Michigan Medicaid Policy | MMP

BULLETIN

BEHAVIORAL AND PHYSICAL HEALTH AND AGING SERVICES ADMINISTRATION

MDHHS

Bulletin Number: MMP 24-41

Distribution: Community Mental Health Services Programs (CMHSP), Prepaid Inpatient Health Plans (PIHP)

Issued: August 30, 2024

Subject: Establishment of Intensive Care Coordination with Wraparound (ICCW)

Effective Date: October 1, 2024

Programs Affected: Medicaid

Note: Implementation of this policy is contingent upon approval of a State Plan Amendment (SPA) by the Centers for Medicare & Medicaid Services (CMS). Once approved by CMS, MDHHS will no longer reimburse the provision of Wraparound separately.

The purpose of this policy is to establish Intensive Care Coordination with Wraparound (ICCW). The policy is intended to define ICCW and provide guidelines for the model as to criteria, organizational structure, qualifications, scope, amount, engagement, planning processes, location, and evaluation and outcomes measurement.

I. Intensive Care Coordination with Wraparound

ICCW is an evidence-informed approach to ensuring comprehensive coordination and holistic planning for children, youth, young adults, and their families with the most intensive needs. ICCW is an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) State Plan service when delivered to children, youth, and young adults under 21 years of age.

Care Coordination includes organization, coordination, linkage, and monitoring of services and supports and advocacy on behalf of the child, youth, or young adult and their family. Coordination and collaboration span across multiple systems, programs, and resources in alignment with systems of care philosophy. Wraparound is the individualized, family-driven and youth-guided planning process facilitated by Care Coordinators that are trained and certified in the Wraparound Planning Process.

The Wraparound Planning Process follows four stages: 1) Hello-Engagement and Team preparation, 2) Help-Initial plan development, 3) Heal-Implementation, and 4) Hope-Transition. The Wraparound Planning Process utilizes a collaborative Wraparound Team approach including a child, youth, or young adult and their family and their choice of professional and natural supports. Care Coordinators facilitate the Wraparound plan development, considering all life domains.

II. Criteria

Children, youth, or young adults, birth to age 21, are eligible for ICCW if they meet all the following criteria:

- Serious Emotional Disturbance, Serious Mental Illness, and/or Intellectual/Developmental Disability;
- Presenting with complex behavioral needs; and
- Have an identified community.

AND two or more of the criteria listed below:

- Currently in or at risk of out-of-home placement.
- Involved in two or more child, youth, or young adult-serving systems, including but not limited to: Mental/Behavioral Health, Juvenile or Adult Criminal Justice, Child Welfare, Adult Protective Services, Education (special education or other school support services)
- Has received other case management or case management-like services, and higher intensity is required to meet needs.
- Lack of an identified support system.
- Presenting with complex medical needs and stabilization has not been reached.
- Has a functional impairment related to school activities, attendance, or performance. This includes but is not limited to experiencing multiple suspensions and/or expulsions.
- Displays significant physical and/or emotional distress after experiencing a traumatic event. Traumatic events may include but are not limited to natural disasters, acts of violence, abuse, neglect.

Note: When a child, youth, or young adult is being served under the Waiver for Children with Serious Emotional Disturbances (SEDW), ICCW is recommended to support the child, youth, young adult and their family through the planning process. At the preference of the child/youth, young adult and their family, Targeted Case Management (TCM) may be utilized instead of ICCW.

If ICCW is not a recommended service based upon the completion of the MichiCANS but the child, youth, or young adult meets medical necessity criteria as outlined in policy, ICCW should be authorized.

TCM cannot be authorized in the Individual Plan of Service (IPOS) when ICCW is authorized in the IPOS. Home-based services and ICCW may be authorized concurrently. Case-management functions performed through home-based services may not billed at the same, specific date/time that ICCW is also being billed to avoid same-time duplication of services.

III. Organizational Structure

ICCW providers must request approval to provide ICCW from MDHHS through a certification process defined by MDHHS, and certification must occur every three years. Programs must be certified to ensure adherence to Medicaid policy requirements and fidelity to the ICCW model.

IV. Qualifications, Training and Responsibilities

A. ICCW Program Administrator

- Attend ICCW 101 Training.
- Attend one annual ICCW booster.
- Provide direct oversight of ICCW Supervisors.
- Provide local oversight of ICCW.
- Align internal policies and procedures, contracts and/or memorandums of understanding with Wraparound philosophy and ICCW policy.
- Broker services as needed.
- Secure local partnership with child, youth, or young adult and family community programs, systems and partners.

B. Care Coordination Supervisor

- Oversee ICCW, including evaluation.
- Receive/process referrals and assign children, youth, or young adults and their families to Care Coordinators.
- Adhere to policies/procedures that align with ICCW.
- Organize and facilitate Community Team meetings quarterly, at minimum.
- Be designated as a Child Mental Health Professional (CMHP) (when overseeing provision to SED youth) and/or Qualified Intellectual Disabilities Professional (QIDP) (when overseeing provision to Intellectual/Developmental Disabilities [I/DD] youth)
- Participate in Person-Centered Planning Process training, including Self Determination.
- Obtain certification in MichiCANS if providing supervision to a Care Coordinator who is responsible for completion of the annual MichiCANS.
- Receive certification in ICCW through MDHHS-provided training prior to supervision of Care Coordinators.
- Maintain certification in ICCW:
    - Complete one annual ICCW booster.
    - Complete at least two MDHHS-provided trainings related to ICCW, one of which must be supervisor specific.
    - Complete an additional 16 hours of annual training related to provision of support to children, youth, or young adults and their families, when supervising the provision of ICCW to those served under the SEDW.
- Provide weekly, individualized supervision and coaching to Care Coordinators and maintain a supervision log.

- Maintain partnership with child, youth, or young adult and family community programs, systems, and partners.
- Ensure Care Coordinators have knowledge of State Plan and SEDW service array and community resources and programs.
- Ensure families and staff have access to a directory of community resources, systems, and programs.

C. Care Coordinator

- Possess a minimum of bachelor's degree in any field.
- Receive certification in ICCW through MDHHS-provided training or have been granted provisional approval prior to provision.
- Maintain certification in ICCW:
  - Complete one annual ICCW booster.
  - Complete at least two MDHHS-provided trainings related to ICCW.
  - Complete an additional 16 hours of training (annually), related to provision of support to children, youth, or young adults and their families, when providing ICCW to those served under the SEDW.
- Participate in and complete MDHHS-required evaluation and fidelity measurements.
- Provide full scope of ICCW and facilitate the Wraparound Planning Process to model fidelity to develop a Wraparound Plan.
- Participate in Person-Centered Planning Process training, including Self Determination.
- Facilitate the Person-Centered Planning Process in alignment with family-driven youth-guided guidelines in adherence to applicable policy to develop an Individual Plan of Service (IPOS).
- Obtain certification in MichiCANS if responsible for the completion of the annual MichiCANS.
- Demonstrate knowledge of State Plan and SEDW service array and community resources and programs.
- Attend Community Team meetings as needed to support their Wraparound Teams.
- Care Coordinators may not have more than one provider role with a family. If Care Coordinators are providing other mental health services, including crisis response, they may not provide ICCW to the same child, youth, or young adult and their family.
- Care Coordinators must adhere to caseload ratio:
  - 1:12 Care Coordinator to Wraparound Teams-dedicated caseload.
  - The dedicated ratio may increase to a maximum of 1:15 when at least three Wraparound Teams are in the Hope phase.

D. Community Team

- Include children, youth, young adults, and parents/caregivers with lived experience and local system and community partners.
- Work as a collaborative body to:
  - Identify available community services and programs.

- Ensure the development and/or maintenance of a directory of community resources, systems and programs.
- Develop new and/or improve existing community services and programs.
- Provide support to local system partners and community partners experiencing challenges meeting the needs of children, youth, or young adults, and their families, with complex needs.
- Provide support to Wraparound Teams.
- Empower the child, youth, or young adult and their family to be involved in designing, implementing, and evaluating services and programs.
- Implement additional activities and responsibilities that reflect the individual needs of the community.

E. Wraparound Team

ICCW requires the development of a Wraparound Team. The Team must be coordinated prior to the development of and adjustments to the Wraparound Plan. Wraparound Teams include but are not limited to the youth, child, or young adult and their family, natural supports, professional supports, and community partners. In the limited circumstance in which a child, youth, young adult, or parent/caregiver is unable to attend a Wraparound Team meeting, Care Coordinators are responsible for ensuring voice and choice.

V. Amount

- Wraparound Teams shall meet once per week, at minimum, during the Hello and Help phases.
- Wraparound Teams shall meet twice monthly, at minimum, during the Heal phase. The Heal phase begins once the plan has been developed and the Team agrees stabilization has been achieved.
- Wraparound Teams shall meet monthly, at minimum, during the Hope phase. The Hope phase begins when the Team agrees that the child, youth, or young adult and family are ready to graduate from the Wraparound Planning Process and no longer show a need for ICCW.
- When a child, youth, or young adult is in placement and the Care Coordinator is facilitating transition planning back to the home and community, the meeting frequency may reflect the needs of the child, youth, or young adult. Only upon Wraparound Plan development or adjustment, may the frequency of Team meetings decrease.
  - Upon discharge, frequency of meetings should align with the phase that the Wraparound Team is in.
- The Care Coordinator must review services at intervals defined in the Individual Plan of Service (IPOS). A formal review of the IPOS shall not occur less often than annually to review progress toward goals and objectives and to assess beneficiary satisfaction.
- Frequency and scope (face-to-face and telephone) of other ICCW monitoring activities must reflect the intensity of the child, youth or young adult's health and welfare needs.

VI. Scope

- Ensure child, youth, or young adult and their family understand the ICCW and the Wraparound Planning Process. When SEDW is being utilized, orient child, youth, or young adult and their family to the SEDW process and service array.
- Ensure documentation from other service providers and systems partners (physicians, medication prescribers, mental health, education, child welfare, juvenile justice, community services, etc.) involved with the child, youth, or young adult and their family is available and utilized to support identified needs.
- Coordinate communication among service providers and systems partners (physicians, medication prescribers, mental health, education, child welfare, juvenile justice, community services, etc.) who are involved with the child, youth, or young adult and their family.
- Ensure child, youth, or young adult and their family are linked to relevant supports, community service providers and systems partners to expand support network and address identified needs.
- Support and empower the Wraparound Team to advocate on behalf of the child, youth, or young adult and family.
- Ensure child, youth, or young adult and their family and Wraparound Team have access to informational material that supports the ability to address identified needs (guidance on navigation of specific services or systems, psychoeducation materials, parent education materials, etc.)
- Ensure Intake has been completed or is scheduled to be completed.
- Ensure service provider is providing all medically necessary services that the child, youth, or young adult and their family choose and taking appropriate action when those services are unavailable.
- Facilitate the brokerage of services and supports as identified through the Wraparound Planning Process.
- Ensure Person-Centered Planning Process is included to develop the IPOS.
- Utilize the Wraparound Planning Process to ensure successful transition of the child, youth, or young adult back into their home and community.
- Facilitate the Wraparound Planning Process with model fidelity to the MDHHS model to develop and update the Wraparound Plan as needed or required.
- Facilitate the Person-Centered Planning Process to develop and complete annual updates to the IPOS.
- Ensure an annual MichiCANS is completed by the appropriate entity.

VII. ICCW Planning Processes

ICCW utilizes both the Wraparound Planning Process and the Person-Centered Planning Process. The Wraparound Planning Process must be provided with fidelity, in accordance with the MDHHS ICCW model. The Person-Centered Planning Process must be provided according to MDHHS policy, including Family Driven and Youth Guided policy.

The Safety/Crisis Plan, Wraparound Plan and the Individual Plan of Service (IPOS) are the resulting plans from the utilization of the Wraparound Planning Process and the Person-

Centered Planning Process. The Wraparound plan should drive development and/or adjustment of the IPOS.

VIII. Required Documentation

- **Safety/Crisis Plan**

  - Safety/Crisis Plans must be developed upon the initial meeting with the child, youth, or young adult and their family.
  - Existing Safety/Crisis Plans are to be reviewed with the child, youth, or young adult and their family following initial utilization, and as needed, to determine if modifications are necessary.
  - Safety/Crisis plans must be developed with fidelity to the MDHHS Wrapround model.

- **Wraparound Plan**

  - The Wraparound Plan must be developed within 30 days of initial service provision.
  - The Wraparound Plan's strategies are to be reviewed at each Team meeting, and Team adjustments to strategies are to be completed by the Care Coordinator.
  - The Wraparound Plan's outcomes are to be reviewed at least monthly, and Team adjustments to the Plan are to be completed by the Care Coordinator.
  - Wraparound Plan elements must be developed with fidelity to the MDHHS Wraparound model to ensure fidelity.

- **Individual Plan of Services (IPOS)**

  - The IPOS Pre-Plan must be developed in the Wraparound Team meeting during the Hello phase.
    - The annual IPOS Pre-Plan must be developed within the Wraparound Team meeting.
  - The IPOS must be developed in the Help phase, following development of the Wraparound Plan. If there is an existing IPOS, it must be updated to reflect the newly developed Wraparound Plan. Each service provider is responsible for providing the narrative for their clinical intervention.
  - The annual IPOS must be developed within the Wraparound Team meeting, driven by the existing Wraparound Plan. Each service provider is responsible for providing the narrative for their clinical intervention.
  - IPOS elements must comply with Michigan Administrative Code R. 330.7199 requirements.

- **Wraparound Team Meeting Minutes**

  - Meeting minutes must be developed following each Wraparound Team meeting and distributed to all Wraparound Team members.
  - Meeting minutes elements must comply with documentation requirements for MDHHS Wraparound model fidelity monitoring.

- **Graduation Summary**

  - The Graduation summary must be completed within the last month of the Hope phase and distributed to the child, youth, or young adult, and their family.
  - The Graduation summary elements must be developed with fidelity to the MDHHS Wraparound model.

IX. Location

The following requirements apply to the child, youth, or young adult and their parents/primary caregivers. Professional and natural supports may join Team Meetings either in-person or via simultaneous audio/visual telemedicine during all phases, according to the preference of the child, youth, or young adult and their parents/primary caregivers.

- All Team Meetings must be provided in-person during the Hello and Help phases.
- Team Meetings may be provided either in-person or via simultaneous audio/visual telemedicine during the Heal and Hope phases, according to the preference of the child, youth, or young adult and their parents/primary caregivers, with the following exceptions:
  - Development of the transition plan (Hope phase) must be completed in-person.
  - Graduation activities (Hope phase) must be completed in-person.
  - Team Meetings are to be provided in-person for the first 60 days upon a child, youth, or young adult transitioning back to their home and community from out-of-home placement.
  - In-person Team Meetings are to be provided once per month, at minimum, for a child, youth, or young adult served under the SEDW during both the Heal and Hope phases.

A. Child Caring Institutions (CCI) and State Hospitals

ICCW is covered by Medicaid for up to 180 days while in placement for the purpose of transition back to the community; ICCW must be suspended once the placement for the child, youth, or young adult has exceeded 180 days. When an ICCW-enrolled child, youth, or young adult is placed at a CCI, including Qualified Residential Treatment Programs (QRTPs) and Psychiatric Residential Treatment Facility (PRTF), or State Hospital, transition planning should begin immediately in conjunction with the Wraparound Team and facility or State Hospital staff.

- A child, youth, or young adult who meets eligibility criteria for ICCW should be referred to the service planning provider in the community in which they reside.
- The Care Coordinator will work with the child, youth, or young adult and their parent/primary caregiver(s) to develop a Wraparound Team. The Wraparound Team will work collaboratively with facility staff and other child-serving systems to facilitate a comprehensive and holistic plan of services and supports that will enable the child, youth, or young adult to return to their community.

- The child, youth, or young adult must have an identified community to transition.
- Medicaid does not cover services provided to a child, youth, or young adult involuntarily residing in non-medical public facilities (i.e. jails, prisons, juvenile detention facilities).
- Must meet federal and state requirements for the provision of ICCW in CCI.

X. Evaluation and Outcomes Measurement

The enrolled ICCW provider will comply with MDHHS ICCW evaluation requirements as determined by the department.

Manual Maintenance

Retain this bulletin until the information is incorporated into the MDHHS Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Typical Providers may phone toll-free 800-292-2550. Atypical Providers may phone toll-free 800-979-4662.

An electronic copy of this document is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Approved

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