INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Division of Mental Health and Addiction

Child Mental Health Wraparound Services

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		• Removed *The Four Key Elements of Wraparound* section • Updated *The Four Phases of the Wraparound Process* section • Updated *The Child and Family Team* section • Removed the *Assessing Wraparound Fidelity* section and subsections • Updated *Section 4: High Fidelity Wraparound Access Sites* • Updated the *Exclusionary Criteria* section • Updated the *Submission of the CMHW Application* section • Added medical necessity language to *Section 6: Plan of Care and Service Authorization*, as well as the sections regarding Habilitation, Respite Care and Training and Support for the Unpaid Caregiver services • Updated *Section 7: Crisis Plan Development* • Added emergency care shelter as an example and reason in the *Participant Termination, Interrupt and Restart Status* section • Updated *Section 9: Level of Need Redetermination* • Updated *A Nonaccredited Agency* section • Updated the *General Provider Requirements* section • Updated the *CMHW Provider Application* section • Updated the *Résumé Submission* section • Updated the *Orientation Training* section • Updated the *DMHA Review of the Provider Application Packet* section and *Incomplete Applications* subsection • Updated the *Reauthorization Process and Provider Responsibilities* section • Updated the *Deauthorization of a Provider* section	

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		• Removed the SOC provider seminar from the *Possible Topics and Examples of Approved Trainings and Conferences* section • Updated the *Wraparound Facilitator Training Requirements* section • Updated the *Indiana Requirements for Wraparound Facilitator Agency Policy* section • Updated the *Core Training Course Descriptions* section • Updated the *Skill-Based Supervision for Wraparound Practice* section • Updated the *Wraparound Facilitation Agency Requirements for Onboarding New Facilitators* section • Updated the introductory text of *Section 13: DMHA and IHCP Provider Agreements* • Updated the *Professional Code of Conduct and CMHW Services Delivery* section • Updated the *Monthly Summary Reports* section • Updated the *Electronic Visit Verification Required for Personal Care Services* section • Updated *The Indiana Youth Services Webpage and Mailing List* section • Updated participation in the local SOC as encouraged rather than required in *Table 2 – Qualifications and Standards for Wraparound Facilitators* • Updated information about freedom of choice in the *Electronic and Case File Documentation and Requirements (Tobi)* section • Updated the *Provider Supervision Requirements* section to include that supervision could be virtual for Habilitation service • Updated the *Service Definition* section of Respite Care services	

Version	Date	Reason for Revisions	Completed By
		• In the *Rescheduling Respite Care* section, clarified that the Wraparound Facilitator must request approval • Updated the *Provider Supervision Requirements* section to include that supervision could be virtual for Training and Support for the Unpaid Caregiver • Added services delivered virtually in the *Service Delivery Standards* section for Training and Support for the Unpaid Caregiver • Updated the *Documentation Requirements* section for Training and Support for the Unpaid Caregiver • Updated *Section 24: Glossary of Terms and Acronyms*	

Table of Contents

Section 1: Purpose

This provider reference module serves as a reference document for service delivery under the Indiana Health Coverage Programs (IHCP) approved home- and community-based High Fidelity Wraparound (HFW) services. These HFW services are provided through the *1915(i) Child Mental Health Wraparound (CMHW) Services State Plan Amendment (SPA) IN-22-0016* and supported by *Indiana Administrative Code 405 IAC 5-21.7*. The 1915(i) CMHW Services State Plan benefit enables the Indiana Family and Social Services Administration (FSSA) 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 program
- Entities interested in applying to become service providers for CMHW services

This module not only defines the CMHW program, provider requirements, services, billing information and state of Indiana expectations for providers, but also provides useful guidelines and resources for those providing services under the CMHW State Plan benefit.

Providers and participants in the CMHW program can find additional information and resources by visiting the following websites:

- The IHCP website at in.gov/medicaid
- The CMHW *Program Description* webpage at in.gov/fssa/dmha
- The CMHW *Provider Information* webpage at in.gov/fssa/dmha

All CMHW service providers are required to subscribe to the DMHA CMHW Providers mailing list to receive CMHW program emails regarding policy updates, as well as other information of interest. Providers can subscribe for FSSA email updates by selecting **DMHA CMHW Providers** as a saved preference after they enter their email and contact information. It is recommended that each authorized staff member who provides services also be subscribed to the mailing list. In addition to the mailing list, 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.

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 1915(i) State Plan HCBS

The provision of 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, under section 1915(i) of the *Social Security Act*. The HCBS program is 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 each state's population, the federal regulations surrounding 1915(i) State Plan HCBS 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

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

- 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) CMHW Services SPA was approved by the CMS, and Indiana promulgated *405 IAC 5-21.7* CMHW 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 State Plan Amendment (CMHW Services SPA)	CMS-Approved SPA: IN-22-0016 Indiana Administrative Code: *405 IAC 5-21.7*	DMHA 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 contained in Section 24: Glossary of Terms and Acronyms of this provider reference module. Additional provider resources can be found on the CMHW Provider Information webpage at in.gov/fssa/dmha.

CMHW Services Overview

CMHW services provide youth with SED with intensive home- and community-based wraparound services 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 [MRO], managed care and so on) and address the following:

- The unique needs of the CMHW participant
- Building upon the strengths of the participant and the participant'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 behavioral 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 that 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
- Behavioral 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. CMHW services available to the eligible participant may include:

- Wraparound Facilitation
- Habilitation
- Respite Care
- Facility-Based Respite Care (FBR) Transportation
- Training and Support for the Unpaid Caregiver (formerly Family Support and Training)

The CMHW 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 program requirements, standards and expectations, including but not limited to, the following:

- CMHW participant application, assessment, eligibility, treatment planning and service delivery
- CMHW provider qualifications, including the DMHA authorization process and provider responsibilities
- State expectations for CMHW Access Sites, Wraparound Facilitators and other CMHW service providers
- Scope, limitations and exclusions to CMHW services
- Requirements for service delivery and reimbursement
- Participant and family rights for CMHW services
- Participant fair hearings 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 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, DMHA, 211, Division of Disability and Rehabilitative Services (DDRS), Division of Aging (DA), Office of Early Childhood and Out-of-School Learning (OECOSL), and Division of Family Resources (DFR).
- FSSA OMPP: The office within the FSSA 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 Plan of Care based on the terms and conditions of the Indiana Medicaid State Plan; may review, approve or overrule the approval or disapproval of any specific POC acted upon by the operating agency

- FSSA DMHA: The state agency that:
  - Serves as the operating agency that oversees the day-to-day functions of the CMHW program
  - Authorizes access site entity (or entities) and oversees access site functions
  - 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 Audit: The state unit that conducts audits to ensure fiscal and policy compliance for any programs funded by the FSSA, including the CMHW program.
- FSSA DFR: The state agency that offers help with job training, public assistance, the Supplemental Nutrition Assistance Program (SNAP), Medicaid and other services.
- Program Integrity: The Program Integrity staff responsible for billing and payment concerns.
- CMS: The agency within the U.S. Department of Health and Human Services (HHS) 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: High Fidelity Wraparound

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, so the plan reflects family values and preferences.
- *Team-based*: The Child and Family Team (CFT) 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.

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 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, a probation officer, 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 and 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 and family. This plan includes any remaining needs to be addressed and the strengths of the participant and family. The team identifies resources that will continue to be available to the participant and 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 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 19: Wraparound Facilitation Service* in this provider reference module for details about Wraparound Facilitation service, including definition and scope.)
- CMHW service providers and non-CMHW community providers who provides the youth and family with resources, services and supports during the treatment process

- Any other unpaid individuals the youth or family selects to assist in implementing the POC. Examples of unpaid individuals include, but are not limited to: friends of the youth or family members, neighbors, unpaid mentors, extended family members who live outside the home, or members of the family's religious organization

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 (see *Section 7: Crisis Plan Development*)

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. All CMHW providers and team members are required to participate in these weekly communication touchpoints. 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.

Section 4: High Fidelity Wraparound Access Sites

A High Fidelity Wraparound (HFW) Access Site is considered the single point of entry to explore a youth's eligibility for the Child Mental Health Wraparound (CMHW) program. CMHW is a Medicaid-funded home- and community-based program administrated by the Division of Mental Health and Addiction (DMHA). CMHW is an alternative to Psychiatric Residential Treatment Facility/State-Operated Facility levels of care. The Access Site provides the following functions:

- Performs application processing with families for HFW
- Provides referral to and resources for applicants who may or may not be eligible for the CMHW program
- Reports data to the DMHA

Access Sites are authorized by the DMHA and are bound to comply with all policies and procedures related to the administration of the CMHW program. This includes but is not limited to compliance with this provider reference module, *Indiana Administrative Code* and *Indiana State Plan Amendment*.

Section 5: Participant Eligibility and Application for CMHW Services

Indiana's Child Mental Health Wraparound (CMHW) program provides 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 (IN-22-0016)*.

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 years
- Resides in their home or community
- Eligible for Medicaid
  - Meets criteria for two or more *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) (or subsequent revision) diagnoses not excluded as exclusionary criteria (see the *Exclusionary Criteria* section)
- Youth does not meet exclusionary criteria for CMHW (see the *Exclusionary Criteria* section)

> *Note: Youth found to be eligible for CMHW services in their 17th year will be entitled to receive 12 months of services as long as all other eligibility requirements continue to be met. For example, a youth enrolled at 17 years and 6 months of age may continue their approved Level of Need (LON) year through age 18 years and 6 months 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 diagnosis of substance use disorder (SUD)
- Diagnosis of a pervasive developmental disorder (autism spectrum disorder [ASD])
- Primary diagnosis of attention deficit hyperactivity disorder (ADHD)
- Primary diagnosis of intellectual/developmental disability
- Dual diagnosis of serious emotional disturbance and intellectual/developmental disability
- Resides in an institutional or otherwise Home- and Community-Based Services (HCBS) noncompliant setting
- Is at imminent risk of harm to self or others

In addition to exclusions noted in the CMHW Service State Plan Amendment (SPA) 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 their 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* established by the Child and Adolescent Needs and Strengths (CANS) tool, which includes:

- Applicant demonstrates significant* emotional and/or functional impairments that impact the level of functioning at home and/or in the community, as a result of a mental illness. A minimum behavioral recommendation of **4** is required. An indication of one or more of the following behavioral or emotional needs is noted as significant*, as identified on the 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 that results in a negative impact on the child's mental health and may indicate a higher LON. A minimum behavioral recommendation of **1** is required.
  - Behavioral health
  - Supervision
  - Family stress
  - Substance abuse

  **"Significant" is determined by an assessed need for immediate or intensive action due to a serious or disabling need in a variety of life domains on the CANS assessment tool used by the state to assess an individual's LON.*

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 LON for CMHW must meet the following qualifications and standards:

- Affiliated with a DMHA-approved Access Site
- Possesses one of the following clinical qualifications:
  - Licensed physician (including licensed psychiatrist)
  - Licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP)
  - Licensed clinical social worker
  - Licensed mental health counselor
  - Licensed marriage and family therapist

  - Advanced practice registered nurse (APRN) under *Indiana Code IC 25-23-1-1(b)(3)* who is credentialed in psychiatric or behavioral health nursing by the American Nurses Credentialing Center
  - Licensed independent practice school psychologist
  - 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 two years' clinical experience
    - A master's degree in social work, psychology, counseling, nursing or other behavioral health field, plus two 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. 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
- Eligibility and exclusionary criteria for the CMHW program
- 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 4: High Fidelity Wraparound Access Sites in this provider reference 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 provide 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

- *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. To further prevent conflict of interest between evaluators, service providers, participant, and family, Wraparound Facilitation organizations adhere to conflict-free standards, including, but not limited to, not providing any other CMHW service except for facility-based Respite Care. The Wraparound Facilitator is not authorized to provide any other CMHW service to the member for whom they are the Wraparound Facilitator. The DMHA, the state entity making eligibility determination and providing authorization for the Plan of Care (POC), is not related by blood or marriage to the participant, any paid caregivers, or to anyone financially responsible for the participant or empowered to make financial or health-related decisions on the behalf of the participant and family. Additionally, the DMHA is not a provider of CMHW services. Participants and families are educated regarding their rights and how to submit complaints or appeals regarding all aspects of the CMHW service delivery, providers, inclusion in treatment planning, DMHA eligibility determination or POC authorization. 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 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 SPA 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 picklist. The picklist consists of the DMHA-approved providers enrolled to provider services in the same county as the family's residence. The applicant and/or family reviews the provider picklist and selects the provider of choice. The signed picklist 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 picklist
- 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.
- The CANS assessment recommendation has been entered into DARMHA.
- For initial eligibility, the CANS must be completed within 90 days of the date of application. For annual eligibility, the CANS must be completed within 30 days of the date of application.
- After the *Youth & Family 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 five 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 three 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 is eligible for the CMHW program, an initial POC is created by the DMHA that includes two 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 6: 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.

All requested services must be directly tied to medical necessity. Services will only be authorized or provided when they are deemed clinically appropriate and necessary for the treatment of the defined underlying need, as determined by applicable guidelines and standards of care.

> *Note: The POC consists of three components: The Intervention Plan (service authorizations), Care Plan and 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:

- *Underlying 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 measurable
- *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 (PA) 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 their 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 through the CFT process, inclusive of how the family coped and managed during initial conditions and the reason for referral. The retelling of the family story is reflected in the review of functional strengths, creation of the family vision and sharing of the family's underlying needs. The Wraparound Facilitator facilitates this process. 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. When developing strategies at the CFT meeting, for every formal (paid) strategy, there should be two informal (unpaid) strategies.

The following define 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
- *Underlying 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 formal (paid) strategy, there should be two informal (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 must be stepped out to include who, what, when, where, why and how the strategy will be accomplished.
- Wraparound works best when other evidence-based practices (EBPs) are included in strategy development.
- Trauma informed care should be used in the development of strategies.
- 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 provides prior authorization for 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:

- Upon 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, if appropriate.
- 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 five 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 service authorization (formerly known as Notice of Action or 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 service authorization is attached to the POC and documents the CMHW services authorized by the DMHA.

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

    - Obtaining the parent/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/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 five business days

> *Note: Following the state's decision to approve or deny the POC, a service authorization 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.
  - 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 five business days.
  - If the Wraparound Facilitator does not submit the required information within five 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 and updating 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 one 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 through the CFT process to discuss the plan's implementation and progress. Any meeting without the family and youth is not considered a CFT meeting.
- A Child and Adolescent Needs and Strengths (CANS) reassessment is completed six 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 five business days.
- Changes in service delivery must not occur unless the DMHA approves the updated POC and generates a service authorization documenting the additional service authorizations.

Section 7: 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. At the first face-to-face meeting with the family, the Wraparound Facilitator is responsible for developing an initial Crisis Stabilization plan that will be used during the first 30 days of the Wraparound process. During the initial Wraparound Team/Child and Family Team (CFT) meeting, the Wraparound Facilitator will use the initial crisis stabilization plan with collaboration from the wraparound team to develop the initial Crisis Plan. 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 Stabilization Plan Development

A Crisis Plan is required for each participant in the CMHW program and can be initiated through the following measures:

- An initial crisis stabilization plan is created with the family and youth at the first face-to-face visit with the Wraparound Facilitator. This plan is designed to keep the youth and family safe until the initial CFT meeting is scheduled, no more than 30 days from the approval for the CMHW program.
- The crisis stabilization plan must be developed and uploaded into the notes section of Tobi by the Wraparound Facilitator. The participant and family receive a copy of this plan until a more comprehensive plan can be established at the first CFT meeting.
- Discussion about a crisis stabilization 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 must be developed with the team and entered into Tobi within five business days of the initial CFT meeting. Early in the wraparound process, during the engagement and initial planning phases, the Wraparound Facilitator with the participant and family develop a comprehensive 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 that 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.
  - Action steps to build coping skills, defuse a situation or provide support during crises across all settings

- Emphasis on identifying and defusing situations, ensuring safety and debriefing the situation to maximize the learning opportunity for the youth and family
- Plan that reflects the youth and family choices and preferences
- Seclusion and restraint not allowed as interventions in the Crisis Plan
  - If any 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 reevaluation 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.
  - As families and youth move toward transition out of Wraparound, the CFT must adapt the Crisis Plan to address any identified situations that may occur after graduation of the program.
- After a crisis occurs, if the Crisis Plan does not successfully defuse the crisis situation, the team should reconvene within three calendar days 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 a minimum, CFT minutes and sign-in sheet would be completed and distributed following the crisis meeting.
  - 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.
- Good Crisis Plans acknowledge and build on the crisis cycle. The Crisis Plan should demonstrate development of steps associated with each phase of the crisis cycle, including: Calm, Trigger, Agitation, Acceleration, Peak, De-escalation and Recovery.
- Crisis Plans change over time based on what is known to be effective.

Crisis Plans should be explicitly reviewed and negotiated at every single CFT meeting with clear evidence around known triggers and action steps involving sustainable supports.

Section 8: 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 service authorization (formerly known as Notice of Action or 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 are needed 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 Restart 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 their home/place of residence for more than 72 hours in a non-Home- and Community-Based Services (HCBS)-approved setting (for example, hospitalization in a treatment facility, psychiatric residential treatment facility [PRTF] or correctional facility).
- The participant has exhausted their eligibility in their 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*: This 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 (for example, the youth needs higher LON and is admitted to a more restrictive setting, such as an acute hospital setting, emergency shelter care, PRTF or a correctional facility.

- 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 reestablished, the participant will be able to resume an active role in CMHW services.
- After eligibility issues are resolved, a status change of Restart 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 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.
  - Upon 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 service authorization being generated for the participant/family with the appeal information.
- *Restart status*: To return a participant to Active status, a Restart 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 *Interrupt* 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
  - Entered emergency shelter care
  - 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 CFT meeting, as well as documented in a formalized transition plan and reflected 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 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* provider reference 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 Division 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/reverify 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 Restart 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 9: Level of Need Redetermination

In accordance with the Centers for Medicare & Medicaid Services (CMS)-approved Child Mental Health Wraparound (CMHW) Service State Plan Amendment (SPA), the member must be reevaluated for continued eligibility for CMHW services within 12 months from the date of initial eligibility for the CMHW program. The Wraparound Facilitator is responsible for monitoring the authorization limits and end dates of the participant's Plan of Care (POC) as well as the participant's CMHW 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 redetermining Level of Need (LON) for CMHW services includes the following:

- A face-to-face reevaluation of the participant must 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 5: Participant Eligibility and Application for CMHW Services* 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 reevaluation application must be reviewed by the DMHA, which will determine whether the youth is eligible to continue in the CMHW program. The Wraparound Facilitator is responsible for submitting the reevaluation results and documentation to the DMHA for review in the Tobi system no later than 45 calendar days prior to the expiration date for the participant's eligibility period/POC. The reevaluation components include:
  - The completed reevaluation application
  - CANS assessment results
  - Updated POC (Intervention Plan, Care Plan and Crisis Plan)
- The DMHA reviews the submitted POC and, within five 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 service authorization (formerly known as Notice of Action or 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
    - Providing a copy of the DMHA-approved POC to review with the participant and family. The service authorization 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. A service authorization, 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
  - 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*: The DMHA has five business days to review the POC. Based on a review of the POC, the DMHA may require additional information to make a determination regarding approval of the POC.
  - The Wraparound Facilitator will have five business 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 service authorization is issued for the Wraparound Facilitator to distribute to all team members. The DMHA database system communicates with the Indiana Core Medicaid Management Information System (*Core*MMIS). *Core*MMIS stores the prior authorization, which allows for billing and payment of approved units of service within the prior authorization.

Section 10: Critical Events and Incident Reporting

All service providers are required to adhere to Indiana 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.

Any CMHW provider 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 and Complaint Reporting website at dmhareport.fssa.in.gov.

In addition to reporting incidents to the 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 behavioral 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 behavioral 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 800-800-5556.

Reportable Incidents

Two categories of incidents must be reported to DMHA:

- Sentinel
- 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 *restraint* is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a participant to move their arms, legs, body or head freely; or a drug or medication when it is used as a restriction to manage the participant's

behavior or restrict the participant's freedom of movement and is not a standard treatment or dosage for the participant's condition. An example is restraints used by police or medical personnel.

- ***Suicide attempt*** – Report instances of the participant committing an act with the intention of causing one's own death. If the participant commits an act and the intention is not to cause their own death, it would not be considered a suicide attempt. For example, the participant intentionally takes an overdose of medications because they are having trouble sleeping. This incident would be reported as a medication error and not a suicide attempt, because the participant's intention was not to cause death. Participants experiencing suicidal thoughts or ideation would not be counted under this heading.
- ***Seclusion*** – Seclusion is the involuntary confinement of a participant alone in a room or area from which the participant is physically prevented from leaving.

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 whether 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, see *What Is Child Abuse and Neglect? Recognizing the Signs and Symptoms* 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.

The following list of incident types are no longer required to be reported to DMHA:

- Elopement
- Medication error
- Serious injury
- Violation of rights
- Police response
- Emergency room visits
- Emergency mental health evaluation

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

Filing an Incident Report With DMHA

All CMHW providers – Wraparound Facilitators and providers of Respite Care, Habilitation, and Training and Support for the Unpaid Caregiver – 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 filed 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 requirement 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.

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.

Example: During a Child and Family Team (CFT) meeting, the youth reports that the Habilitation provider restrained the youth using a therapeutic hold. Because several providers are present, it is the Wraparound Facilitator's responsibility to file an incident report within 72 hours due to this critical incident. All incident reports must be completed online on the DMHA Incident 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 that a follow-up report is required 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

Copies of incident and follow-up reports can be accessed by the Wraparound Facilitator and the Wraparound Facilitator Supervisor through Tobi. If you are the individual entering an incident report, you can print a copy of the report before submitting it to the DMHA.

Incident Report Training

CMHW Incident Reporting training is a ***required*** DMHA training that must be completed by ***all*** **CMHW providers** on a yearly basis. After completing the training, providers should email DMHAyouthservices@fssa.in.gov to notify the DMHA of completion. The DMHA will then send the provider a certificate of completion. Failure to complete the training requirement, or any aspect of the incident reporting process, could result in **corrective action**.

Section 11: Participant Complaints

The Division of Mental Health and Addiction (DMHA) process for investigating a complaint is to get a full understanding of the incident by contacting each individual involved. To ensure the health, safety and wellbeing of all participants, the DMHA is obligated to investigate all complaints. Cooperation from all Child Mental Health Wraparound (CMHW) providers is required.

When an investigation is complete, depending on the findings, the DMHA may take action following the guidelines in the *Provider Sanction Policy* at in.gov/fssa/dmha.

When a program participant, family member, provider or interested party wishes to share a concern or complaint related to the CMHW program or one of its providers with the DMHA, they may do so in any of several ways:

- Express concerns to the Wraparound Facilitator, who then makes a report to the DMHA.
- Send email to DMHAYouthServices@fssa.in.gov.
- Submit via the web-based DMHA Incident and Complaint Reporting website at dmhareport.fssa.in.gov

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 for the person filing the complaint (email or telephone)

The DMHA will keep confidential any pertinent identifying information when safe and appropriate to do so.

An investigation will begin within 72 hours of receipt of the complaint.

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 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, communication of findings will be sent to the CMHW service provider that is the subject of the complaint or grievance. The CMHW service provider will correct any identified deficiency within the timeline established by the DMHA.

If the CMHW service provider fails to correct the deficiency within the established timeline, the DMHA 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 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)
- 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. This means that an agency cannot be approved as a CMHW service provider until they have at least one individual staff member providing that service, except in the case of facility-based Respite Care providers. For facility-based Respite Care, licensed agencies are authorized, not individual rendering providers. See the *Rendering Provider Application* form (*State Form 55696 [R / 9-18]*) available on the CMHW *Provider Information* webpage at in.gov/fssa/dmha for additional information regarding provider criteria.

> *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. 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. This means that an agency cannot be approved as a CMHW service provider until they have at least one individual staff member providing that service, except in the case of facility-based Respite Care providers. For facility-based Respite Care, licensed agencies are authorized, not individual rendering providers.

See the *Rendering Provider Application* form (*State Form 55696 [R / 9-18]*) available on the CMHW *Provider Information* webpage at in.gov/fssa/dmha for additional information regarding provider criteria.

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 the *Rendering Provider Application* form (*State Form 55696 [R / 9-18]*) available on the CMHW *Provider Information* webpage at in.gov/fssa/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 adult and youth cardiopulmonary resuscitation (CPR) certification
  - CPR certification must include an online and in-person skills training.
- INkless electronic fingerprinting screen (completed within the last year)
- Local law enforcement screen (completed within the last three months) for every state and county in which the applicant has resided for the past five years
- Child abuse registry screen (completed within the last year) for each state in which the applicant has lived for the past five years
  - For Indiana, this information must be obtained from the Indiana Department of Child Services (DCS).
  - For other states, the applicant is responsible for following the state's policies for obtaining a child abuse registry screen.
- Five-panel drug screen (completed within the last year); or agency meets the same requirements established for federal grant recipients specified under *41 US Code (USC) 10 Section 702(a)(1)*
  - See additional information in the *Drug Screen Requirements* section.
- Search made for provider's name on the Office of Inspector General (OIG) Exclusions Database and results submitted to the DMHA upon initial application and with each reauthorization
  - The OIG Exclusions Database search must be completed within the month before submission.

- Instructions for searching on the OIG Exclusions Database and how to print results can be accessed from the *Exclusions Database Search* webpage at exclusions.oig.hhs.gov.

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 (HHS) 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 USC 10 Section 702(a)(1)*.
- The DMHA will deny all applicants who 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 (SPA) and in *Indiana Administrative Code 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 first submit a résumé, then complete training and then submit an application.

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 direct experience with youth between the ages of 6–17 who present with SED. The SED experience requirement for services is as follows:

- Habilitation – Minimum of two years of qualifying experience as defined by the DMHA
- Respite Care – Minimum of one year of qualifying experience as defined by the DMHA

- Training and Support for the Unpaid Caregiver – One of the following:
  - Minimum of two 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 behavioral 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 behavioral health center may also be considered as qualifying experience.

The most recent qualifying experience must be no more than three years prior to the date of application. Experience more than eight 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 children's day care, who throughout their years of experience has cared for children classified as seriously emotionally disturbed
- A bus driver with children on their 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 this section and *Section 13: DMHA and IHCP Provider Agreements* in this provider reference module, as well as the provider application forms and the *DMHA Youth Home and Community-Based Services Provider Agreement* before undertaking the application process.

Résumé 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 the month and year of each experience. Résumés and SED experience documentation should be emailed to DMHAYouthServices@fssa.in.gov or entered into the Provider Management Application Portal

The DMHA will review the applicant's résumé to determine whether the applicant's experience meets DMHA-defined criteria to qualify as a CMHW service provider. The number of years and type of experience required are 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 complete the required CMHW provider training correlating to the services for which the applicant has met criteria

to apply (for example, Wraparound Facilitator, Habilitation, Respite Care, and 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 DMHA-approved training.
- For applicants pursuing approval as providers of Habilitation, Training and Support for the Unpaid Caregiver, and/or Respite Care, training will include a web-based training with defined pass/fail criteria.
  - The successful completion of competency measures is required to receive training credit and to apply for authorization as a CMHW provider.

Provider Application Packet Submission

> *Note: Conditions that will delay processing for DMHA approval and IHCP 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 CMHW *Provider Information* webpage 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 Demographics 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, Facility-Based Respite Care (FBR) Transportation, 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 Demographics Form*

DMHA Review of the Provider Application Packet

After receiving the application packet, the DMHA reviews the packet. The DMHA will only process complete application packets. The DMHA has 30 business days to review a completed application.

Incomplete Applications

Incomplete applications will not be processed. The applicant will receive an email from the DMHA Youth Provider Team notifying the applicant that they must resubmit a complete application. The missing required elements will be included in the email. The applicant must then submit a new, complete application packet. If the application is returned as incomplete, the DMHA has 30 business days to review the application upon resubmission after the missing required elements are addressed.

> *Note: Please refrain from contacting the DMHA regarding your application's status unless it has been longer than 30 business days since it was emailed.*

DMHA Final Decision and Authorization 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 Indiana Family and Social Services Administration (FSSA) letterhead and will contain an official signature.

Authorization letters direct the eligible provider applicant to contact the IHCP fiscal agent (Gainwell Technologies) Provider Enrollment Unit for the IHCP provider application (see the *Provider Enrollment* provider reference module at in.gov/medicaid/providers) 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 IHCP (Medicaid) Provider Enrollment section for more information.*

Applicant Disqualification Criteria

> *Note: The following is not an exhaustive list but represents circumstances that may result in immediate disqualification of the applicant as a DMHA-approved CMHW provider.*
>
> *Any conviction in the past five 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
- Applicant with conviction record of four or more misdemeanors (that are not related to the health and safety of a child)
- Applicant currently on probation or parole
- Applicant identified as a perpetrator of child abuse or neglect
- Applicant with a record of substantiated child abuse or neglect

- Applicant who had approval revoked as an individual or staff of an agency by any division within the FSSA or DCS
- 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, the provider must notify the DMHA immediately.*

IHCP (Medicaid) Provider Enrollment

The DMHA authorization letter directs the eligible provider applicant to complete an IHCP provider application. The applicant must submit the DMHA CMHW service provider authorization letter with the IHCP provider enrollment application for processing.

Providers will not appear on the picklists 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 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 − *Behavioral Health Provider* and provider specialty 611 − *CMHW Service Provider*. See the *IHCP Provider Enrollment Type and Specialty Matrix* at in.gov/medicaid/providers for provider enrollment documentation requirements.
- Providers that are already enrolled as provider type 11 − *Behavioral Health Provider* must add provider specialty 611 − *CMHW Service Provider* to their provider profiles. To add provider specialty 611, providers can make the change in these ways:
  - Online using the **Specialty Changes** option on the *Provider Maintenance* page of the IHCP Provider Healthcare Portal
  - By mailing or faxing a completed *IHCP Provider Specialty Maintenance Form* at in.gov/medicaid/providers
- Providers must obtain rendering National Provider Identifiers (NPIs) for each authorized staff member to be eligible for reimbursement of services. Only individual providers enrolled using their Social Security number as their taxpayer identification may enroll as billing providers, rather than as rendering providers.

For detailed information about the IHCP enrollment process, see the *Provider Enrollment* provider reference module at in.gov/medicaid/providers.

As part of the IHCP Provider Agreement, all providers are required to verify and maintain proof of verification that no employee or contractor is an excluded individual or entity with the Health and Human Services (HHS) OIG. For additional information, see the IHCP Provider Agreement.

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 picklists and is eligible to be placed on a Plan of Care (POC) and to bill for services.

> *Note: After the applicant has received the IHCP approval letter, the applicant must email the letter to the DMHA to be activated on the picklist. Email the IHCP approval letter to DMHAyouthservices@fssa.in.gov.*

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). When 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 three years
- *Nonaccredited agency*: At least every two years
- *Individual provider*: At least every two 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 on the CMHW Provider Information webpage at in.gov/fssa/dmha.*

- 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.

> *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 deauthorization of the provider as a CMHW service provider.
- In compliance with *405 IAC 1-1.4-4*, the FSSA may impose one or more of the following sanctions if a provider has violated any rule established under *Indiana Code 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 by email to the DMHA at DMHAYouthServices@fssa.in.gov.

Providers that voluntarily close rather than reauthorize will not be eligible to apply for any DMHA Youth Services program for a period of one year 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 picklist 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 this *DMHA CMHW Services* module and other CMHW-related bulletins or documentation published by the DMHA and Office of Medicaid Policy and Planning (OMPP).

Provider authorization may be revoked under the following conditions (not an exhaustive 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 in.gov/medicaid
- 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 this module
- Any conviction for a misdemeanor related to the health and safety of a child
- Any felony conviction
- Any pending criminal charges
- Provider with conviction record of four or more misdemeanors (that are not related to the health and safety of a child)
- Provider currently on probation or parole
- Provider identified as a perpetrator of child abuse or neglect
- Failure to report to the DMHA a provider's conviction of any crime or finding that would affect the provider's eligibility for CMHW authorization
- Provider testing positive for any of the drugs tested for in the five-panel drug test described in the *Drug Screen Requirements* section
- Provider 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
- Provider with an open corrective action or termination by any division within the FSSA
- Any other condition that is in direct violation of the CMHW program requirements

Providers that are deauthorized may not reapply for authorization as a CMHW provider for a period of no less than one year.

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)
- Any other entity using state or federal funds to conduct training or a conference whose subject matter is related to behavioral 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. 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:

- 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
- Topics related to behavioral health – diagnosis, serious emotional disturbance (SED), serious mental illness (SMI)
- Trauma-informed care
- Evidence-based practices
- Substance abuse or addiction
-

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. This documentation is required to be submitted upon reauthorization.

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 *DARMHA Training and Support* webpage on the Data Assessment Registry Mental Health and Addiction (DARMHA) website at dmha.fssa.in.gov/darmha.
- Attend a yearly wraparound booster training.

Wraparound Facilitator Supervisors must also complete the following:

- An additional day of training, *Supervisor Training*, which is an introduction to training and coaching tools

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 High Fidelity Wraparound (HFW) through state-funded initiatives.

Wraparound Facilitator agencies will be expected to follow the requirements in this section:

- Wraparound supervisors and facilitators are required to participate in all DMHA wraparound trainings as outlined in the *Core Training Course Descriptions* section.
- To provide support and ongoing coaching by the DMHA site coach, upon request Wraparound Facilitation agencies will make available their Child and Family Team (CFT) schedule and/or submit recordings of CFT meetings to the DMHA Site Coach for review. When available and/or if requested, the DMHA site coach can observe and provide support to supervisors and facilitators during CFT meetings.
  - Wraparound Facilitator Supervisors will participate in coaching with their assigned DMHA site coach quarterly at minimum.
  - Supervisors are required to participate in monthly check-ins with DMHA site coaches

- Supervisor-to-staff ratio does not exceed one to 10 (1:10) regardless of funding source. This includes any supervisor who partners with families.
- 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. The allowance of 1:12 ratio is to be used during times of fluctuation in Wraparound Facilitation staff and should not be assumed as the ratio maximum.
- Supervisors must provide skill-based 1:1 supervision to Wraparound Facilitators a minimum of twice a month. Supervisors are required to document each supervision episode, using the approved DMHA tool. This documentation should be submitted to the DMHA site coach monthly on the 5th business day of the month following supervision. The DMHA site coach will discuss and provide feedback during regularly scheduled coaching sessions with the wraparound supervisor.
- In addition to the above, supervisors should provide ongoing skill-focused training or group supervision to all wraparound staff as based on organizational trends. Supervision should occur monthly. Documentation should be submitted to the DMHA site coach on the 5th business day of the month following supervision.
- Wraparound Facilitator must offer or link families and youth participating in wraparound with access to needed non-CMHW supports.
- The Wraparound Facilitation organization adheres to conflict-free standards including but not limited to not providing any other CMHW service except for facility-based Respite Care.
- The Wraparound Facilitator is DMHA-authorized to provide only Wraparound Facilitation and is not authorized to provide any other CMHW service to the member for whom they are the Wraparound Facilitator.
- 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
  - CANS Training must be completed by Wraparound Facilitators and supervisors
  - CANS Booster Training
- Wraparound Basics
- **Supervisor Training**: 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

- Wraparound Booster Training: Booster trainings will be organized based on current statewide trends and address advanced skill growth around identified skills.
  - Identify and address statewide trends.
  - Develop an increased understanding of targeted skills.
  - Implement practice around desired skill set.

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, tools are used to assist in guiding this process.

Wraparound Facilitation Agency Requirements for Onboarding New Facilitators

This policy should be followed every time a new wraparound facilitator is hired.

Training Components for Wraparound Practitioner

The wraparound agency and supervisor will support and document that the new Wraparound Facilitator has completed the following and is prepared to partner with families:-

1. Be accompanied to team meetings by a supervisor for a minimum of four weeks.
2. Shadow a minimum of two different experienced Wraparound Facilitators in the field for at least two weeks without partnering with any families.
3. Complete a minimum of two CFT meeting observations with different Wraparound Facilitators.
4. Daily access to Wraparound Supervisor..
5. Have all case notes reviewed, as demonstrated by the supervisor's signature on the notes and documentation for a minimum of four weeks.
6. Shadow the Wraparound Supervisor in learning and becoming familiar with Tobi processes and procedures for a minimum of four weeks.
7. Develop an elevator speech that describes the wraparound process.
8. Review and demonstrate understanding of the four phases of wraparound process.
9. Review and demonstrate understanding of the crisis planning process.
10. Review and demonstrate understanding of the 10 principles.

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

Section 13: DMHA and IHCP Provider Agreements

Division of Mental Health and Addiction (DMHA)-approved Child Mental Health Wraparound (CMHW) service providers must be authorized by the 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 program.

By signing the IHCP and DMHA provider agreements, the provider agrees to the policies and expectations provided in the IHCP provider reference modules and this module, as amended periodically, as well as all related provider bulletins and notices. Please see the *DMHA Youth Services Home- and Community-Based Wraparound Services Provider Agreement*.

All amendments to the IHCP provider reference modules and this 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 is binding on publication. Receipt of all information is presumed when the information is emailed to the provider's current email address on file with the 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 Youth Services* webpage at in.gov/fssa/dmha. 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 CMHW Providers email database, accessible from the *Announcements* webpage at in.gov/fssa/dmha.
- Providers will maintain current contact information at all times with the DMHA and Medicaid (Office of Medicaid Policy and Planning [OMPP]) for all avenues of contact, including but not limited to electronic mail address, physical mail-to address, and 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.
- A provider's 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)
- DMHA database, Tobi

*Core*MMIS is maintained by the OMPP. The DMHA maintains Tobi.

> *Note: Providers must notify the DMHA **and** the IHCP of any provider changes requiring notification. The 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
  - Service authorizations (formerly known as Notices of Action or NOAs) that are used to communicate DMHA authorization for CMHW services to the Wraparound Facilitator
  - The CMHW provider database 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 (picklists) 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 (personal and doing business as [DBA])
- Additional service locations
- Tax identification changes
- Changes in ownership (CHOWs)
- 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 the *Update Your Provider Profile* webpage at in.gov/medicaid/providers 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 or request to provide additional CMHW services) that is maintained in the DMHA database must submit the changes to the DMHA by completing a *Provider Demographics* form (*State Form 55353 [R3/8-21*]), accessible from the CMHW *Provider Information* webpage 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 at DMHAYouthServices@fssa.in.gov 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* webpage at in.gov/fssa/dmha):

- *Application Cover Sheet*: All applicants must complete this form to indicate the purpose of the application.
- *Provider Demographics Form*: Only required when providers are requesting initial authorization or reauthorization as CMHW service providers, or when updating demographic information. If the 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, Facility-Based Respite Care (FBR) Transportation, 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 Demographics 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 authorization 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 authorization letter and are not retroactive.

Solicitation of CMHW Services

The CMHW program adheres to state regulation regarding solicitation of CMHW services. *Indiana Administrative Code 405 IAC 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 member, 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 diseases, ICFs/IID or CRFs/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 member to receive a service that the member either does not want or does not need.*
> 5) *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.
- *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 program and where the provider is located.
  - Contact at the event must be initiated by the participant, their family or their authorized representative.
- *Social media and websites*: Service providers may have a business social media page and a website. Providers must abide by all policies and regulations related to the CMHW program and this policy.
  - Potential clients may contact you to request information about the CMHW 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 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. This is not an exhaustive list.

- *In-home activities*: When a service provider is providing a service that is typically provided 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 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 program while participating in the reward activity.
- *Activities not allowed*: The following activities are not allowed with CMHW program participants:
  - Taking the participant to the provider's private or personal residence for any reason other than those activities approved in the POC and consistent with the provider code of conduct.
  - Buying gifts for the participant and/or the family
  - Including the participant in activities that include the provider's own family or friends or activities that are for the provider's own benefit. This includes any time the provider is with the youth regardless of whether or not the provider is claiming billing time.
  - Any activity that the parent is responsible for and capable of doing
- *Family friends who become service providers*: Providers with a personal relationship with the participant/family must differentiate between the personal relationship and CMHW service delivery.
- *Healthy boundaries*: The following are examples 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, the provider should explain to the family this is not allowed and should be discussed in a CFT meeting.
  - Adhere to all CMHW service delivery requirements and limitations as documented in this provider reference module and the 1915(i) CMHW 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 behavioral health provider.
  - 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 may increase the family's stress. Request assistance with billing issues from the Wraparound Facilitator or the IHCP fiscal agent (Gainwell Technologies).
  - 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.
- *Professional communication*: Providers should always maintain professional and clear communication with families and with fellow providers. This includes but is not limited to the scheduling and cancelation of meeting times, and/or if the provider needs to vacate their role on the family's team.

If a provider fails to follow these guidelines while serving in the capacity of an identified CMHW service provider on the POC, the DMHA may 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 14: 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 at DMHAyouthservices@fssa.in.gov.

> *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 Division of Mental Health and Addiction (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 provider reference modules on the *IHCP Provider Reference Modules* webpage at in.gov/medicaid/providers.
- All documentation for CMHW services is subject to review by the Centers for Medicare & Medicaid Services (CMS), the Indiana Family and Social Services Administration (FSSA), including the 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 during the review and authorization process. (See *Section 6: Plan of Care and Service Authorization* in this module for additional information and requirements.)
- *Service authorization (formerly known as Notice of Action or NOA) statements*: Documentation of the DMHA-approved Intervention Plan authorizing CMHW services, units of service and the providers of the services. (See *Section 6: Plan of Care and Service Authorization* in this module for additional information about service authorization.)

- *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 *(This requirement applies only to Wraparound Facilitators.)*
- *All other documentation* pertaining to the participant's enrollment in CMHW services, CFT meetings, referral, evaluation, reassessment, service delivery, monthly summaries and Crisis Plan, as required by the FSSA DMHA and the OMPP

Content Standards for Service Notes

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

- Participant's name – nicknames are insufficient
- IHCP Member ID (also known as RID)
- CMHW service provided (Habilitation, Training and Support for the Unpaid Caregiver, Respite Care, 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 of 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
  - New information for the month (*Some information may be similar month to month, but most of the report should be new information*.)
  - Statements about how the participant responded to strategies
  - Strengths and successes
  - A discussion of progress being made, as well as areas that continue to be needed 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.

A monthly report is required even when services are not provided for that month. The monthly report should summarize why services were not provided.

Section 15: 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 19–23* 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 service authorization (formerly known as Notice of Action or 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 service authorization
- 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* provider reference module accessible from the *IHCP Provider Reference Modules* webpage at in.gov/medicaid/providers.
  - 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 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 service authorization 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 service authorization is generated and provided to the Wraparound Facilitator (who provides it to the participant, family and service providers on the POC). The service authorization documents a decision that affects the participant's authorization of benefits for the CMHW program.

The service authorization 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
- Effective dates
- 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 is not an approved service on the service authorization.
- 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 service authorization.

When the Wraparound Facilitator receives the service authorization, they are 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 service authorization 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 service authorization.

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 service authorization. All CMHW service claims are billed through the IHCP on the professional claim (*CMS-1500* claim form, 837P electronic transaction or IHCP Provider Healthcare Portal [IHCP Portal] professional claim).

See *Sections 19–23* 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 on the IHCP provider website at in.gov/medicaid/providers.

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 800-457-4584 or to your Provider Relations 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 eight minutes of service must be provided.

Units of service activity time for one day are totaled to submit one claim. Remaining units that are less than eight 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 eight minutes or more is rounded up to a 15-minute unit of service.
  - A partial unit of service totaling seven 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 seven 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 eight minutes each, units billed will equal two units of service (as 24 minutes of the service was provided on that day).

Note: Home- and community-based 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 – Unexpected*: One unit of service provided is 0-24 hours on a date of service.
- *Respite – PRTF*: One unit of service for the date of service is established by the current IHCP-approved psychiatric residential treatment facility (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 nonhourly Training and Support for the Unpaid Caregiver 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 22: Training and Support for Unpaid Caregiver* in this module for a service description and limitations associated with the nonhourly training and support service.)

The following general billing information applies to the nonhourly 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 20 $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 100 $1.00 units of service.
- The Wraparound Facilitator is responsible for maintaining documentation to support claims for all items and services purchased via the nonhourly Training and Support for the Unpaid Caregiver services.
- The Wraparound Facilitator must have documented authorization on the POC 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 nonhourly 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.

Electronic Visit Verification Required for Personal Care Services

The *21st Century Cures Act* requires Medicaid providers of personal care services to use an electronic visit verification (EVV) system to document services rendered.

CMHW providers are required to use EVV to document Habilitation and hourly Respite Care services (procedure code and modifier combinations) indicated in *Service Codes That Require Electronic Visit Verification*, accessible from the *Code Sets* webpage at in.gov/medicaid/providers.

> *Note: For certain services, as indicated on the code table, the EVV requirement is waived if the service is performed in a 24-hour congregate setting. Providers are instructed to use the HQ modifier to indicate when that is the case.*

Providers may use an EVV system of their choice; however, providers are responsible for ensuring that the system selected complies with federal requirements, including documentation of the following information:

- Type of service performed
- Individual receiving the service
- Date of the service
- Location of service delivery
- Individual providing the service
- Time the service begins and ends

For more information, see the *Electronic Visit Verification* webpage at in.gov/medicaid/providers.

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 one month on the same claim.
- 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 program documentation standards.
- Services billed to the IHCP must meet the service definitions and parameters as published in the 1915(i) CMHW program rule and this module.
- Updated IHCP billing and policy information is disseminated through IHCP provider bulletins (see the *Bulletins and Reference Modules* webpage at in.gov/medicaid/providers), 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, accessible from the homepage at in.gov/medicaid/providers, or the appropriate 837 electronic transaction. See the *Claim Submission and Processing* provider reference module for instructions on completing the IHCP Portal professional claim. See the *Electronic Data Interchange* provider reference module for information about 837P transactions.

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 engages 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 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 Youth 1915(i) CMHW Quality Improvement [QI] 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. Site coaches provide technical assistance, coaching and training through the use of Wraparound Fidelity Assessment System tools provided by the University of Connecticut and the National Wraparound Implementation Center. The provider specialist, provider coordinator and clinical QI Specialist offer support and oversight for all CMHW providers and ensure that all providers are qualified to provide CMHW services.

The Indiana Youth Services Webpage and Mailing List

The *Indiana Youth Services* webpage at in.gov/fssa/dmha is intended to educate and assist the public, service providers, Access Site, participants and families about Indiana's home- and community-based services programs for youth with serious emotional disturbances (SED). 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 CMHW service providers are required to subscribe to the DMHA CMHW Providers mailing list to receive CMHW program emails regarding policy updates, as well as other information of interest. Providers can subscribe for FSSA email updates by selecting **DMHA CMHW Providers** as a saved preference after they enter their email and contact information. It is recommended that each authorized staff member who provides services also be subscribed to the mailing list. In addition to the mailing list, 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.

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 the IHCP provider website at in.gov/medicaid/providers.

Section 17: Quality Assurance

The quality assurance process helps the Child Mental Health Wraparound (CMHW) program ensure 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 & Procedure* webpage at in.gov/fssa/dmha.

The DMHA is required to conduct quality assurance reviews to routinely monitor provider files and documentation. The reviews are conducted to ensure that providers are in compliance with all policies, practices and procedures of the CMHW program.

The DMHA Quality Improvement team is responsible for conducting quality assurance reviews and improvement activities. This team works closely with the Indiana Health Coverage Programs (IHCP), providers and the local community to affirm all participants are receiving services based on CMHW program policies, procedures, High Fidelity Wraparound (HFW) and a System of Care (SOC) 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 the 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 youth 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

When the DMHA requests a quality review, cooperation from the provider is required, and providers are expected to submit requested documentation within 24 hours or within the time frame requested by the DMHA. The DMHA may request that the files be submitted electronically via encrypted email to ensure HIPPA compliance. The following documents will be requested:

- Monthly reports
- Supervision reports
- Service notes
- Billing/service hours
- CFT meeting minutes

Providers must follow instructions from the DMHA to send requested documents in an encrypted format.

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.

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 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 continuous quality improvement are identified and pursued.

Quality-assurance processes are implemented in the following ways:

- Qualified provider enrollment function
- Program Integrity audits
- Quality assurance review
- Financial integrity audits
- Quality Improvement Strategic Planning

Qualified Provider Enrollment Function

The Office of Medicaid Policy and Planning (OMPP) uses a fiscal agent contractor, Gainwell Technologies, to assist in processing approved IHCP Provider Agreements. The contractor enrolls DMHA-authorized, eligible providers in the Core Medicaid Management Information System (*Core*MMIS) for claim processing. The fiscal agent contractor also conducts training and provides technical assistance concerning claim processing.

Program Integrity Audit Process

The CMHW program auditing function is incorporated into the function of the Indiana Family and Social Services Administration (FSSA) OMPP Program Integrity staff. The FSSA has expanded its program integrity activities by using a multipronged approach to program integrity activity that includes provider self-audits, contractor desk audits and full on-site audits. The Program Integrity staff sifts and analyzes claim 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 audit activities describe post payment financial audits to ensure the integrity of IHCP payments. Detailed information on Program Integrity policy and procedures is available in the *Provider and Member Utilization Review* provider reference module at in.gov/medicaid/providers.

The state employs a hybrid Program Integrity approach to overseeing waiver programs, incorporating oversight and coordination by the Program Integrity staff, as well as engaging the full array of technology

and analytic tools available through the Fraud and Abuse Detection System (FADS) contractor arrangements.

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 & Patient Abuse* webpage 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* provider reference module covers utilization review.

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

Continuous Quality Improvement Strategic Planning Process

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

- CMHW participants and families
- Providers
- Wraparound Facilitators
- General public
- Family and Youth Empowerment Team
- Other FSSA divisions

The DMHA team meets regularly 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.

Using all data and other information gathered, the DMHA team develops a quality improvement strategy to address pertinent issues that impact program effectiveness and integrity. The plan is reviewed, and progress is updated regularly.

Section 18: 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 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
- Service authorization (formerly known as Notices of Action or 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 Core Medicaid Management Information System (*Core*MMIS) that processes claims for payment.
- Provider selection profiles (picklists) 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 Plan of Care* – The POC is a single document created in three parts: The Intervention Plan, the Care Plan and the Crisis Plan.
- The *service authorization* 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.
- *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 picklist to assist them in selecting the Wraparound Facilitator and CMHW service providers.
- *CFT meeting attendance and composition*: Documentation is provided of all CFT meetings, team composition and team member attendance, including meeting sign-in sheets and CFT meeting minutes.
- *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 six 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 Facilitator 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 through Tobi must be done by the approved user and not a designee or trainee. 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 them. Training modules and videos for using Tobi can be found under the Announcements section of Tobi.

Section 19: 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 includes the Intervention Plan, the Care Plan and the Crisis Plan. The Wraparound Facilitator facilitates and supervises this process. Each CMHW 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 3: 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 12: Service Providers* in this module for additional information about applying for DMHA approval as a CMHW service provider. See Table 2 for Wraparound Facilitator-specific provider qualifications and standards.

Table 2 – 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 as shown in the Other standards table row.*	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 two 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	N/A	N/A
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: Glossary of Terms and Acronyms*.) Agencies are encouraged to participate in the local System of Care (SOC), where established, which endorses the values and principles of wraparound.	N/A	N/A

	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 12: Service Providers* 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 (DCS) abuse registry screen ➢ Five-panel drug screen, or agency meets the same requirements specified under the *Federal Drug Free Workplace Act 41, US Code (USC) 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	N/A	N/A

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.

- 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
  - Ensure 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 Indiana Medicaid State Plan or other community-based services, when indicated.

Activities Not Allowed

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

- Duplicative services covered under the Indiana Medicaid State Plan
- Any CMHW service other than Wraparound Facilitation
  - Wraparound Facilitation agencies may not provide any other CMHW service other than Wraparound Facilitation and facility-based Respite Care.
- 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 Service State Plan Amendment (SPA), as supported by *405 IAC 5-21.7*. The Wraparound Facilitator adheres to the following service delivery standards:
  - The Wraparound Facilitator partners with no more than 10 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.
  - In some circumstances, such as Wraparound Facilitator staff turnover, facilitators may temporarily partner with up to 12 youth.
  - 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 service authorization (formerly known as Notice of Action or NOA).

- The Wraparound Facilitator makes sure that Wraparound Facilitation does not duplicate any other CMHW or Indiana Medicaid State Plan service.

Documentation Requirements

The Wraparound Facilitator is responsible for adhering to all general documentation requirements described in this 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 18: Tobi (the DMHA Case Record Management System)* 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.
- *Service authorization (formerly known as Notice of Action or 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 service authorization 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.
- *CFT minutes and sign in sheets* are maintained in the DMHA database to track team meeting attendance and basic fidelity expectations.
- *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 by participant/caregiver signature on the Attestation Form. The Wraparound Facilitator maintains a signed and dated copy of the Attestation Form in the participant case file.
- *Choice of service providers*: The participant/family are provided with the provider picklist 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 picklist 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 18: Tobi (the DMHA Case Record Management System)* in this module for additional information.
- *CMHW Services Level of Need Redetermination* 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 Child and Family Team (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 contact team members in person or by telephone, email or text message. All contacts made must be documented in the agency's records 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 five 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 and maintained by the Wraparound Facilitator. CFT meeting minutes and team attendance is documented by the Wraparound Facilitator and then 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 within agency records. 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 3 for Healthcare Common Procedure Coding System (HCPCS) code, code modifier, code description, billing unit and unit rate information.

Table 3 – 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	$1,074.69 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 15: Service Claim and Billing Overview* in this module for detailed claims and billing instructions. See the provider reference modules on the *IHCP Provider Reference Modules* webpage at in.gov/medicaid/providers 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 service authorization.*

Service Definition

The goal of the Habilitation service 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 skills through development of social, emotional, and decision-making skills, such as the following:

- 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

All requested services must be directly tied to medical necessity. Services will only be authorized or provided when they are deemed clinically appropriate and necessary for the treatment of the defined underlying need, as determined by applicable guidelines and standards of care.

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 12: Service Providers* in this module for additional information about applying for DMHA approval as a CMHW service provider.

Service-specific qualifications and standards for CMHW Habilitation service providers are listed in the following sections.

Provider Type Eligible To Bill for Service

The following providers are eligible to bill for CMHW Habilitation services:

- Accredited agency
- Nonaccredited agency
- Individual service providers

> *Note: Accredited and nonaccredited agencies must receive approval from the DMHA for an individual to provide this service, based on the qualifications of the individual.*

License

The following providers do not need any special licenses to provide CMHW Habilitation services:

- Accredited agency
- Nonaccredited agency
- Individual service provider

Certificate

Nonaccredited agencies and individual service providers do not need any specific licensure or certification to provide CMHW Habilitation services. Accredited agencies must demonstrate one of the following:

- Approved as a community mental health center by the DMHA (*440 IAC 4.1-2-1*)
- Accredited by a DMHA-approved national accrediting entity (AAAHC, COA, URAC, CARF, ACA, JCAHO or NCQA (For definitions of accrediting entities, see *Section 24: Glossary of Terms and Acronyms*.)

Other Standards for CMHW Habilitation Service Providers

The following standards are required for a DMHA-approved Habilitation service provider.

The individual:

- Is at least 21 years of age
- Possesses a high school diploma or equivalent
- Has two years of qualifying experience working with or caring for children and youth with serious emotional disturbance (SED), as defined by the DMHA. See *Section 12: Service Providers* in this module for additional information about SED experience requirements.
- Has completed and submitted proof of the following screens:
  - Fingerprint-based national and state background screen
  - Local law enforcement screen
  - State and local Department of Child Services (DCS) abuse registry screen
  - Five-panel drug screen, or agency meets same requirements specified under the *Federal Drug Free Workplace Act 41, US Code (USC) 10 Section 702(a)(1)*.
- Provides 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.

> *Note: Agencies must maintain documentation that the individual providing the service meets service standards and requirements.*

Provider Supervision Requirements

Habilitation providers are required to obtain one hour of 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.

- Supervision may be in person or virtual.
- 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.
- Supervision must be obtained from one of the following:
  - Licensed health service provider in psychology (HSPP) under *Indiana Code IC 25-33-1*
  - Licensed marriage and family therapist (LMFT) under *IC 25-23.6-8*
  - Licensed clinical social worker (LCSW) under *IC 25-23.6-5*
  - Licensed mental health counselor (LMHC) under *IC 25-23.6-8.5*
  - Advanced practice registered nurse (APRN) under *IC 12-15-5-14(d)*
- 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

Documentation of Supervision

Providers are required to maintain documentation of supervision. Documentation of supervision is not an appropriate component of the participant file; this documentation must be maintained in a secure, separate location.

Supervision must be adequately documented in a "supervision summary note format" agreed upon by the CMHW service provider and supervisor. The documentation must include:

- Name of the individual receiving supervision
- Date of supervision
- Beginning and ending times of the supervision session
- Indication of participant cases reviewed
- Challenges the Habilitation provider has faced and supervisory suggestions for their improvement
- Signature of the individual providing supervision
- Credentials of the individual providing supervision

The FSSA, DMHA or their delegates 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 their 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 psychoeducation 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 participants to become more independent, integrated or productive in the community (including skills to stay on task, follow instructions and manage their time)
- Guided supervision, monitoring, psychoeducation, 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 strength-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
- Services provided to participant's family members
- Services provided to give the family or caregiver respite
- Services provided that are 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 Indiana Medicaid State Plan (such as activities of daily living)
- Attending the CFT meetings or completing the *Monthly Summary Report*
- Services furnished to a minor by parents, stepparents 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 required to attend and participate in the CFT meetings.
- No activity funds or incentives may be requested or provided outside those agreed upon at the CFT meetings. Funds that are decided upon must be sustainable by the family 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.
- 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.

  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, documentation of supervision and the *Monthly Summary Report*. Providers must adhere to all general documentation requirements as described in *Section 14: Documentation Standards and Guidelines* in this module, referenced in service-specific *Sections 19-23*, 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 4 for Healthcare Common Procedure Coding System (HCPCS) code, code modifier, code description, billing unit and unit rate information.

Table 4 – 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	$19.54 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 15: Service Claim and Billing Overview* in this module for detailed claim and billing instructions. See the provider reference modules on the *IHCP Provider Reference Modules* webpage at in.gov/medicaid/providers 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 service authorization (formerly known as Notice of Action or NOA).*

Service Definition

Respite 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.

Respite Care service is a special name for a short-term break for caregivers. Families need a break from time to time to look after their own needs. Under the Child Mental Health Wraparound (CMHW) program, there are many options to ensure families can find the best fit when needing a short-term break. Most respite breaks are planned. However, on rare occasions, something unexpected may occur.

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. CMHW Medicaid-funded services are provided to address the behavioral health needs of the child within the family.

All requested services must be directly tied to medical necessity. Services will only be authorized or provided when they are deemed clinically appropriate and necessary for the treatment of the defined underlying need, as determined by applicable guidelines and standards of care.

There are four types of Respite Care services:

- Routine hourly
  - Routine hourly is billed up to 6 hours and 45 minutes a day. At hour 7, routine hourly switches to routine daily.
- Routine daily
  - Routine daily is billed 7 to 24 hours.

> ***Note:*** *For routine respite daily the following applies:*
>
> - *Cannot exceed 14 consecutive days.*
> - *A minimum of 30 days must pass after a 14-consecutive-day stay before daily routine respite may be used again.*
> - *Routine respite daily service is limited to 40 days per service plan year.*

- Unexpected respite
  - Unexpected respite is used for a time when the caregiver has an unplanned emergency that would put the child's health and safety at risk if respite is not provided. Unexpected respite is not used for when the youth is in crisis. Unexpected respite is when emergencies, unplanned situations or unexpected trips can create a need for immediate care by an alternative caregiver. Unexpected respite will be added to the Plan of Care (POC) after the service has begun.
    - Acceptable request: Caregiver must go out of town to care for a sick relative and all informal supports have been exhausted.
    - Unacceptable request: Caregiver had a stressful week and would like to take a break to focus on self-care.

> ***Note:*** *For unexpected respite, the following applies:*
>
> - *Unexpected respite is only provided on a daily basis (24 hours in the same day).*
> - *Unexpected Respite Care can only be billed for two units/days per stay. On the third day and beyond, billing must switch to the routine respite daily rate.*
> - *Unexpected respite service is limited to 40 days per service plan year.*

- Psychiatric residential treatment facility (PRTF)
  - This type of respite is intended for youth with the highest need for safety. PRTF Respite Care is not to be used in place of acute care. The need for PRTF respite is determined at the Child and Family Team (CFT) meeting through strategy development and is required on the Plan of Care.

See the *Billing Information* section for service codes, billing and reimbursement information for respite services.

Locations

Respite Care services may be provided in the following locations:

- Home- and Community-based: Within the participant's home or community
- Facility-based: Within a DMHA-authorized facility (see the *Facility-Based Licensure* section)

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, who may be a danger to themselves or others, or requires regular monitoring of medications for 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 their profession in the state.

Service-Specific Provider Qualifications and Standards

All providers must be approved by the DMHA to deliver CMHW services. See *Section 12: Service Providers* in this module for additional information about applying for DMHA approval as a CMHW service provider.

Service-specific qualifications and standards for CMHW Respite Care providers are listed in the following sections.

Provider Type Eligible To Bill for Service

The following providers are eligible to bill for CMHW Respite Care services:

- Accredited agency
- Nonaccredited agency
- Individual service provider

Respite Care service providers, who are relatives, must meet all the following criteria in addition to the criteria in *Section 12: Service Providers* in this module:

- Approved by the DMHA as a CMHW service provider
- Determined by the Child and Family Wraparound Team that use of a relative is in participant's best interest
- Selected from the picklist by the family/child to provide the service

- Maintains the qualifications required for Respite Care service for an individual service provider (see the *Other Standards for All CMHW Respite Care Providers* section)
- Related by blood, marriage or adoption
- Does not live in the home with the child and is not the child's primary caregiver

> *Note: Relatives may provide Respite Care services in their home. For example, grandmother is an approved individual Respite Care provider. She may provide Respite Care services to her grandchild in her home.*

Wraparound Child and Family Team Meetings

The following are guidelines for the Wraparound Child and Family Team (CFT) meetings:

- Attendance at CFT meetings is mandatory for all Respite Care providers.
- Meetings may last an hour or more. Providers are required to stay for the entire meeting, so plan accordingly.
- Meeting attendance may be virtual for Respite Care providers who live more than 60 miles from the CFT meeting location.
- Attendance is not billable. Time spent at the CFT meeting is included in the reimbursement rate for Respite Care.
- Reoccurring absences from meetings may result in corrective action up to and including de-authorization as a provider.

Facility-Based Licensure

One of the locations where Respite Care services can be provided is in a DMHA-authorized facility. However, special licensure is required. The following applies to accredited and nonaccredited agencies:

- One of the following licensure types is required:
  - Emergency shelters licensed under *465 IAC 2-10*
  - Foster homes licensed under *IC 31- 27-4* and *IC 31-27-4-3* only when the Licensed Child Placing Agency is the 1915(i)-approved agency provider
    - The DMHA will have the authority to request a copy of the home study that was conducted on the foster parent providing 1915(i) Respite Care services.
  - Other child caring institutions licensed under *IC-31- 27-3*
  - Child care centers licensed under *IC 12- 17.2-4*
  - Child care homes licensed under *IC 12- 17.2-5-1*
  - School-age child care project licensed under *IC 12- 17-12*
  - Psychiatric residential treatment facility (PRTF) licensed under *465 IAC 2-11-1* as a private secure residential facility for Medicaid certification under *405 IAC 5-20-3.1*
- Accredited agencies must also demonstrate one of the following:
  - 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: Glossary of Terms and Acronyms*.)
  - Emergency shelter care *(465 IAC 2-10)*

> *Note: For more information about how to obtain licensure, please contact the Indiana Department of Child Services or the Division of Family Resources. The DMHA does not oversee the process of obtaining licensure. Except for the PRTF license, the DMHA assumes that all other licenses are being used for the sole purpose of providing Respite Care services for the CMHW program.*

Other Standards for CMHW Respite Care Providers

Documentation of the standards outlined in this section must be handled as follows:

- Accredited and nonaccredited agencies that have been authorized by the DMHA to provide Respite Care in a facility must maintain documentation for each employee.
- Individuals, including relatives authorized to provide Respite Care, must submit the documentation to the DMHA for review and approval.
- Nonaccredited agencies that are not authorized to provide Respite Care in a facility must also submit the documentation to the DMHA for review and approval.

The following standards are required for a DMHA-approved CMHW Respite Care provider:

- The individual is at least 21 years of age and has a high school diploma or equivalent.
- The individual has one year of qualifying experience working with or caring for serious emotional disturbance (SED) youth (see *Section 12: Service Providers* in this module for additional information).
- The individual has completed and submitted proof of the following screens:
  - Fingerprint-based national and state 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*, *US Code 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.

Eligible Activities

The following activities are eligible for reimbursement under the CMHW Respite Care service:

- Assistance with daily living skills
- Assistance with accessing/transporting to/from community activities
- Assistance with grooming and personal hygiene
- Meal preparation, serving and cleanup
- Administration of medications
- Supervision
- Recreational and leisure activities

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
  - Any relative who is the primary caregiver of the participant
  - Anyone living in the participant's residence
- Respite Care services provided as a substitute for regular childcare to allow the parent/caregiver to hold a job, engage in job-related or job search activities, or attend school
- Respite Care services provided to the participants while they attend school, including virtual schooling
- Services not provided face-to-face
- Duplicative of any service covered under the Indiana Medicaid State Plan
- Billing for time spent attending the CFT meetings or completing any CMHW-related documentation
- Billing for unexpected respite if the Wraparound Facilitator was not notified within 48 hours of the youth beginning Respite Care service
- Respite Care that exceeds current amount, frequency and/or duration limits (see Table 5).
- Activities not authorized by the DMHA
- Respite Care provided in place of acute care when the youth is in crisis or placement by the Department of Child Services
- Respite Care provided in a PRTF as a replacement for the participant's need for admission to a PRTF for treatment

> *Note: Providers may not provide Respite Care in their own home unless the DMHA has authorized the provider and/or the agency as facility-based or relative Respite Care provider.*

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 meeting process, be documented in the POC and authorized by the DMHA with a current service authorization (formerly known as Notice of Action or NOA)
- The activities the youth will participate in during Respite Care should be discussed and agreed upon in the CFT meeting.
- The service provider is required to participate and attend the CFT meetings.
- Meeting attendance may be virtual for Respite Care providers that live more than 60 miles from the CFT meeting location.
- Unexpected Respite Care must be reported, in writing, by the service provider to the Wraparound Facilitator within 48 hours. The service provider must provide a detailed summary of the request and include a description of the emergency that occurred and how the child's health and safety was at risk if Respite Care had not been provided.
- Upon receipt of the unexpected Respite Care request, and verification of the justification, the Wraparound Facilitator will request the necessary units on the Intervention Plan and submit a

correlating Care Plan with a strategy reflective of the unexpected Respite Care service following the completion of services.

- Unexpected Respite Care can only be billed for two units/days per stay. On the third day and beyond, billing must switch to the routine rate.
- Unexpected Respite Care cannot be added to the POC prior to the respite stay.
- The DMHA requires that all authorized providers obtain 10 hours per year of ongoing professional development training to maintain authorization. See *Section 12: Service Providers* in this module for additional requirements for facility-based Respite Care training.
- Home- and community-based Respite Care service 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 the 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.
- Agencies authorized as facilities are required to notify the DMHA within 10 days of any changes with the status of licensure.
- Agencies authorized as facilities are required to notify and receive approval from the DMHA if operating or planning to operate any other service or program out of the DMHA authorized facility.

Rescheduling Respite Care

Deviation from the CFT meeting-planned respite schedule may only occur under extreme circumstances, which must be approved by the DMHA. Reschedule requests should be initiated by the family by contacting their Wraparound Facilitator. The Wraparound Facilitator must request approval for reschedule by emailing the DMHA at DMHAYouthServices@fssa.in.gov.

Example of an acceptable reschedule: The child is sick with a fever when they are scheduled for Respite Care. This is an extreme circumstance and is therefore allowed.

Example of an unacceptable reschedule: Mom has dinner plans with a friend scheduled for every Monday, so has planned Respite Care in the POC for every Monday. Mom's dinner plan gets rescheduled last minute from Monday to Tuesday, so Mom requests Respite Care to be rescheduled to Tuesday. This is not considered an extreme circumstance and is therefore not allowed.

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 14: Documentation Standards and Guidelines* in this CMHW provider reference module and according to Medicaid rules and regulations. Additionally, Respite Care providers must document a running total of daily Respite Care services used by the caregiver/participant in every monthly report. This is inclusive of all daily Respite Care services regardless of the location. If monthly reports are not submitted timely, no further units will be requested. This information is needed to update the Plan of Care.

The DMHA monitors all Respite Care service providers to ensure that the service is being provided as specified in the POC and in accordance with this CMHW provider reference module. Monitoring may

include, but is not limited to, an unannounced visit to the DMHA-authorized home or facility during the period the Respite Care service is approved.

Billing Information

See Table 5 for Healthcare Common Procedure Coding System (HCPCS) codes, code modifiers, code descriptions and billing unit and unit rate information.

Table 5 – Service Codes and Billing Information for Respite Care Services

Respite Service	HCPCS Code and Modifier	Description and Hours/Units	Unit and Rate	Limitations (Amount/ Duration/ Frequency)
Respite routine hourly	T1005 HA	Unskilled Respite Care, not hospice; 15-minute units; Child Mental Health Wraparound services	$14.53 per unit 1 unit = 15 minutes	Billed for 15 min – 6 hours and 45 minutes per day Max allowed 27 units per day
Respite routine daily	S5151 HA	Unskilled Respite Care, not hospice; daily unit; Child Mental Health Wraparound services	$402.97 per unit 1 unit = 1 day	Billed for 7–24 hours per day Service not to exceed 14 consecutive days at any one time Max 40 days per Care Plan year
Unexpected respite	S5151 HA U1	Unskilled Respite Care, not hospice; daily unit; Child Mental Health Wraparound services; respite unexpected daily	$463.42 per unit 1 unit = 1 day	Billed for 0–24 hours per day. Service not to exceed 2 consecutive days at any one time. Max 40 days per Care Plan year
Psychiatric Rehabilitation Treatment Facility Respite	S5151 HA U2	Unskilled Respite Care, not hospice; daily unit; Child Mental Health Wraparound services; respite daily in Medicaid-certified PRTF	$408.77 per unit 1 unit = 1 day	Billing day is same policy as Medicaid PRTFs Service not to exceed 14 consecutive days at any one time Max 40 days per Care Plan year

Note: For all Respite Care services a "day" starts and ends at midnight.

Providers cannot bill for any activity listed in the *Activities Not Allowed* section for this service. See *Section 15: Service Claim and Billing Overview* in this CMHW provider reference module for detailed

claim and billing instructions. See the provider reference modules on the *IHCP Provider Reference Modules* webpage at in.gov/medicaid/providers for general claim and billing information.

The unit of service should only be calculated out of the actual units needed based on the results of the strategy that the team came up with during the CFT meeting, while implementing the Intervention Plan.

> *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 service authorization.*

Respite Care Billing Examples

The following are examples of Respite Care billing.

Example 1:

During the CFT meeting, the team agrees that the youth will spend an upcoming weekend at a facility that is authorized by the DMHA to provide Respite Care. The caregivers plan to drop off the youth on Friday after school with pickup on Sunday evening.

The youth arrives at 6 p.m. on Friday evening.

- Friday 6 p.m. to midnight = 6 hours or 24 units of hourly Respite Care
- Saturday midnight to midnight = 24 hours or 1 unit of daily Respite Care
- Sunday midnight to 6 p.m. = 18 hours or 1 unit of daily Respite Care

The POC and billing for this youth should reflect two routine Respite Care daily units and 24 routine Respite Care hourly units.

Example 2:

The youth is dropped off unexpectedly at the respite home at 11 p.m. on Friday.

The youth is picked up by the caregivers on Sunday at 6:30 a.m.

Provided the Wraparound Facilitator is notified within 48 hours and there is an appropriate rationale for requesting unexpected Respite Care, billing for this respite stay is two Unexpected Respite Care daily units and 6.5 routine hourly units.

Section 22: Training and Support for the 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 support to the caregiver that preserves the family unit and increases caregiver 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).

All requested services must be directly tied to medical necessity. Services will only be authorized or provided when they are deemed clinically appropriate and necessary for the treatment of the defined underlying need, as determined by applicable guidelines and standards of care.

> *Note: Nonhourly fees for Training and Support for the Unpaid Caregiver services are reimbursed only to Wraparound Facilitation agencies 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 nonhourly 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 nonhourly 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-authorized Child Mental Health Wraparound (CMHW) Training and Support for the Unpaid Caregiver 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 the Unpaid Caregiver service.

Service-Specific Provider Qualifications and Standards

All providers must be approved by the DMHA to deliver CMHW services. See *Section 12: Service Providers* in this module for additional information about applying for DMHA approval as a CMHW service provider.

Service-specific qualifications and standards for CMHW Training and Support for Unpaid Caregiver providers are listed in the following sections.

Provider Type Eligible To Bill for Service

The following providers are eligible to bill for CMHW Training and Support for the Unpaid Caregiver (FST) services:

- Accredited agency
- Nonaccredited agency
- Individual service provider

License

The following providers do not need any special licenses to provide CMHW Training and Support for the Unpaid Caregiver (FST) services:

- Accredited agency
- Nonaccredited agency
- Individual service provider

Certificate

Nonaccredited agencies and individual service providers do not need any special qualifications to provide CMHW Training and Support for the Unpaid Caregiver (FST) services.

Accredited agencies must demonstrate one of the following:

- 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: Glossary of Terms and Acronyms.*

Other Standards for CMHW Training and Support for the Unpaid Caregiver (FST) Providers

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 two years of paid, qualifying experience working with or caring for serious emotional disturbance (SED) youth (see *Section 12: Service Providers* in this module for additional information) or caregivers of children or youth with SED, or certification as a Parent Support Provider
- Can complete and submit proof of the following screens for the individual providing the service:
  - Fingerprint-based national and state background screen
  - Local law enforcement screen
  - State and local Department of Child Services (DCS) abuse registry screen

- Five-panel drug screen, or agency meets the same requirements specified under the *Federal Drug Free Workplace Act 41, US Code (USC) 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 one hour of 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.
- Supervision may be in person or virtual.
- 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 FST services.
- Supervision must be obtained from one of the following:
  - Licensed health service provider in psychology (HSPP) *under Indiana Code IC 25-33-1*
  - Licensed marriage and family therapist (LMFT) under *IC 25-23.6-8*
  - Licensed clinical social worker (LCSW) under *IC 25-23.6-5*
  - Licensed mental health counselor (LMHC) under *IC 25-23.6-8.5*
  - Advanced practice registered nurse (APRN) 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

Documentation of Supervision

Providers are required to maintain documentation of supervision. Documentation of supervision is not an appropriate component of the participant file; this documentation must be maintained in a secure, separate location.

Supervision must be adequately documented in a "supervision summary note format" agreed upon by the CMHW service provider and supervisor. The documentation must include:

- Name of the individual receiving supervision
- Date of supervision
- Beginning and ending times of the supervision session
- Indication of participant cases reviewed
- Challenges the Training and Support for the Unpaid Caregiver provider has faced and supervisory suggestions for their improvement

- Signature of the individual providing supervision
- Credentials of the individual providing supervision

The Indiana Family and Social Services Administration (FSSA), DMHA or their delegates 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 behavioral health needs
- Learning communication and crisis de-escalation skills geared for working with participant's behavioral health and needs
- More than one caregiver of a participant may receive training at the same time

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 Indiana Medicaid State Plan
- Billing for time spent attending the CFT meetings or completing the *Monthly Summary Report*
- Reimbursement 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 POC, and be authorized by the DMHA with a current service authorization (formerly known as Notice of Action or NOA).
- The service provider providing the training and support services must be documented in the POC and authorized by the DMHA with a current service authorization.
- 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; however, up to two hours per month may be provided virtually or via telephone.
- The hourly service provider is required to attend and 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 14: Documentation Standards and Guidelines* in this module, referenced in service-specific *Sections 19-23*, and according to Medicaid rules and regulations.

In addition to general documentation requirements, the Wraparound Facilitator is required to retain receipt of payment for any nonhourly training and support service activity (class/conference registration, fees, supplies and so on).

See the Indiana Health Coverage Programs (IHCP) website at in.gov/medicaid 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 Information

See Table 6 for Healthcare Common Procedure Coding System (HCPCS) codes, code modifiers, code descriptions, and billing units and unit rate information.

Table 6 – 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 the unpaid caregiver – hourly	H2015 HA	Comprehensive community support services, per 15 minutes; CMHW services	$19.54 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

Service	HCPCS Code and Modifier	HCPCS Code Description	Unit and Rate	Service Ratio	Limitations (Amount/ Duration/ Frequency)
Training and support for the unpaid caregiver – nonhourly/ family	S5111 HA	Home care training, family; per session; CMHW 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 nonhourly fees are only reimbursed to Wraparound Facilitation agencies 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 – nonhourly/ nonfamily	S5116 HA	Home care training, nonfamily; per session; CMHW 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 nonhourly fees are only reimbursed to Wraparound Facilitation agencies 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 these services. See *Section 15: Service Claim and Billing Overview* in this module for detailed claims and billing instructions. See the provider reference modules on the *IHCP Provider Reference Modules* webpage at in.gov/medicaid/providers 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 service authorization.*

Section 23: Facility-Based Respite Care Transportation Service

Service Definition

Facility-Based Respite Care (FBR) Transportation service is a nonmedical transportation service offered to enable Child Mental Health Wraparound (CMHW) participants to travel to a respite care facility to receive facility-based Respite Care services when no other transportation is available to the participant. This service is to overcome barriers to families and youth to assist with transportation to and/or from the youth's home within 120 miles of the facility-based respite care location.

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 12: Service Providers* in this module for additional information about applying for DMHA approval as a CMHW service provider.

Service-specific qualifications and standards for CMHW FBR Transportation providers are listed in the following sections.

Provider Qualifications

Provider qualifications for FBR Transportation services are presented in Table 7.

Table 7 – Provider Types, Qualifications and Requirements

Provider	Acceptable Types	Qualifications	Requirements
Accredited Agency	1) Emergency shelters licensed under *Indiana Administrative Code 465 IAC 2-10* 2) Licensed Child Placing Agency (LCPA) *(The DMHA will have the authority to request a copy of the home study that was conducted on the foster parent providing 1915(i) Respite Care services.)* 3) Other child-caring institutions licensed under *Indiana Code IC-31- 27-3* 4) Child Care Centers licensed under *IC 12- 17.2-4*	AAAHC, COA, URAC, CARF, ACAC, JCAHO or NCQA Accreditation (For definitions of accrediting entities, see *Section 24: Glossary of Terms and Acronyms*.)	DMHA-authorized accredited agencies must receive authorization from the DMHA for licensed facility. Individuals providing the service must be authorized by the DMHA. Agencies must maintain documentation that the individual providing the service meets the following requirements and standards: 1) Individual is at least 21 years of age and possesses a high school diploma or equivalent. 2) Individual has completed and submitted proof of the following screens: a) Fingerprint-based national and state background screen b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen d) Five-panel drug screen, or agency meets same requirements specified under the *Federal Drug Free Workplace Act 41 United States Code USC 10 Section 702(a)(1)* 3) Documentation of the following: a) Current driver's license b) Proof of current vehicle registration c) Proof of motor vehicle insurance coverage 4) Complete the DMHA required service provider training, including but not limited to: a) CMHW services orientation b) Cardiopulmonary resuscitation (CPR) certification

Provider	Acceptable Types	Qualifications	Requirements
Nonaccredited Agency	1) Emergency shelters licensed under *465 IAC 2-10* 2) Licensed Child Placing Agency (LCPA) *(The DMHA will have the authority to request a copy of the home study that was conducted on the foster parent providing 1915(i) Respite Care services.)* 3) Other child caring institutions licensed under *IC -31- 27 -3* 4) Child Care Centers licensed under *IC 12- 17.2 -4*	None	DMHA-authorized nonaccredited agencies must receive authorization from the DMHA for licensed facility-based Respite Care. Individuals providing the service must be authorized by the DMHA. Agencies must maintain documentation that the individual providing the service meets the following requirements and standards: 1) Individual is at least 21 years of age and possesses a high school diploma or equivalent. 2)Individual has completed and submitted proof of the following screens: a) Fingerprint-based national and state background screen b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen d) 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)* 6) Documentation of the following: a) Current driver's license b) Proof of current vehicle registration c) Proof of motor vehicle insurance coverage 7) Complete the DMHA required service provider training, including but not limited to: a) CMHW services orientation b) CPR certification

Other Standards for FBR Transportation Providers

The individuals providing the service must meet the requirements as listed in Table 7 as well as the following service provider requirements (agencies must maintain documentation that the individual providing the service meets the following requirements and standards):

- Maintain the vehicle or vehicles used in the provision of transportation services in good repair.
- Retain and make available upon request, records of regular and appropriate maintenance.
- Ensure the vehicle used for transportation services is properly registered with the Indiana Bureau of Motor Vehicles (BMV).
- Retain and make available upon request, documentation confirming the provider has the appropriate insurance as required under Indiana law.
- Drivers must adhere to all Indiana traffic laws and regulations, including but not limited to speed limits, seat belts and cell phone laws.
- Maintain a travel emergency preparedness kit, first-aid kit, fire extinguisher, spare tire and jack in the authorized vehicle.

Accredited agencies must submit verification of all documentation to the DMHA:

- Initially at point of DMHA authorization of the CMHW agency
- At least every three years after initial submission

Nonaccredited agencies must submit verification of all documentation to the DMHA:

- Initially at point of DMHA authorization of the CMHW agency
- At least every two years after initial submission

Utilization of FBR Transportation

To use FBR Transportation service, the following steps must be completed:

1. The family must have picked Respite Care that will take place in a DMHA-authorized facility as a service through the Child and Family Team (CFT) meeting process.
1. At the CFT meeting, the team will determine if transportation is needed. All natural and community supports must be exhausted before using FBR Transportation.
2. After determining that FBR Transportation is needed, the CFT will brainstorm when FBR Transportation is needed. (For example, is FBR Transportation needed only for a one-way trip from home to the FBR facility? Is it needed only from the FBR facility to home? Or is it needed for both trips from home to the FBR facility and back home again?)
3. The CFT (during the CFT meeting) will use MapQuest or Rand McNally to determine the distance from the youth's home to the FBR facility. This will determine how many units of FBR Transportation service are needed. The shortest distance must be used.
4. The Wraparound Facilitator will print the FBR Transportation picklist and obtain the caregiver's signature.
5. The Wraparound Facilitator will then upload the picklist to the participant page in Tobi and update the Intervention Plan and the strategies in the Care Plan under the caregiver's underlying need.

The strategy in the Care Plan must include the dates and times of pickup and drop-off from the youth home to the FBR facility and home again for a round trip. It must note what natural and community-based options have been exhausted. It must also include the shortest distance determined by MapQuest or Rand McNally.

If a round trip is not needed, this needs to be indicated in the strategy. For example, if a caregiver will be taking youth to the FBR facility, and then the youth needs FBR Transportation home.

Eligible Activities

FBR Transportation services allowed activities may include, but are not limited to the following:

- Transporting the participant from home to the FBR facility.
- Transporting the participant from the FBR facility to home.

Activities Not Allowed

The following activities are not eligible for reimbursement under the FBR Transportation service:

- Duplicative services covered under the Indiana Medicaid State Plan
- Service offered in addition to medical transportation required under *Code of Federal Regulations 42 CFR 431.53*; FBR Transportation services shall not replace these
- Transportation used to access recreational activities, trips to and from school, or other activities that will require transportation during the participant's stay in an FBR facility

Service Standards

These service standards must be followed for FBR Transportation services:

- Transportation services must follow a written service plan addressing specific needs determined by the participant's Plan of Care (POC).
- Whenever possible, family, neighbors, friends or community agencies that can provide this service without charge will be used.
- Transportation may only be provided from participant's home to an FBR facility and from the FBR facility to the participant's home.
- Upon pickup, participant's caregiver must sign and time/date stamp the transportation log indicating that the youth has been successfully picked up by the provider. When the youth returns, the caregiver must again sign and time/date stamp, indicating that the youth has successfully returned to their care.

Documentation Standards

Documentation standards must be followed for FBR Transportation services:

- Identified under the Caregiver Underlying need as a strategy. Strategy must include information as to why natural supports were unable to provide transportation, as well as dates, times and locations of pickup and drop-off.
- Services outlined in the POC and service authorization (formerly known as Notice of Action or NOA); provider must have the following sent with the participant or received prior to transportation to the FBR facility:
  - Care Plan
  - Crisis Plan
  - Intervention Plan

- Service authorization
- Caregiver emergency contact information

- Providers are required to have a paper copy of the Crisis Plan, developed by the CFT, secured in the vehicle whenever participants are being transported.
- Provider must maintain a DMHA-approved transportation logbook that references MapQuest or Rand McNally designated route of shortest distance between pickup and drop-off locations. Each trip must reference the participant number of the youth being transported. The log must also have space for the caregiver to sign and date and time stamp.
- The determination of need of this service is decided upon at the CFT meeting. Using MapQuest or Rand McNally, the team will map the shortest distance to determine the units of FBR Transportation needed to support the family.

Billing Information

Transportation services are reimbursed when a participant requires transportation to access facility-based Respite Care services. Transportation is provided at a single rate or base trip within 15 miles of the respite care facility. When providing transportation for more than 15 miles, transportation will be reimbursed at the base rate plus an additional rate for each mile over the initial 15 miles.

See Table 8 for Healthcare Common Procedure Coding System (HCPCS) codes, code modifiers, service descriptions, rates and pay of rate information.

Table 8 – Service Code and Billing Information for Facility-Based Transportation Services

Code	Modifier 1	Modifier 2	Modifier 3	Service	Rates	Pay of Rate
T2003	HA=Child/ Adolescent Program	U1=Basic	UB=Base Trip	Transportation Base, Basic Up to 15 miles One base rate can be used once per day.	$30.02	Base rate/trip
T2003	HA=Child/ Adolescent Program	U1=Basic		Transportation, Basic Trip Mileage To be used if needed after base rate is exhausted	$1.36	Per mile

Section 24: Glossary of Terms and Acronyms

The following acronyms and definitions apply to the Child Mental Health Wraparound (CMHW) program and the policy and procedures outlined in this module:

1915(i) CMHW Services: *Child Mental Health Wraparound* (CMHW) services provide 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

IN211: Indiana 211 (IN211) is a free service that connects Hoosiers with help and answers from thousands of health and human service agencies and resources right in their local communities. IN211's team is comprised of community navigators who are skilled at actively listening and identifying needs and providing referrals that best meet those needs.

837P electronic transaction: This transaction allows providers to submit claims electronically to the Indiana Health Coverage Programs (IHCP). The 837P transaction can be used instead of the IHCP Provider Healthcare Portal (IHCP Portal) to submit claims.

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.

AMHH: 1915(i) Adult Mental Health Habilitation services program. Services provided for individuals and their families, or groups of adult persons who are living in the community and who need help on a regular basis with serious mental illness or co-occurring mental illness and addiction disorders.

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 assist in determining the individual's strengths, needs and functional impairment. The tool is administered to individuals who are 18 years of age or older.

Access Site: The single point of entry to explore a youth's eligibility for the Child Mental Health Wraparound (CMHW) program.

Applicant: Refers to an individual applying for a Division of Mental Health and Addiction (DMHA) Youth Home- and Community-Based 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 Division of Mental Health and Addiction (DMHA) through the Data Assessment Registry Mental Health and Addiction

(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.)

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 Division of Mental Health and Addiction (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 Centers for Medicare & Medicaid Services (CMS)-approved 1915(i) Home- and Community-Based Services (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. The 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 Centers for Medicare & Medicaid Services (CMS)-authorized professional claim form used to submit paper claims to the Medicaid fiscal contractor for reimbursement of rendered, Division of Mental Health and Addiction (DMHA)-approved Home- and Community-Based Services (HCBS).

COA: *Council on Accreditation*

***Core*MMIS:** Indiana's Medicaid Management Information System (MMIS) or claim-payment system.

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 Home- and Community-Based Services (HCBS), may be either accredited or nonaccredited. Both types of agencies must be approved by the Division of Mental Health and Addiction (DMHA) to be enrolled as HCBS providers.

CSL: Indiana's *Consumer Service Line* is a 24-hour toll-free line for consumers to share complaints, questions and concerns about services, treatments, procedures, rights and policies. The Division of Mental Health and Addiction (DMHA) contractor processes calls and informs the DMHA. The toll-free number is 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* supports the development of alternatives to nursing home care and coordinates home- and community-based services and funding through the statewide INconnect Alliance.

DARMHA: The *Data Assessment Registry Mental Health and Addiction* electronic system is accessed to report Child and Adolescent Needs and Strengths (CANS) assessment ratings to the Division of Mental Health and Addiction (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 Child Mental Health Wraparound (CMHW).

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. The 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 Home- and Community-Based Services (HCBS) program, including provider enrollment, eligibility determinations and service authorizations.

EVV: *Electronic visit verification*, the Medicaid-required documentation of personal care services.

FBR Transportation: Facility-Based Respite Care (FBR) Transportation service is a nonmedical transportation service offered to enable Child Mental Health Wraparound (CMHW) participants to travel to a respite care facility to receive facility-based Respite Care services when no other transportation is available to the participant.

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), Office of Medicaid Policy and Planning (OMPP), Office of Early Childhood and Out-of-School Learning (OECOSL), and 211.

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 Child Mental Health Wraparound (CMHW) program. See *Training and Support for the Unpaid Caregiver*.

Gainwell: *Gainwell Technologies* is the Indiana Health Coverage Programs (IHCP) fiscal agent responsible for maintaining the Core Medicaid Management Information System (*Core*MMIS) database for all IHCP providers and members – including enrolled CMHW providers and approved CMHW participants, as well as their authorized CMHW services approved by the Division of Mental Health and Addiction (DMHA). Gainwell performs claim processing and reimbursement for eligible providers of CMHW and other fee-for-service, nonpharmacy Medicaid services. Gainwell assigns IHCP Provider IDs required for reimbursement of all IHCP claims. Gainwell also maintains the IHCP provider website and all provider reference modules.

Habilitation: These services 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 the Centers for Medicare & Medicaid Services (CMS) under Section 1915(c) of the *Social Security Act.*

Health means physical and behavioral well-being.

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 Indiana Administrative Code (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's Medicaid program is collectively referred to as the *Indiana Health Coverage Programs* (IHCP). The IHCP provides a healthcare safety net for low-income children and adults, including those who are aged, disabled, blind, pregnant or meet other eligibility requirements. The IHCP receives federal and state funds to operate the program and reimburse providers for reasonable and necessary medical care for eligible members. Each state administers its own Medicaid program within the provisions of federal legislation and broad federal guidelines issued by the Centers for Medicare & Medicaid Services (CMS). The Indiana Family and Social Services Administration (FSSA) administers the IHCP. The IHCP includes the 590 Program, Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise (including Children's Health Insurance Program) and Traditional Medicaid.

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 service authorization (formerly known as Notice of Action or 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 25-23.6-8.5*

LON: *Level of Need* is one of the federal eligibility requirements for the Child Mental Health Wraparound (CMHW) program. The Centers for Medicare & Medicaid Services (CMS) requires that a participant must meet defined requirements for LON and eligibility to enroll in the 1915(i) Child Mental Health Wraparound Services State Plan Amendment (CMHW program).

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 means an individual who has been deemed eligible for Indiana Health Coverage Program (IHCP) services.

Member ID: *Member identification number* used to identify individuals eligible for Indiana Health Coverage Programs (IHCP) services, including tracking and claim processing for eligible services. This includes the Home- and Community-Based Services (HCBS) program. This is also known as recipient identification number (RID).

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 their practice under state law, for maximum reduction of physical or mental disability and restoration of a member to their best possible functional level.

NCQA: *National Committee for Quality Assurance*

Needs-based eligibility criteria: Factors used to determine an applicant's eligibility for Child Mental Health Wraparound (CMHW) services. For additional information, see *Section 5: Participant Eligibility and Application for CMHW Services*.

NOA: *Notice of Action* is now referred to as a service authorization (see *Service authorization*).

Nonaccredited agency: A community service agency that does not have a national accreditation

NPI: *National Provider Identifier* is the1996 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 Child Mental Health Wraparound (CMHW) service providers that do not perform healthcare services. Home- and Community-Based Services (HCBS) providers may submit claims using their Provider ID.)*

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 (FSSA). The OMPP administers the Indiana Health Coverage Programs (IHCP) in accordance with federal and state requirements, which includes responsibility for financial oversight of the Home- and Community-Based Services (HCBS) program.

Outpatient behavioral 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 Home- and Community-Based Services (HCBS) by the Division of Mental Health and Addiction (DMHA).

POC: The *Plan of Care* is the individualized plan of treatment that guides the Home- and Community-Based Services (HCBS) delivery and includes the Intervention Plan, Care Plan and Crisis Plan.

Provider agency: A Division of Mental Health and Addiction (DMHA)-authorized agency provider of Child Mental Health Wraparound (CMHW).

Provider agency staff member: Refers to a staff member providing Child Mental Health Wraparound (CMHW) services under the direction and supervision of a Division of Mental Health and Addiction (DMHA)-authorized provider agency.

Provider Healthcare Portal (IHCP Portal) is a secure, web-based tool where Child Mental Health Wraparound (CMHW) providers may view CMHW authorization, claim and other information. Provider enrollment, provider profile updates and claims (including claims for Division of Mental Health and Addiction (DMHA)-approved CMHW services rendered) may also be submitted via the IHCP Portal. The

IHCP Portal is accessible from the IHCP Providers homepage at in.gov/medicaid/providers. For more information about using the IHCP Portal, see the *Provider Healthcare Portal* provider reference module at in.gov/medicaid/providers.

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 Jan, 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).

Recreational: Activities people do to relax or have fun (for example, activities done for enjoyment).

Rendering provider: The individual authorized by Division of Mental Health and Addiction (DMHA) to provide or render Child Mental Health Wraparound (CMHW) services to a CMHW program participant.

Rendering NPI: The individually assigned National Provider Identifier (NPI) required for each rendering provider of Child Mental Health Wraparound (CMHW) services.

Respite Care: Services provided to participants. 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.

SED: *Serious Emotional Disturbance*, as defined in *440 IAC 8-2-4* (individuals from age of 6 through 17).

Service authorization: Formerly known as Notice of Action or NOA, the service authorization is a written notice given to each Home- and Community-Based Services (HCBS) applicant and participant for any action that will affect their HCBS benefits. The service authorization includes actions to approve or deny an applicant's eligibility for HCBS; all Division of Mental Health and Addiction (DMHA)-approved Child Mental Health Wraparound (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 service authorization for prior authorization to provide and bill the Indiana Health Coverage Programs (IHCP) for the DMHA-approved services. The IHCP will deny reimbursement for any service that is not listed on the service authorization or exceeds the DMHA-approved amount of each service.

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.

Site coach: *See Youth 1915(i) Quality Improvement Site Coach.*

Tobi: The Indiana Family and Social Service Administration (FSSA) electronic management system that processes and tracks the Home- and Community-Based Services (HCBS) program. The database stores all applications, demographic information, the Child and Adolescent Needs and Strengths (CANS) information, documentation of choice, grant providers, picklists, Plans of Care (POCs), costs and approvals and denials, and is used by the Wraparound Facilitator to manage the POC and generate and store the service authorizations. After the Wraparound Facilitator enters the approved POC in the Division of Mental Health and Addiction (DMHA) database, the DMHA database interfaces with the Core Medicaid Management Information System (*Core*MMIS) 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*

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 Plan of Care (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 Child Mental Health Wraparound (CMHW) service. Children and youth who participate in the Home- and Community-Based Services (HCBS) program must receive Wraparound Facilitation. The individual who facilitates and supervises this process is the Wraparound Facilitator.

Youth 1915(i) Quality Improvement Site Coach: Division of Mental Health and Addiction (DMHA) staff member, also known as site coach, who provides technical assistance, coaching and training to all Wraparound Facilitator organizations, their Wraparound Supervisor and Wraparound Facilitator staff. Site coaches meet regularly with Wraparound Facilitation organizations and their staff to support the implementation of high-fidelity wraparound practice.