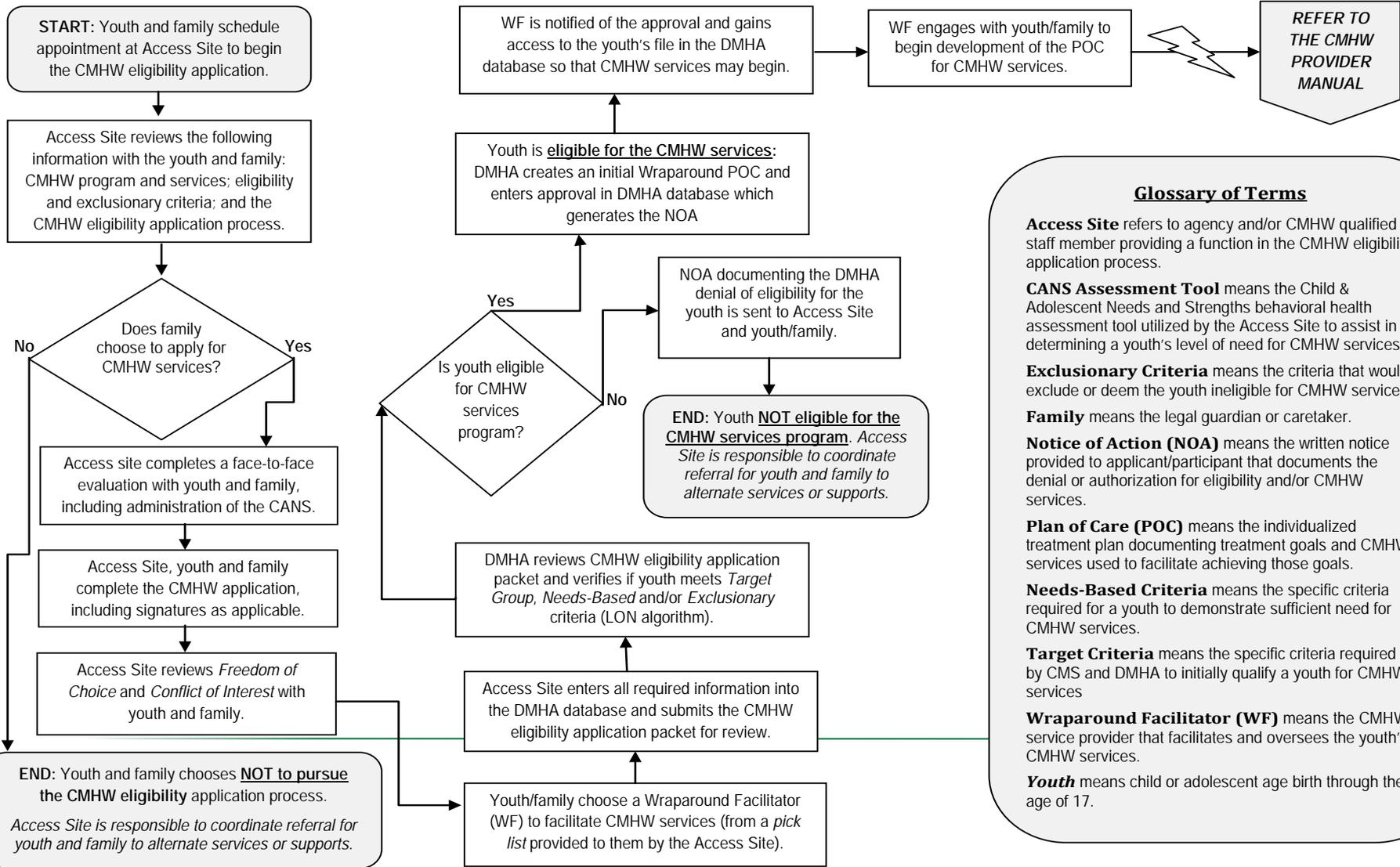
Eligibility Criteria (Cont'd)

- Exclusionary Criteria:

The following exclusionary criteria are used to identify those youth the CMHW services program is not designed to serve:

- 1) A youth who is at imminent risk of harm to self or others
- 2) A youth who is identified as not able to feasibly receive intensive community-based services without compromising his/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

CMHW SERVICES ELIGIBILITY APPLICATION PROCESS



Glossary of Terms

Access Site refers to agency and/or CMHW qualified staff member providing a function in the CMHW eligibility application process.

CANS Assessment Tool means the Child & Adolescent Needs and Strengths behavioral health assessment tool utilized by the Access Site to assist in determining a youth's level of need for CMHW services.

Exclusionary Criteria means the criteria that would exclude or deem the youth ineligible for CMHW services.

Family means the legal guardian or caretaker.

Notice of Action (NOA) means the written notice provided to applicant/participant that documents the denial or authorization for eligibility and/or CMHW services.

Plan of Care (POC) means the individualized treatment plan documenting treatment goals and CMHW services used to facilitate achieving those goals.

Needs-Based Criteria means the specific criteria required for a youth to demonstrate sufficient need for CMHW services.

Target Criteria means the specific criteria required by CMS and DMHA to initially qualify a youth for CMHW services

Wraparound Facilitator (WF) means the CMHW service provider that facilitates and oversees the youth's CMHW services.

Youth means child or adolescent age birth through the age of 17.



CMHW Services*

- Wraparound Facilitation
- Habilitation
- Respite Care
- Family Support & Training

*Services are discussed in detail in Service Specific Training, and in the manual.



Wraparound Facilitation

- A comprehensive service comprised of a variety of specific tasks and activities provided by a certified Wraparound Facilitator that are designed to support and facilitate the Wraparound process for youth and families enrolled in CMHW Services.



Habilitation

- This service—intended to build the youth’s strengths, resilience and positive outcomes—enhances the youth’s level of functioning and development of life/social skills.
- **Required State Sponsored Trainings include Demonstrated Competency Measures in order to become approved.**



Respite

- A useful service available to families on a short-term basis to give relief to family/caretakers and/or provide adequate supervision and support to the youth in the absence of their family/caretaker during an emergency.



Family Support & Training

- The service provides training and education for family/caregivers in order to assist the family/caregiver in better supporting the youth within the family and the community.
- **Required State Sponsored Trainings include Demonstrated Competency Measures in order to become approved.**



Point of Entry—Access Sites

- DMHA-approved
- Single point of service access and information for youth, families and providers in need
- Disseminate information regarding Local, State, and Federal funded intensive behavioral health services
- A means to explore eligibility for services
- Policies and procedures can be found on the DMHA System of Care Webpage. (Link is found at the end of this presentation.)



Provider Enrollment

- Indiana has made assurances to CMS that, in order to receive funding for the 1915(i) CMHW Services State Plan Amendment, all providers **initially and continually** meet the standards and qualifications required to deliver CMHW Services.
- DMHA Youth Services must approve all applicants before enrollment as a CMHW Services provider with Medicaid.
- CMS requires the State to ensure that CMHW Services recipients receive access to a full-continuum of behavioral health services that are provided in a manner that will ensure the health and safety of those individuals.



Provider Enrollment (Cont'd)

- There is **no automatic enrollment** of providers approved for other DMHA Youth Services including PRTF Transition Waiver and MFP-PRTF Grant Services.
- Approved providers for CMHW Services who are also approved, enrolled providers of the PRTF Transition Waiver may apply to have the date of their re-approval for those services adjusted to reflect the date of re-approval for the CMHW Services, provided that they meet all other re-approval criteria.



Provider Enrollment (Cont'd)

- Applicant submits Résumé and Experience Summary to DMHA
- DMHA reviews résumé and experience to determine if applicant meets criteria to prequalify for provider approval.
- Approved applicants are notified and the prequalified applicant is referred to Service Specific Training.
- Applicant attends Provider Orientation.



Provider Enrollment (Cont'd)

- Applicant attends service specific training
 - Successfully completes competency training and testing, as applicable, and is awarded training certificate
 - Applicant does not successfully complete training and testing and is denied training certificate
 - Those who do not receive a training certificate may attempt another training after six months, **and** must gain an additional six months relevant experience in the interim.



Provider Enrollment (Cont'd)

- Agency types—interested parties may choose to enroll as one of three types of provider
 - Accredited agency
 - Certified thru DMHA as Community Mental Health Center or
 - Accredited community service agency
 - Non-accredited Agency
 - Individual



Provider Enrollment (Cont'd)

- Applicant submits provider application packet as outlined on the Provider Approval Instruction Form and Service Application form for DMHA review and approval.
 - Forms are posted to the DMHA System of Care webpage.
 - **Do not use PRTF Transition Waiver forms.**
 - New! A Specialty Comment of up to 256 characters is now an option to appear next to the providers name on pick lists.



Provider Enrollment (Cont'd)

Note: Only complete packets will be reviewed. Incomplete packets will not be processed. An email will be sent to applicants at the email address listed on the demographic form listing missing elements and a deadline for submission. If the missing elements are submitted timely, the packet will then be processed. If not, the entire packet will be shredded.



Provider Enrollment (Cont'd)

- DMHA reviews the application packet
 - Approved applicants will receive a letter of approval via email. Approval letters are on FSSA letterhead and are signed by DMHA designated staff
 - Applicant is denied approval. Applicant may appeal the DMHA decision.
 - Approved provider must then complete the Indiana Health Care Plan (Medicaid provider) enrollment



Provider Enrollment (Cont'd)

- Enrollment with Indiana Health Care Plan
 - The DMHA approved provider may not bill for services until approved and enrolled in IHCP as a CMHW Service provider.
 - Hewlett Packard (HP) is the Medicaid fiscal agent
 - More information about enrollment with Medicaid can be found at <http://provider.indianamedicaid.com/become-a-provider/enroll-as-a-provider.aspx> (or, www.indianamedicaid.com)



Provider Enrollment (Cont'd)

- Provider completes IHCP application and submits it to HP/Medicaid for review and approval.
 - Approved Applicants will be enrolled and become eligible to be selected as a service provider, placed on a plan of care, and be reimbursed for services
 - Denied applicants will be notified. Denial decisions may be appealed.



Provider Enrollment (Cont'd)

- IHCP notifies DMHA that a provider has been approved and enrolled.
- DMHA activates the provider in the case management system.
- Provider appears on pick lists and is eligible to appear on the plan of care



Provider Personnel File Maintenance

- Providers are required to maintain their personnel files. All documentation submitted to DMHA for approval, changes, etc, is required to be maintained by the provider.
- Documentation requirements have some variation among services. These are discussed in greater detail in service specific training, and listed on the Service Provider Application Forms.
- Participant documentation and file maintenance is the responsibility of the provider, and must be HIPAA compliant.



Provider Changes and Update

- It is the responsibility of the provider to notify and keep current DMHA and IHCP of any changes in status.
- For changes reportable to DMHA, providers should use a demographic form, and should make only one change per form.
- For information related to changes reportable to ICHP is available on the Medicaid website. You may also contact your provider representative.



Contact information

DMHA has made a recent addition to its provider agreement for the Youth Services Programs: It is the **responsibility of the provider** to maintain current contact information at all times with DMHA and IHCP for all avenues of contact, including but not limited to electronic mail addresses, physical mailing addresses, all telephone and fax numbers, and any other relevant avenue of communication. This includes the agreement to accept and/or respond to certified mail. If the provider refuses to accept delivery of certified mail or if mail is undeliverable due to the failure of the provider to provide accurate delivery information to the State or its agents, the provider will be in violation of the provider agreement. Violation of the provider agreement may be the basis of revocation of approval to provide services.



Renewal of DMHA Approval

- Periodically, providers are required to assure DMHA, OMPP and CMS that they continue to meet criteria established for the CMHW Services program.
- Timeframes for re-approval will be three years for accredited providers and two years for non-accredited providers and individuals.
- Medicaid has a separate, additional provider revalidation process and timeframe.



Renewal of DMHA Approval

- Instructions for renewal of approval to provide services can be found in the CMHW Services Program Manual, and are consistent with the current renewal procedures for the PRTF Transition Waiver.
- It is the **responsibility of the provider** to monitor the date of renewal, and to submit the renewal of approval application packet 60-days before the expiration of the current approval period.
- Failure to submit the renewal of approval application packet may result in termination of the provider.



Renewal and Professional Development

- Providers are required to complete ten (10) hours per year of Continuing Education credits to be eligible for renewal of approval. More information regarding eligible CEUs is included in the CMHW Services Program Manual.
- The Annual System of Care conference is an excellent opportunity to obtain the required CEU credits while developing professional relationships, and is highly recommended by DMHA Youth Services.



CMHW Services Manual

- DMHA Youth Services has drafted a CMHW Services Program Manual.
- Providers should review, print, and make frequent reference to the provider Manual.
- The Manual gives detailed explanation on a wide variety of topics including participant eligibility, expectations of providers, service definitions, enrollment procedures, billing and claims, incident reporting, complaints, and more.



IHCP Manual and Communications

- Medicaid is the payer of services, and as with all Medicaid providers, CMHW Services providers come under Medicaid Authority.
- It is the responsibility of the provider to review and comply with any and all relevant Medicaid rules, regulations, and standards.
- Medicaid has its own revalidation process, and will notify providers when due. In order to remain eligible to provide services, compliance is required.
- Termination from Medicaid=termination from CMHW Services



Child and Family Freedom of Choice

- Participants/families have freedom of choice regarding the following aspects of CMHW Services delivery:
 - Determining who will participate in the Child and Family Team.
 - Identifying the plan of care Needs and the Strategies for meeting those needs.
 - Selecting the services that will be included in the plan of care.
 - Choosing the DMHA-approved CMHW Services provider(s).
 - Changing the CMHW Services provider(s) at any time during enrollment in the CMHW Services program.



Provision of Services

- The initial plan of care is created by DMHA Youth Services once a youth has been determined to be eligible for the program.
- The initial plan of care includes only the service of Wraparound Facilitation, the provider of which was selected by the applicant during the application process.
- The Wraparound Facilitator receives the youth's file from DMHA and the Wraparound process begins.



Provision of Services

- The Wraparound Facilitator meets with the family to learn the family story.
- Together they determine who will be participating members of the Child and Family Team as natural supports.
- The family determines the services, and selects the providers of those services.
- The selected providers become child and family team members.



Selection of Providers

- Families are given pick lists by their Wraparound Facilitator that include all of the enrolled CMHW Services providers of a service in a county.
- Lists are generated in random order each time.
- Specialty comments of up to 256 characters appear on the provider pick list by the agency/individual's name



Solicitation

Solicitation Is NOT allowed

- Solicitation, or fraudulent, misleading, or coercive offers by a provider to deliver a service to a CMHW Services recipient is prohibited. Examples include, but are not limited to:
 - Door to door solicitation
 - Use of any advertisement prohibited by federal or state statute or regulation
 - 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
 - Accepting referral and Quid Pro Quo (i.e. only providing one service if the participant agrees to also select the provider for another service.)



Provision of Services

- Child and Family Team develops a plan of care that the Wraparound Facilitator then submits to DMHA for approval.
- Once the Plan of Care is approved, a Notice of Action is generated and sent to the providers listed on the plan of care as well as the family.
- Plan of care decisions may be appealed.



Provision of Services

- Only after a Notice of Action is generated are services considered approved to be provided and eligible for reimbursement.
- Services are not back-dated.
- Providers are not to provide services not approved of in the Plan of Care.
- Services provided must meet the service requirements defined by the CMHW Services program.



Clinical Documentation

- **Service notes**
 - Must be in Medicaid approved format as demonstrated in service specific training
 - Must comply with service standards
 - Must be maintained in the participant's file
 - Must be provided on demand to DMHA, OMPP, and/or the Wraparound Facilitator
- **Monthly Summaries**
 - Required to be submitted timely to the Wraparound Facilitator each month



Clinical Documentation

- Documentation for requirements for **each encounter**:
 - Name of youth
 - Youth's RID number
 - Type of service provided
 - Date of service provided
 - Location of service
 - Start and end time along with duration in exact time
 - Underlying need worked on indentified in the Plan of Care
 - Strategies employed from the Plan of Care during the session
 - Progress made (what did you do? How did the youth respond?)
 - Your name, qualifications, signature and date
 - **Wrap Facilitation may request at anytime**



Documentation Requirements

- DMHA review of documentation primarily focuses on programming, but can include all technical aspects.
- Medicaid review of documentation primarily focuses on required elements of the services notes, but can include all aspects.
- Providers may wish to develop a template to ensure that all elements are included.
- The template should expand to any needed length for narrative.



Quality Assurance Reviews

- Quality Assurance reviews are conducted as a CMS requirement to ensure providers comply with the rules, regulations, and standards of the program, and may be conducted without prior notice.
- DMHA conducts Quality Assurance reviews that will focus on program aspects, but may include technical requirements.
- OMPP/SUR will conduct reviews focused on billing, claims, and other Medicaid program aspects.



Incident Reporting

- Indiana state law (*Indiana Code (IC) 31-33, et. al.*) requires reporting of suspected child abuse or neglect to the Indiana Department of Child Services (DCS). DCS is the single state agency responsible for administering the federal *Child Abuse Prevention and Treatment Act* under *42 U.S.C. 5106 et seq.*
- The Division of Mental Health and Addiction (DMHA) requires that all providers comply with state law and notify the DCS of alleged child abuse, neglect, or exploitation within 24 hours of the event.
- Providers are also required to report to the DMHA sentinel and other critical incidents within 24 hours of the incident, using an incident report form developed specifically for youth programs, and found on the DMHA SOC webpage.



Incident Reporting

- Complete incident report (located on DMHA SOC website)
- Fax to DMHA Youth Services
- Notify the Wraparound Facilitator within 24 hours that you are the one to “discover” the reportable event
- If discovery of the event and the event occur on different days, each date should be noted in the incident report.
- Required Parties include:
 - Wraparound Facilitator
 - DMHA Youth Services
 - Guardian
 - DCS- if applicable
 - Law Enforcement – if applicable
- **Reporting timeframes are 24 hours for a sentinel event, and 72 hours for a non sentinel event.**



Incident Reporting

- **Sentinel Event**

- Loss of life
- Suicide
- Loss of limb or gross motor function

- **Critical Incident**

- Use of restraint
- Medication error
- Suicide attempt
- Violation of rights
- Elopement
- Serious injury
- Seclusion or restraint
- Abuse, Neglect, or exploitation

- **Incident requiring Police or DCS response or involvement**



Health Insurance Portability and Accountability Act

- **Clinical Documentation and HIPAA**

- <http://www.hhs.gov/ocr/privacy/>
- Use this website to understand privacy practices and Federal requirements
- How to protect Protected Health Information (PHI)
 - Files must be stored securely (locked file cabinet)
 - If stored electronically, they must be secured by user name and password to access and not on a communal computer used by others
 - This includes phones containing participant contact information



WebPages

- SharePoint—no longer available to providers
- DMHA System of Care Webpage:
<http://www.in.gov/fssa/dmha/2766.htm>
- DMHA Calendar:
<http://www.in.gov/activecalendar/CalendarNOW.aspx?fromdate=1/1/2014&todate=1/31/2014&display=Month&display=Month>
 - Select from Agency dropdown “DMHA SOC” and search. This will filter to include only youth services information.



Child Mental Health Wraparound Services

- Questions?
 - Please submit all questions to DMHAYouthServices@fssa.in.gov