Magellan Healthcare, Inc.

2025 Provider Handbook for the Care Management Entity

Standard operating procedures for High Fidelity Wraparound in Wyoming

Revised November 2024

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SECTION 1: INTRODUCTION

Welcome

Welcome to the Wyoming Care Management Entity Supplement. This document supplements the Magellan National Provider Handbook, addressing policies and procedures specific for the Wyoming Care Management Entity. This supplement is to be used in conjunction with the Magellan National Provider Handbook, as applicable. When information in this supplement conflicts with the national handbook, or when specific information does not appear in the national handbook, the policies and procedures in the Wyoming Care Management Entity supplement take precedence.

Our purpose is in building relationships with children, youth, families, family organizations, Tribes and their governments, physical and behavioral healthcare communities, educational communities, human services systems, child welfare and judicial systems, faith-based organizations, and other stakeholders to achieve a system of care that is a true fit with the needs and culture of Wyoming's communities below. We will fulfill this purpose through active relationship building consisting of a variety of mechanisms for outreach and engagement of key stakeholders across the state.

Our goal for overall system of care relationships is to engage each stakeholder's interest and active participation in the High Fidelity Wraparound process. This includes youth-centered, family-driven care planning and care coordination to ensure children, youth and families have access to the most effective and least restrictive services and supports to meet their needs. We adhere to the principle of "no surprises" when it comes to our relationships. Our communication strategies are geared toward keeping providers informed and up to date on any operational or system changes. We adhere to an open-door communication policy for our network.

Our outcomes will include seamless service delivery for enrolled children, youth and families, enhanced communication, and collaboration among system partners in the system of care and provision of timely and effective community-based services and supports that promote resiliency and family wellness.

High Fidelity Wraparound in Wyoming is made possible by the Wyoming Department of Health, Division of Healthcare Financing.

SECTION 1: INTRODUCTION

Contact Information

Magellan Care Management Entity Staff Directory and Functions

Contact Information:

- Monday through Friday, 8 a.m. to 5 p.m.
- After-hours (24/7): 1-855-883-8740
- TTY Line: 711
- Website: www.MagellanofWyoming.com

Directory and Functions:

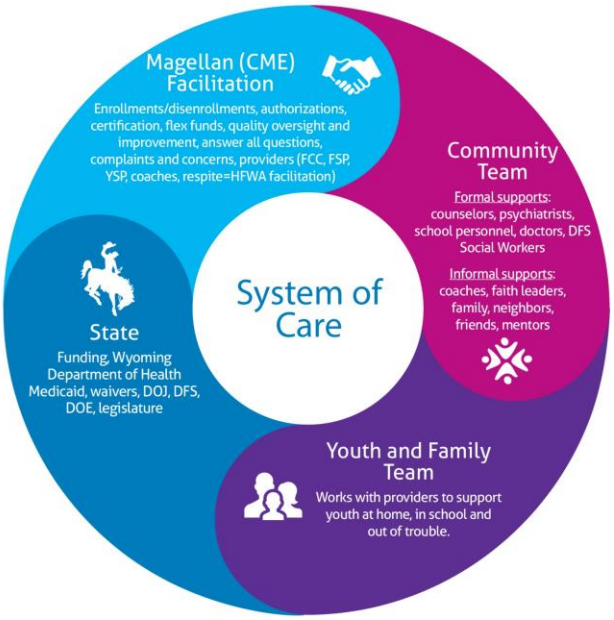
- ***Account Operations Manager*** (FuentesR@MagellanHealth.com): Oversees the High Fidelity Wraparound program.
- ***Clinical Reviewer*** (WYClinical@MagellanHealth.com): Manages referral questions, enrollee eligibility, approvals, and care coordination.
- ***Senior Care Worker*** (WYClinical@MagellanHealth.com): Handles enrollee eligibility, approvals, and care coordination.
- ***Clinical Contract Adviser*** (WYClinical@MagellanHealth.com): Manages enrollee eligibility, state contract timelines, approvals, and care coordination.
- ***Information Technology*** (IT) Director (WYProvider@MagellanHealth.com): Addresses provider portal issues.
- ***Network Management Analyst and Training***(WYProvider@MagellanHealth.com): Manages provider enrollment and contracting.
- ***Quality Director*** (WYQuality@MagellanHealth.com): Oversees reporting and outcome activities, handles complaints, grievances, and critical incidents.
- ***Provider Outreach Specialist:*** Edits outreach materials, improves resources, conducts training, and engages community partners.

If you need assistance, email WyProvider@MagellanHealth.com at any time.

SECTION 1: INTRODUCTION

Magellan's Care Management Entity Model

As a vital partner within the Magellan network, your role is crucial in our mission to enhance the health and well-being of our enrollees. Our success hinges on our collaboration with you in identifying enrollee risks, managing utilization, coordinating care, and ultimately improving the overall quality of outcomes. Our aim is to establish the necessary support systems to cater to the diverse needs of our enrollees.



The nationwide shift toward person-centered healthcare is gaining momentum, emphasizing the improvement of care quality while simultaneously reducing costs. This paradigm shift in care coordination redirects the focus from merely addressing ailments to understanding what truly matters to everyone.

Aligned with this perspective, Magellan:

- Adheres to High Fidelity Wraparound principles.
- Implements an intensive care coordination program for Wyoming enrollees.
- Prioritizes ensuring an individualized, team-driven process is being offered to youth and their families.
- Measures the outcomes of High Fidelity Wraparound Services for our enrollees.

At the core of the High Fidelity Wraparound approach are the youth and family enrollees. Our methodology considers their strengths, behavioral health, physical well-being, and socioeconomic status when determining the appropriate course of care.

How does the Care Management Entity work? Our model is built upon five pillars:

1. **Proactive risk and needs:**
   Predicting individuals' level of risk and future utilization helps us enroll them in the appropriate level of care coordination and provide additional support, if needed. This helps avoid the need for higher levels of care and to avert crisis. The use of surveys, such as the CASII, ESCII, CANS, and ACEs are utilized to achieve this. Our target population consists of youth with serious emotional disturbances or serious persistent mental illness. Emotional disturbances, in the context of Serious Emotional Disturbance (SED), Serious Persistent Mental Illnesses (SPMI) or mental health disorders, refer to a range of psychological and emotional challenges that significantly impact an individual's overall well-being and functioning. These disturbances encompass various emotional, behavioral and cognitive

difficulties that can disrupt a person's ability to lead a healthy and fulfilling life.

2. **Utilization management:**
   We collaborate with providers to help tailor care to each person's needs, ensuring the individual's culture, preferences and goals are considered. This includes ongoing case reviews and prior authorizations for High Fidelity Wraparound. Magellan's review ensures services are authorized in the type, scope, duration, amount and frequency required to meet the individualized needs of each youth, as documented in their Plans of Care.

3. **Care coordination:**
   High Fidelity Wraparound care coordination is based on prioritized needs, which fall on a continuum based on needs, complexity of care and the support individuals need to achieve wellness. Our role is to ensure families are connected to community-based services and supports. This looks and feels different than a case management model. Care coordination focuses on building the team and case management is more of doing things for and activities with the families.

4. **Quality and outcomes:**
   We track our progress using evidence-based practices, High Fidelity Wraparound tools, clinical practice guidelines, discharge planning and other best practices through a measurement suite that allows us to monitor utilization trends and analytics in real time.

5. **Provider training and certification:**
   We work collaboratively with individuals and agencies to ensure training supports accessible, quality, youth and family-centered, evidence based and innovative care. Principles used rely on the National Wraparound Initiative.

SECTION 1: INTRODUCTION

Care Management Overview

According to the National Wraparound Initiative, "Wraparound is a planning process that follows a series of steps to help children and their families realize their hopes and dreams. The wraparound process also helps make sure children and youth grow up in their homes and communities. It is a planning process that brings people together from different parts of the whole family's life." High Fidelity Wraparound includes trainers, coaches, and mentors to ensure best practices and conformity to the model.

The following principles highlight the core values with the wraparound process (reprinted from The Wraparound Process User's Guide):

1. **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 enrollees' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.
2. **Team-based**
   The wraparound team consists of individuals agreed upon by the family and committed to them through informal, formal, community support, and service relationships.
3. **Natural supports**
   The team actively seeks out and encourages the full participation of team enrollees drawn from family enrollees' networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support.
4. **Collaboration**
   Team enrollees work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team enrollees' perspectives and resources. The plan guides and coordinates each team enrollee's work toward meeting the goals.
5. **Community-based**
   The wraparound 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 youth and family integration into home and community life.
6. **Cultural humility**
   The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, identity of the youth and family and their community.
7. **Individualized**
   To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports and services.
8. **Strengths-based**
   The wraparound process and the wraparound plan identify and build on the capabilities, knowledge, skills and assets of the youth and family, their community and other team enrollees.

9. **Unconditional**
   Despite challenges, the team persists in working toward the goals until the team reaches agreement that a formal wraparound process is no longer required.
10. **Outcome-based**
    The team ties the strategies of the wraparound plan to clear goals for success, monitors progress and revises the plan accordingly.

Fidelity to these ten principles is required and evidence must be included in the youth's Plan of Care.

SECTION 2: MAGELLAN'S PROVIDER NETWORK

Contracting with Magellan

Our philosophy

Magellan's provider agreements protect enrollees, providers, and Magellan by defining:

- The rights and responsibilities of the parties.
- The application of Magellan's policies and procedures to services rendered to enrollees.
- The programs/services available to enrollees.
- The provider network for enrollee use.
- The reimbursement for covered services.

Depending on a provider's type of practice, Magellan issues an individual or Agency agreement.

Our policy

To be eligible for referrals of and reimbursement for covered services rendered to Wyoming Care Management Entity, each provider, whether, individual practitioner, or group practice, must sign a Magellan Provider Participation Agreement agreeing to comply with Magellan's policies, procedures, and guidelines. If you apply for network inclusion and are declined, Magellan will provide written notice of the reason for the decision.

Magellan does not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

Active provider definition

An active provider in Wyoming's Care Management Entity is defined as someone who meets the following requirements, initially and ongoing:

- Has active status and in good standing with Wyoming Medicaid.
- Has met all the Care Management Entity training requirements for certification.
- Has met the educational and age requirements for the role he or she is serving.
- Has a National Provider Identifier number with the appropriate taxonomy.
- Has a valid address in the Magellan of Wyoming system.
- Has a valid address in the Wyoming Medicaid system.
- Receives a clear background check that includes the FBI and Central Registry that will be monitored for compliance on an annual basis.
- Obtains a CPR/First Aid certification that will be monitored for compliance on an annual basis.
- Maintains the following insurance that will be monitored for compliance on an annual basis:
    - Commercial *general liability insurance coverage*. Maintain during the entire term of the Agreement, against claims arising out of bodily injury, death, damage to or destruction of the property of others, including loss of use thereof, and including underground collapse and explosion, and products and completed operations, in an amount not less than five hundred

thousand dollars ($500,000.00) per occurrence and one million dollars ($1,000,000.00) general aggregate.
    - *Business Automobile Liability Insurance*. Maintain during the entire term of the Agreement automobile liability insurance in an amount not less than five hundred thousand dollars ($500,000) per occurrence.
- There are no sanctions or exclusions for provider participation. This would include providers appearing in the Office of Inspector General database.

Providers cannot be participating in the Wyoming Care Management Entity if they have received any state or federal sanctions or have been excluded from any state of federal programs.

If a provider does not meet these requirements, he or she will be terminated from the network within 30 days. Termination will be immediate if there is evidence of a sanction or exclusion for provider participation in Wyoming Medicaid. Magellan will notify the Department of Health so that the provider can be removed from the Wyoming Care Management Entity taxonomy.

*If at any time between certification and recertification you no longer meet any of the minimum qualification requirements, you must notify Magellan immediately.

Provider responsibility

1. Complete your enrollment and screening - See Provider Enrollment Information.
2. Understand the different roles and responsibilities of each provider role - See Provider Types.
3. Understand the obligations and comply with the terms of the Magellan provider agreement.
4. Be familiar with and follow the policies and procedures contained within this handbook supplement and the Magellan National Provider Handbook.
5. Sign a Magellan provider agreement.
6. Complete required trainings prior to service delivery.
7. Participate in and successfully meet all requirements associated with Magellan's certification and recertification process.
8. Maintain enrollee Medical Records in accordance with Health and Human Services and the CMS 1500 Provider Manual, all other applicable federal, state, local laws, rules and regulations including, but not limited to, the information required in submission to Magellan for High Fidelity Wraparound.
9. Provide services in accordance with applicable state and federal laws and certification standards.

Magellan's responsibility

1. Help with your administrative questions during normal business hours (Monday-Friday, 8 a.m.-5 p.m. Mountain Standard Time).
2. Submit a Magellan provider agreement to providers identified for participation in the Magellan provider network.
3. Indicate the clients and services covered by the agreement based on the contracted reimbursement schedule.
4. Execute the agreement after it has been returned and signed by the provider and the provider has successfully completed the certification process. The effective date of the agreement is the date Magellan signs the agreement, unless otherwise noted.

SECTION 2: MAGELLAN'S PROVIDER NETWORK

Network Provider Training - Certification

Our philosophy

Magellan is committed to promoting quality care. In support of this commitment, providers must meet a minimum set of criteria to be able to provide High Fidelity Wraparound services.

Our policy

To be eligible to provide High Fidelity Wraparound services, Magellan network providers are required to successfully complete the qualification and certification process prior to being accepted as a network provider. Our High Fidelity Wraparound coaching staff is the primary source for competency requirements needed for certification. We verify and certify providers in accordance with the criteria required under Wyoming's 1915(B) and (C) Children's Mental Health Waivers and developed with the Wyoming Department of Health. Only certified and contracted providers may render High Fidelity Wraparound services as an in-network provider.

Provider responsibility

1. Successful completion of all Central Registry and Federal Bureau of Investigations/Department of Criminal Investigations background screenings.
2. Complete the Onboarding Training via the online training platform.
3. Complete the Child and Adolescent needs and Strengths (CANS) through the Praed Foundation which must be renewed annually a part of the recertification. – See Provider Manual
4. Review, Attest the required provider trainings, a full copy can be found in the Provider Manual
5. Collaborate with Magellan Wyoming Care Management Entity staff to schedule your certification training with a coach with a passing score of 80% in the training curriculum.
6. Work with the Magellan Wyoming Care Management Entity coaches to further develop the High Fidelity Wraparound competency through mentoring, observation, and document review.

Magellan's responsibility

1. Provide a mechanism to attest trainings are completed.
2. Provide a High Fidelity Wraparound coach.
3. Notify you promptly if any required information is missing from the certification process.
4. Notify you when the certification process is completed.
5. Recertify providers every year.
6. Maintain a process to prepare, evaluate and certify network providers that does not discriminate based on a enrollee's benefit plan coverage, race, color, creed, religion, gender, sexual orientation, marital status, age, national origin, ancestry, citizenship, physical disability, or any other status protected by applicable law.

Network Provider Training - Recertification

Our policy

Magellan High Fidelity Wraparound providers are required to undergo annual recertification. Recertification is a year-long process that includes evaluation of provider performance in the Magellan network, including, but not limited to, coordination of care, service and outcomes, enrollee service and adherence to Magellan policies and procedures. If providers are identified as not rendering High Fidelity Wraparound services, there will be education and interventions that may include a continuum from education to a hold on new referrals to a referral to the Magellan Quality Improvement Team. Providers will need to work with a coach to create a Professional Development Plan for the recertification process, complete continuing education hours, send documentation to the coach for scoring, and have a passing score on the tracking sheet requirements. Continuing education must include abuse and neglect training may take the form of webinars, classes and trainings. The specific requirements for recertification will be sent each year by the Magellan Lead Trainer.

Provider responsibility

1. Complete all provider recertification forms and submit to Magellan. This includes:
    a. Timely completion of all training/education requirements as applicable to your provider type.
    b. Complete and submit in a timely manner other supporting documentation.
    c. Complete required documentation review and supporting tracking sheet.
2. Resolve all corrective action plans.
3. Remain administratively compliant will all High Fidelity Wraparound requirements.
4. All High Fidelity Wraparound providers are expected keep the clinical needs of enrollees as their sole priority. Acting outside the clinical needs of enrollees may result in denial of recertification.

Magellan's responsibility

1. Provide you with a recertification form and instructions for completion and submission.
2. Review the materials you submit in a timely manner, including review by a certified High Fidelity Wraparound coach for recertification determination.
3. Take into consideration any concerns of administrative, legal/ethical or quality of care issues that are identified.
4. Inform you of the outcome of your recertification review.

SECTION 2: MAGELLAN'S PROVIDER NETWORK

Updating Practice Information

Our philosophy

We are committed to maintaining current, accurate provider practice (agency or solo provider) contact information in our database so that enrollees have correct information when choosing a provider and to enable our providers to receive important communications from Magellan in a timely manner.

Our policy

Magellan's policy is to maintain accurate databases, updated in a timely manner with information received from our providers to facilitate efficient and effective provider practice information. The most efficient and effective way to communicate administrative information changes and to keep provider information up-to-date is through our online provider portal, www.MagellanProvider.com.

Providers are required to notify Magellan and/or confirm any changes in administrative practice information using our online Provider Data Change Form. By using the Provider Data Change Form, providers can update information online in real time, a method more efficient and accurate than other forms of communication. Providers who do not update their data when changes occur, or do not attest to data accuracy as required, may be put "on hold" for new referrals until review and attestation of data accuracy is completed. Those changes can be made at www.MagellanProvider.com under *My Practice*.

Note: Some changes to provider information may result in the need for a contract amendment, such as facility or group name changes, changes of ownership, change of address, adding a new service location for a facility or a change to Taxpayer Identification Numbers; these still require notification to the Care Management Entity. The Provider Data Change Form application will direct you when these notifications need to occur. Providing or billing for services in any of these situations should NOT commence until you have notified network staff and received confirmation that all required changes have been implemented, which could include the amending of existing agreements or the need for new agreements to be issued.

Provider responsibility

- Update changes in your administrative practice information listed below using our online Provider Data Change Form by signing in to www.MagellanProvider.com and selecting *Display/Edit Practice Information.*
- Notify us within 10 business days of any changes in your practice information including, but not limited to changes of:
    - Service, mailing or financial address,
    - Telephone number,
    - Business hours,
    - Email address,

    - Taxpayer Identification Number,
    - Practice website URL,
    - Practice specialty or areas of clinical expertise.
- When changes are made to the following, those changes also need to be made to National Provider Identifier and Wyoming Medicaid. If these changes are not updates, providers will risk being terminated from active provider status:
    - Service, mailing or financial address,
    - Telephone number,
    - Business hours,
    - Email address,
    - Taxpayer Identification Number,
    - Practice website URL,
    - Practice specialty or areas of clinical expertise.
- Notify us within two business days if you are unable to accept new referrals along with the associated reason. Associated reasons include, but not limited to:
    - Illness or maternity leave,
    - Practice full to new patients,
    - Professional travel, sabbatical, vacation, leave of absence, etc.
- Promptly notify us of any changes in group practices, including, but not limited to:
    - Practitioners departing from your practice,
    - Practitioners joining your group practice,
    - Service, mailing, or financial address,
    - Practice ownership, including a change in Taxpayer Identification Number and/or National Provider Identifier,
    - Telephone number,
    - Business hours,
    - Email address,
    - Practice website URL.
- Promptly notify us of any changes to information reviewed during the credentialing process, including but not limited to:
    - Licensure or certification, including state licensing board actions on your license,
    - Board certification(s),
    - Hospital privileges,
    - Insurance coverage,
    - New information regarding pending or settled malpractice actions.
- Promptly respond to us regarding enrollee or other inquiries about the accuracy of your practice information, including but not limited to the information listed above. Failure to respond to inquiries regarding the accuracy of your information may impact your network participation status.
- See the Magellan Organizational and Facility Provider Supplement to this Provider Handbook for submitting changes in facility/organizational practices.
- Contact your field network coordinator or area contract manager if directed to do this by the online application – some changes may require a contract amendment before you can initiate or bill for services.

- Update and maintain your Provider Profile information (enable you to enhance your profile, which enrollees see in online provider searches, by uploading your photo, a personal statement, professional awards, etc.).
- Each time you make any changes noted above using the online Provider Data Change Form or in response to any request from Magellan, it is important to attest that your data is current and accurate. Even if you have no changes, *Magellan requires that you review your practice information and attest that your information is correct, including appointment availability, at least quarterly.* Failure to update administrative practice information may impact your network participation status.

Magellan's responsibility

- Maintain our online Provider Data Change Form resulting in real-time information with no additional verification requirements.
- Contact you for clarification if needed.
- Notify you if Magellan enrollees tell us they believe your provider data is incorrect.
- Notify you if your change in information impacts your referral and/or network participation status.

SECTION 2: MAGELLAN'S PROVIDER NETWORK

Covered Services

Magellan manages the provision of High Fidelity Wraparound services, pursuant to the CMS 1500 Manual that is available on the Department of Health website. Providers should furnish necessary services in the amount, duration, and scope, as indicated on the plan of care, that are necessary to address the enrollees behavioral health condition. Magellan will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness or condition. Provider shall render such services in accordance with federal and state regulations, law, rules, waivers, Medicaid provider policy manuals and any additional applicable provider manuals as well as Magellan policies and procedures. A covered service during the first 46 days and subsequent authorization spans are outlined in the timelines and requirements (Appendix A & B) and per the role specific statement of work.

Youth and Family Training covered services include (for 1915 (c) Waiver Enrollees only):

- Skill development and training to support appropriate social interaction.
- Skill development and training to support successful family interactions.
- Intervention coaching to support the development of coping skills and techniques.
- Techniques for strength-based behavior management and/or support.
- Specific training on successfully accessing community, cultural, and recreational activities.
- Training and education directly related to helping the youth and family through objectives and action planning identified in the individualized Plan of Care.
- Providing instruction regarding health and safety issues.
- Training on waiver procedures associated with service provision and waiver responsibilities.
- Planning and/or crisis intervention training specific to the Plan of Care.
- Supporting the youth and family with the development of skills leading to better self-advocacy in the Family Care Team.
- Support with skill development related to the identification of services and resources pertinent to youth and family needs.
- Explaining and interpreting policies, procedures, and relationships that have an impact on the youth and family's ability and/or providing monthly reporting to the Family Care Coordinator regarding successes and challenges.
- This service may require collaboration with a qualified licensed mental health professional in service design and evaluation.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Cultural Competency and Humility

Our philosophy

Magellan is committed to embracing the rich diversity of the people of Wyoming. We believe in providing high quality care to culturally, linguistically, and ethnically diverse populations, as well as to those who need visual assistance and are hard of hearing. All people entering the behavioral health care system must receive equitable and effective treatment in a respectful manner, recognizing the role that individual spoken language(s), gender, and culture plays in a person's health and well-being.

Our policy

Magellan staff are trained in cultural diversity and sensitivity in order to refer enrollees to providers appropriate to their needs and preferences. Magellan also provides cultural competency/humility training, technical assistance, and online resources to help providers enhance their provision of high quality, culturally appropriate services. Magellan continually assesses network composition by actively recruiting, developing, retaining, and monitoring a diverse provider network compatible with the enrollee population.

Provider responsibility

1. Provide Magellan with information on languages you speak.
2. Provide Magellan with any practice specialty information you hold on your certification application.
3. Enrollees must be provided with information instructing them how to access these services. Interpretation services are the facilitation of oral or sign-language communication, either simultaneously or consecutively, between users of different languages.
4. Should a enrollee need interpretation or translation services, a provider must make that request of Magellan. A provider may also assist a family in their request for interpretation or translation service.
5. Provider must document the family's preferred language in the electronic health record.
6. Provider must document any reasonable accommodation requests from a family in the electronic health record. The provider should notify Magellan of this request via the Provider Resource Center or email to WYClinical@MagellanHealth.com.

Magellan's responsibility

1. Provide ongoing education to deliver competent services to people of all cultures, races, ethnic backgrounds, religions, and those with disabilities.
2. Provide language assistance to Magellan call-center callers using interpreter services or to those with limited English proficiency during all hours of operation at no cost to the enrollee.
3. Assist providers in locating interpreters for our enrollees when requested by the enrollee or when requested by the provider.
4. Provide easily understood enrollee materials, available in the languages of the commonly encountered groups and/or groups represented in the service area; and
5. Monitor gaps in services and other culture-specific provider service needs. When gaps are identified,

Magellan will develop a provider recruitment plan and monitor its effectiveness.

6. Provide oral and American Sign Language (ASL) interpretation services. In accordance with Title VI of the Civil Rights Act, Prohibition against National Origin Discrimination, providers must make oral interpretation services available to persons with limited English proficiency (LEP) at all points of contact. Oral interpretation services are provided at no charge to enrollees.
7. Accommodate reasonable accommodation requests at no charge to enrollees.
8. In general, any document that requires the signature of the enrollee, and that contains vital information regarding treatment, medications or service plans must be translated into their preferred/primary language if requested by the enrollee or his/her guardian.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Enrollee Access to Care

Our philosophy

Magellan's corporate philosophy believes that enrollees are to have timely access to appropriate services.

Our policy

We require network providers to be accessible within a time frame that reflects the clinical urgency of the enrollee's situation. In the event of a medical emergency, call 911.

Provider responsibility

- Ensure that nrollees know how to access Magellan customer service line at 1-855-883-8740. Ensure that enrollees know that they may access the customer service line 24 hours a day, seven days a week.
  - Inform enrollees of how to proceed, should they need services after business hours.
- Provide the enrollee and/or family access to the Electronic Health Record through the secure Client Portal. Ensure the enrollee and/or family is able to utilize their portal to access their Plan of Care, team meeting minutes, message hub, and demographic information.
- Provide coverage for your practice when you are not available, including, but not limited to utilization of the back-up Family Care Coordinator or an answering service with emergency contact information.
- Respond to telephone messages in a timely manner.
- Contact Magellan immediately if you are unable to see the enrollee within established timeframes.
- Follow the prior authorization process outlined in the provider manual.

- Provide outreach to enrollee and Magellan when enrollee does not follow up with recommended services.
- Providers are responsible for ensuring enrolled youth and families have a crisis plan that appropriately addresses the family team's identified potential crises.
- Your responsibility when a crisis happens is to:
  - Convene a crisis meeting with the Child and Family team.
  - Do a behavioral exploration if appropriate for the situation.
  - Facilitate a meeting that brainstorms options the family can choose to prevent, intervene, and respond to the crisis if it should happen again.
    - You can review more about crisis intervention by reviewing the Online Learning Platform training. To find that training, please email WyProvider@MagellanHealth.com. You may also reach out to your supervisor or coach for more specific information on best practices to respond to a crisis.
- Providers cannot and should not try to replace clinical services when those services are needed. If a youth appears to be a danger to self or poses an imminent threat to someone else, please

engage professional support as appropriate, e.g., call 911, call 988, call the youth's therapist, call law enforcement, or go to the nearest emergency room.

Magellan's responsibility

- Communicate the full scope of the enrollee's situation when making referrals.
- Assist with follow-up service coordination for enrollees transitioning from out-of-home placement and returning to the community.
- Review the Plan of Care for authorization requests within 14 calendar days of the initial request. For more information, please see the Provider Manual.
- For the duration of a youth's High Fidelity Wraparound enrollment, service coordination between Magellan and the state's utilization management contractor will occur as needed to assist with transitions to and from higher levels of care. This coordinated effort will include email correspondence and case reviews to share status updates between the youth's assigned Family Care Coordinator, Magellan and the utilization management contractor. If concerns or barriers present within the case, all parties will work together to identify solutions as needed.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Initiating High Fidelity Wraparound

Our philosophy

Magellan wants enrollees to receive the most appropriate services and experience the most desirable outcomes.

Our policy

We assist enrollees in optimizing their benefits by reviewing and authorizing the most appropriate services to meet their behavioral health care needs. Magellan conducts timely prior authorization reviews to evaluate the enrollee's clinical situation and determine the medical necessity of the requested services.

We do not pay incentives to employees, peer reviewers (e.g., physician advisors), or providers to reduce or forego the provision of clinically necessary care. We do not reward or offer incentives to encourage non-authorization or under-utilization of behavioral health care services.

Provider responsibility

- Maintain active Medicaid provider status.
- Understand federal Medicaid standards applicable to providers.
- Comply with federal Medicaid standards.
- Prior to delivery services, verify enrollee eligibility.
- Referrals can come from anywhere and must be submitted to Magellan within two business days.
- Follow instructions outlined in the CMS-1500 on the Medicaid fiscal agent website.

Magellan's responsibility

- Operate a toll-free telephone line to respond to provider questions, comments, and inquiries. That number is 1-855-883-8740.
- Make decisions about prior authorizations within contractual guidelines and timeframes.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Prior Authorization Process

Our philosophy

Magellan's corporate philosophy believes that enrollees are to have timely access to appropriate services.

Our policy

Magellan manages the prior authorization process for all High Fidelity Wraparound enrollees, ensuring that providers connect with families timely, regardless of Medicaid waiver eligibility. This process supports the intention of the Medicaid waivers and the process of High Fidelity Wraparound.

Provider responsibility (1915 (b) Waiver)

Referral Process:

- Respond to Magellan within 48 hours of referral notification and document with contact note in the Electronic Health Record.
- Verify Medicaid eligibility for the potential enrollee.
- Provide the family with list of potential providers and document with the Choice of Provider Form with guardian signature. Complete contact note in the Electronic Health Record.
- Give choice of CASII/ECSII Independent Assessor and document with contact note in the Electronic Health Record.
- Complete the referral form and submit to Magellan.

Application Process:

- Complete Level of Care with a Qualified Mental Health Professional ensuring required credentials, signatures, and document with contact note in the Electronic Health Record.
- Facilitate with the family and Independent Assessor the CASII/ECSII Assessment and document with contact note in the Electronic Health Record.
- Initiate and complete the High Fidelity Wraparound custom assessments, ensuring all guardian signatures and facilitator signatures are complete. Document with contact note in the Electronic Health Record.
- Document all contacts and submit the completed application within the seven-day authorization period.
    - Contact the family within 72 hours of notification and document the first contact.

After Enrollment:

- Work with the family to complete assessments and documentation for continued Prior Authorization including Plan of Care with guardian signature.

- Complete and document the Family Story, CANS Licensed Assessment, ACE Survey, and Crisis Plan along with the Child and Family Team meeting. Document with contact note in the Electronic Health Record.
- Maintain ongoing documentation, including a minimum of two contacts per month with the youth and family.

Continuous Prior Authorization:

- Submit updated Plans of Care and Prior Authorization requests within 30 days before the last covered day of the current authorization.
- Ensure timely and complete submission of documentation to prevent gaps in Prior Authorization spans.
- Respond timely to requests for additional information within the prior authorization process.
- Assist families with Medicaid-related issues and notify Magellan of any changes in Medicaid eligibility.
- Providers may request up to 14 days administrative extension of prior authorizations, as long as request are submitted before the last day of current prior authorization.
    - Providers may request administrative extension by going to the Provider Resource Center. The total of the requests may not exceed 14 calendar days per prior authorization time frame.
- Providers may request expediated processing of a review decision, to be completed within 3 business days after receipt of the application and/or prior authorization request.
    - Providers may request expedited processing by going to the Provider Resource Center.
    - Request may be made when routine timeframes may jeopardize the enrollee's life or health or ability to maintain maximum function.

Provider responsibility (1915 (c) Waiver)

Referral Process:

- Respond to Magellan within 48 hours of referral notification and document with contact note in the Electronic Health Record.
- Verify Medicaid eligibility for the potential enrollee.
- Provide the family with list of potential providers including Family/Youth Support Partner to complete Youth and Family Training. Document with the Choice of Provider Form with guardian signature. Complete contact note in the Electronic Health Record.
- Give choice of CASII/ECSII Independent Assessor and document with contact note in the Electronic Health Record.
- Complete the referral form and submit to Magellan.

Application Process:

- Complete Level of Care with a Qualified Mental Health Professional ensuring required credentials, signatures, and document with contact note in the Electronic Health Record.

- Facilitate with the family and Independent Assessor the CASII/ECSII Assessment and document with contact note in the Electronic Health Record.
- Initiate and complete the High Fidelity Wraparound custom assessments, ensuring all guardian signatures and facilitator signatures are complete. Document with contact note in the Electronic Health Record.
- Document all contacts and submit the completed application within the seven-day authorization period.
    - Contact the family within 72 hours of notification and document the first contact.
- Assist in the Medicaid Financial Application for enrollment of the 1915 (c) Waiver. This form should be completed with youth financial information only. The Medicaid Financial Application should be uploaded to the documents section of the Electronic Health Record.
- Support the process of the family connecting with the Medicaid specialist in their outreach for financial verification and additional documentation.

After Enrollment:

- Work with the family to complete assessments and documentation for continued Prior Authorization including Plan of Care with guardian signature.
- Complete and document the Family Story, CANS Licensed Assessment, ACE Survey, and Crisis Plan along with the Child and Family Team meeting. Document with contact note in the Electronic Health Record.
- Maintain ongoing documentation, including a minimum of two contacts per month with the youth and family.
- Ensure that Youth and Family Training occurs at minimum once a quarter and documented with a contact note in the Electronic Health Record.

Continuous Prior Authorization:

- Submit updated Plans of Care and Prior Authorization requests within 30 days before the last covered day of the current authorization.
- Ensure timely and complete submission of documentation to prevent gaps in Prior Authorization spans.
- Respond timely to requests for additional information within the prior authorization process.
- Assist families with Medicaid-related issues and notify Magellan of any changes in Medicaid eligibility.
- Ensure Family/Youth Support Partner is continuously written into the Plan of Care for completion of Youth and Family Training at minimum of once a quarter.
- Providers may request up to 14 days administrative extension of prior authorizations, as long as request are submitted before the last day of current prior authorization.
    - Providers may request administrative extension by going to the Provider Resource Center. The total of the requests may not exceed 14 calendar days per prior authorization time frame.
- Providers may request expediated processing of a review decision, to be completed within 3 business days after receipt of the application and/or prior authorization request.

- Providers may request expedited processing by going to the Provider Resource Center.
- Request may be made when routine timeframes may jeopardize the enrollee's life or health or ability to maintain maximum function.

Magellan's responsibility

Referral and Prior Authorization:

- Process and manage the Prior Authorization for all High Fidelity Wraparound enrollees.
- Reach out to the family to confirm their choice of provider if not already documented.
- Notify the Family Care Coordinator/Agency of the family's choice and respond within 48 hours.
- Magellan will respond to any referral or request for enrollment within 2 business days.

Application Review and Approval:

- Authorize seven days for the application period and notify the Family Care Coordinator of Medicaid eligibility issues.
- Review and approve completed application submissions and issue enrollment notifications to the family and providers.
- Notify providers of the Prior Authorization for 46 days following enrollment and communicate all documentation requirements.
- Magellan will process all enrollee applications within 3 business days once application information is verified as complete.
- Magellan will notify a youth and/or family of enrollment within 2 business days of the final eligibility notification or date of the notification email from Wyoming Medicaid.

Continuous Prior Authorization Review:

- Review requests for continued Prior Authorization.
- Confirm Medicaid eligibility before approving service authorizations and notify the Family Care Coordinator of any lapses.
- Coordinate with Wyoming Medicaid's fiscal agent to communicate Prior Authorization details.
- Magellan will process applications and prior authorization requests within 14 calendar days.
    - Magellan may process up to 14-day extension of the above turnaround time in instances when the need for additional information is in the enrollees best interest.
        - This extension is to ensure continuous authorization and service delivery to families in instances where an original request for prior authorization is incomplete.
        - In allowing this extra time, Magellan will process the requested prior authorization without penalty.
    - The original submission date will be used to process the Prior Authorization once all requested details are received.

SECTION 3: THE ROLE OF THE PROVIDER AND MAGELLAN

Provider Websites

Our websites

Magellan uses the following websites to interact with providers:

- www.MagellanProvider.com – this website allows providers to manage their practice.
- Electronic health record – this website serves as the electronic health record.
- www.MagellanofWyoming.com – this website serves to share information with the provider network and enrollees.
- Find a provider – We host an online Provider Directory for families.

Our philosophy

Magellan is committed to reducing administrative burdens on our providers by offering web-based tools for retrieving and exchanging information.

Our policy

Magellan's site specifically for Wyoming providers is www.MagellanofWyoming.com. Magellan's corporate provider website at www.MagellanProvider.com. The website, electronic health record, is used to manage the enrollee's electronic health record. These are our primary portals for provider communication, information and business transactions. These websites are continually updated to provide easy access to information and greater convenience and speed in exchanging information with Magellan. We encourage you to use these websites often as self-service tools for supporting your behavioral health practice.

Provider responsibility

To realize the benefits of the provider websites, you should:

1. Have access to a personal computer, internet service provider and current web browser software.
2. Sign into Magellan's websites to access secure applications (e.g., eligibility, authorizations and claims) by using your username and password.
3. Visit our websites frequently to take advantage of capabilities and access resources, like the Frequently Asked Questions under the "Provider Hub" at www.MagellanofWyoming.com.
4. Provide feedback on difficulties you may experience in using our online resources or on ideas you have for enhancements.
5. *For group practices, group administrator is assigned based on an agency's original application submission and subsequent change request to Magellan.

Magellan's responsibility

1. Maintain operation of website and phoneline services 24 hours a day, seven days a week. Live operation is available Monday through Friday, 8 a.m. to 5 p.m. Mountain Standard Time.
2. Inform users of service problems if they occur.
3. Use your feedback to continually improve our website.

A Commitment to Quality

Our philosophy

Magellan is committed to continuous quality improvement and outcomes management through its company-wide Quality Improvement Program that includes assessment, planning, measurement, and re-assessment of key aspects of care and service.

Our policy

In support of our Quality Improvement Program, providers must be familiar with our guidelines and standards and apply them in High Fidelity Wraparound work with enrollees in order to provide safe, effective, enrollee-centered, timely, efficient, and equitable services in a culturally sensitive manner.

Provider responsibility

1. Follow the policies and procedures outlined in the Provider Responsibility sections in this handbook.
2. Meet documentation standards as outlined in the Timelines and Requirements Document.
3. Participate as requested in plan of care reviews, quality monitoring and other quality improvement activities.
4. Review the provider scorecard for improvements in quality, efficiency, fidelity, and outcome measures.
5. Use evidence-based practices.
6. Adhere to principles of enrollee safety.
7. Attend or log on to provider training, certification and orientation sessions.
8. Participate in the completion of a remediation plan if quality of care concerns are indicated.
9. Complete and return provider satisfaction surveys and the Wraparound Fidelity Index (WFI-EZ).
10. Consider incorporating the use of secure technology into your practice to make accessing services more convenient for enrollees, e.g., email communication, electronic appointment scheduling, appointment reminders, and online access to personal health record information.
11. Assist with transition of care if you leave the network, or the enrollee wants to change providers, or stop services prior to service authorization expiration.
12. Assist in the investigation of enrollee grievances and critical incidents, when necessary.
13. Attend committee meetings and provider workgroups, if requested.

Magellan's responsibility

1. Consider your feedback on High Fidelity Wraparound practice guidelines, prevention programs, enrollee safety policies, and new technology assessments.

2. Consider your feedback in our quality committees and External Quality Improvement Committee.
3. Provide information about provider performance including enrollee satisfaction, enrollee ratings related to fidelity and a provider scorecard with quality, efficiency, fidelity, and outcome measures to providers, enrollees, and customers.
4. Monitor provider satisfaction with our policies and procedures as they affect you and your practice.
5. Provide detailed information about how we will assess your practice during site visits and Plan of Care reviews.
6. Join with you to develop a clear remediation plan to improve quality of care when necessary.
7. Resolve provider complaints within applicable timeframes.

SECTION 4: THE QUALITY PARTNERSHIP

Provider Input

Our philosophy

Magellan believes that provider feedback concerning our programs and services is a vital component of our quality program.

Our policy

Magellan obtains provider input through participation in quality collaborative and improvement activities, the External Quality Improvement Committee, and Internal Quality Improvement Committee. We offer opportunities to give feedback through participation in our quality programs or via requests for specific feedback.

Provider responsibility

1. Provide feedback to Magellan to actively improve the quality of care provided to youth and families.
2. Participate in quality improvement and utilization oversight activities, such as those related to fidelity and outcome tools and performance measurement.
3. Return completed provider satisfaction surveys, if requested.
4. Attend the External Quality Improvement Committee.
5. Provide suggestions, compliments, or file a complaint through the Magellan website or by contacting your Wyoming staff for investigation and resolution of the issue at WyQuality@MagellanHealth.com.

Magellan's responsibility

1. Advise you of the forums available for your feedback.
2. Actively request input regarding enrollee care.
3. Actively request your input in the development and/or update of our policies and procedures.
4. Consider your input while developing or reviewing new and established policies, procedures, programs, and services.
5. Establish and maintain a Quality Improvement Committee to oversee all quality functions and activities.
6. Provide designated staff with expertise in quality assessment and continuous quality improvement; and
7. Develop and evaluate reports, indicate recommendations to be implemented and facilitate feedback to providers and enrollees.

SECTION 4: THE QUALITY PARTNERSHIP

Provider Complaint Process

Our philosophy

To achieve a high level of enrollee satisfaction and care, Magellan believes in providing a mechanism for providers and external agencies to express complaints related to , service, confidentiality, policy, procedure, payment, or any other communication or action by Magellan.

Our policy

Magellan defines a provider complaint as any verbal or written expression originating from a provider and delivered to any employee of Magellan that voices dissatisfaction with a policy, procedure, payment, or any other communication or action by Magellan.

Provider responsibility

- Submit complaints to Magellan:
  - Call Magellan at 1-855-883-8740 to report a complaint to any Magellan staff.
  - Fax a written complaint to 888-656-2597.
  - Access the Magellan of Wyoming website and complete the online form.
  - Email a written complaint to WyQuality@MagellanHealth.com. If emailing protected health information, use secure e-mail.
  - Mail a written complaint to Magellan of Wyoming, PO Box 1963, Evanston, WY 82931.
- Provide pertinent information to assist in investigating your complaint, such as relevant contact information (e.g., name, provider name, phone number, email, etc.), the subject of the complaint and a description of the complaint.

Magellan's responsibility

- Operate a toll-free telephone line to respond to provider questions, comments and inquiries. That number is 1-855-883-8740.
- Thoroughly investigate each provider complaint using applicable statutory, regulatory, and contractual provisions, collecting all pertinent facts from all parties and applying Magellan's written policies and procedures.
- Resolve and provide resolution to the provider within 90 calendar days of receipt.
- Operate a system to capture, track and report the status and resolution of all provider complaints, which includes all associated documentation, whether the complaint is received by telephone, in person or in writing.

SECTION 4: THE QUALITY PARTNERSHIP

Enrollee Grievance Process

Our philosophy

To achieve a high level of enrollee satisfaction and care, Magellan believes in providing a mechanism for enrollees to express dissatisfaction related to care, services, or confidentiality.

Our policy

Magellan maintains a grievance system that complies with the Wyoming Department of Health contractual requirements and in accordance with state and federal law and regulation and ensures the prompt internal resolution of all grievances in accordance with all applicable state and federal laws and the Medicaid State Plan, 1915(b), and 1915(c) waivers. A grievance is defined as an expression of dissatisfaction about any matter other than an adverse benefit determination. Examples of grievances include:

- Dissatisfaction with quality of care,
- Dissatisfaction with quality of services provided,
- Aspects of interpersonal relationships such as rudeness of a provider or a network employee or failure to respect a enrollee's rights regardless of whether remedial action is requested, and
- Dissatisfaction with network administration practices. Administrative grievances are generally those related to dissatisfaction with the delivery of administrative services, coverage issues and access to care issues.

Provider responsibility

- Assist enrollees in filing a grievance in one of the following ways:
    - By calling Magellan anytime at 1-855-883-8740. Tell the person who answers the phone at Magellan that you want to assist a enrollee to file a grievance.
    - Mailing the enrollee's grievance to Magellan of Wyoming, P.O. Box 1963 Evanston, WY 82931.
    - Submit the grievance at www.MagellanOfWyoming.com via an online form.
    - Email WyQuality@MagellanHealth.com.

Magellan's responsibility

- Ensure Magellan staff are educated concerning the importance of the grievance and appeal procedures, the rights of the enrollee and how to instruct a enrollee to file a grievance/appeal.
- Assist enrollees in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.
- Refer all enrollees who are dissatisfied with Magellan, its subcontractors, or its network providers in any respect to the Magellan staff authorized to review and respond to

grievances and appeals and require corrective action.

- Maintain a website in which a grievance can be submitted electronically.
- Allow the enrollee or a representative or provider acting on the enrollee's behalf, with the enrollee's written consent, to file a grievance either orally or in writing, including online through the Magellan of Wyoming website. Grievances can be filed at anytime.
- Once a grievance is received, Magellan will:
    - Acknowledge the grievance in writing within two business days from date of receipt.
    - Make a good faith effort to resolve the concern at the time of the initial call or involve a supervisor or designee to resolve the issue.
    - Thoroughly investigate each enrollee grievance using applicable statutory, regulatory and contractual provisions, collecting all pertinent facts from all parties.
    - Resolve the grievance and provide written notification of the resolution to the grievance within 90 calendar days.

SECTION 4: THE QUALITY PARTNERSHIP

Critical Incident Reporting

Our philosophy

In our quest for our enrollees to receive quality behavioral healthcare services, we routinely review quality of care concerns and critical incident outcome occurrences to identify opportunities for improvement.

Our policy

We initiate quality of care reviews for known incidents if an individual, who is a Magellan enrollee at the time of the incident and who has been in the High Fidelity Wraparound program within six months (180 days) of the incident, completes suicide or homicide and/or engages in other behaviors that result in harm to the enrollee or others.

Provider responsibility

It is the provider's responsibility to enter a critical incident report, **within one working day** of any notification of a critical incident event into the Fidelity Electronic Health Record.

A provider is responsible for including the following into their incident report:

- Reporting Provider.
- Date Reported to Provider.
- Date of Incident.
- Location of Incident.
- People Involved (Role).
- Type of Incident.
- Description of Incident.
- Result of Incident (including injuries, property damage, legal charges, behavioral consequences).
- Actions Taken (including post incident medical interventions) and Incident Follow Up.

The provider is responsible in the case of suspected abuse, neglect, abandonment or exploitation to follow Wyoming State reporting laws, along with their Magellan reporting requirements. Contact local law enforcement or the local Office of the Department of Family Services to make a mandatory verbal report.

Magellan's Quality Improvement Department can be reached during business hours at 1-855-883-8740 or via email at WYQuality@MagellanHealth.com.

Magellan's responsibility

- Serve as a resource to manage the clinical situation presented by the critical incident.
- Complete a review for known incidents in which a enrollee is involved in below:
  - Suspected abuse, including intimidation.
  - Suspected sexual abuse.
  - Suspected neglect.
  - Suspected self-neglect.

  - Suspected self-abuse.
  - Suspected abandonment.
  - Suspected exploitation.
  - Police involvement.
  - Injuries caused by restraints.
  - Injury to the participant.
  - Crime committed by a participant.
  - Elopement.
  - Medication errors.
  - Use of restraints.
  - Suicide threat/attempt.
  - Homicide threat/attempt.
  - Self-harm, requiring medical intervention.
  - Death
- Review all serious critical incidents in a timely manner.
- Send a copy of the incident report to the Wyoming Department of Health, Division of Healthcare Financing, via email within 24 hours.

Record Reviews and Documentation

Our philosophy

Magellan is committed to ensuring behavioral health record documentation meets federal and state regulations as well as Magellan standards.

Our policy

Magellan conducts routine record reviews to monitor the record documentation of providers against Magellan standards and to measure network provider performance against important process elements of the Magellan High Fidelity Wraparound Program. Magellan may also conduct record reviews under special circumstances to investigate or follow up on quality of care concerns, adverse incidents, or grievances about the service or administrative practices of a provider.

Provider responsibility

To comply with this policy your responsibility is to:

- Ensure a enrollee's behavioral health record is:
    - Accurate in electronic health record;
    - Safeguarded against loss, destruction or unauthorized use and is maintained in an organized fashion for all enrollees evaluated or provided services
    - Is accessible for review and audit; and
    - Readily available for review and provides the information required for Quality Review
    - Timely response to follow-up requests and correspondence concerning audit reviews

- Maintain a record for each enrollee serviced which includes, minimally, the following:
    - Enrollee identifying information – i.e., name, date of birth, gender, social security number, Medicaid number and legal guardianship.
    - Primary language spoken by the enrollee and any translation needs of the enrollee.
    - Evidence that enrollee rights and responsibilities are reviewed.
    - Signed and dated releases for communication with all involved parties in the enrollee's care including other behavioral health providers, the Wraparound Agency, and the enrollee's Primary Care Physician/Pediatrician or documentation of refusal.
    - Services provided through the provider, date of service, service site and name of service provider.
    - Diagnoses.
    - Plan of Care and Crisis Plan.

    - Documentation of family's freedom of choice, particularly in regard to a family's choice between institutional and waiver services, and choice on service delivery preferences (face-to-face service and/or telehealth).
    - The enrollee's Child and Adolescent Needs and Strengths (CANS) evaluation.
    - Referrals including follow-up and contact documented in a Contact Note.
    - Documentation of crisis plan meetings and follow up.
    - Signed and dated consent forms.
    - Documentation in the Contact Note of each visit must include:
        - Date and begin and end times of service.
- Provider's record documentation must match all submitted claims and align with service billed on the claim (e.g., diagnosis, date of birth, procedure code). Per Medicaid policy, do not submit a claim for payment that is not fully documented in Magellan's electronic health record.
- Ensure that documentation and/or records are maintained for at least six years after the last good, service or supply has been provided to a enrollee or an authorized agent of the state or federal government, or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.

Magellan's responsibility

- Conduct Record Reviews or reviews of enrollee records to:
    - Verify that services for which reimbursement was made were provided to enrollees,
    - Identify and overcome barriers to care that a enrollee may encounter
    - Ensure that providers render High Fidelity Wraparound that is documented according to established standards.
- Ensure that record reviews address the following:
    - Quality of care consistent with professionally recognized standards of practice.
    - Adherence to High Fidelity Wraparound practice guidelines.
    - Enrollee rights and confidentiality and informed consent.
    - Cultural competency.
    - Enrollee safety.
    - Compliance with waiver requirements.
    - Compliance with critical incident reporting requirements.
    - Plan of Care components, including criteria to determine if the plan includes evidence of implementation as reflected in Contact Notes and evidence that the enrollee is either making progress toward meeting goals/objectives or there is evidence the plan has been revised/updated to meet the changing needs of the enrollee.
    - Continuity and coordination of care, including adequate discharge planning and engagement of natural supports.

- Ensure that appropriate corrective action is taken when a provider or provider's staff furnishes inappropriate or substandard services, does not furnish a service that should have been furnished, or is out of compliance with federal and state regulations.
- Monitor and evaluate corrective actions taken to ensure that appropriate changes are made in a timely manner.

Provider Satisfaction

Our philosophy

Provider satisfaction is one of our core performance measures. Obtaining provider input is an essential component of our quality program.

Our policy

Annually, Magellan surveys participating providers in our provider network who have rendered services to enrollees during the survey period to determine their level of satisfaction with Magellan as well as with key aspects of the service they received from us while assisting our enrollees.

Provider responsibility

1. Complete the survey.
2. Contact Magellan with any comments, suggestions or questions.

Magellan's responsibility

1. Monitor provider satisfaction with Magellan and Magellan's policies and procedures.
2. Share aggregate results of our provider satisfaction surveys with our providers, customers, and enrollees.
3. Use provider survey findings to identify opportunities for improvement and to develop and implement actions for improving our policies, procedures, and services.

Fraud, Waste and Abuse

Our philosophy

Magellan takes provider fraud, waste and abuse very seriously. We engage in considerable efforts and dedicate substantial resources to prevent these activities and to identify those committing violations. We have made a commitment to actively pursue all suspected cases of fraud, waste and abuse and will work with law enforcement for full prosecution under the law. For definitions, corporate policies and more information, see the Fraud, Waste and Abuse section of our National Provider Handbook.

Our policy

Magellan does not tolerate fraud, waste, or abuse, either by providers, enrollees, or staff. Accordingly, we have instituted extensive fraud, waste, and abuse programs to combat these problems. Magellan's programs are wide-ranging and multi-faceted, focusing on prevention, detection, and investigation of all types of fraud, waste and abuse in government programs and private insurance.

Provider responsibility

Magellan providers are expected to develop, implement, and maintain their own written Compliance Plan which adheres to applicable federal and Wyoming state law and any applicable guidance on such plans issued by the United States Office of Health and Human Services Office of the Inspector General ("HHS- OIG") or the Wyoming Department of Health. All persons employed by or contracted with a Magellan-contracted provider will be governed under that provider's Compliance Plan and the provider is responsible for the individuals' actions.

As it relates to the Medicaid Program, fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Fraud may include deliberate misrepresentation of need or eligibility, providing false information concerning costs or conditions to obtain reimbursement or certification or claiming payment for services which were never delivered or received.

Federal False Claims Act

Providers must be familiar and comply with the Federal False Claims Act. The False Claims Act (FCA) provides, in pertinent part, that:

a. Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a Member of the Armed Forces of the United States a

false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government;. or (4) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government, is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus three times the amount of damages, which the Government sustains because of the act of that person.

b. For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

Procedures Relating to Provider Exclusion from Federally or State-Funded Programs

Your responsibilities, as required by the Centers for Medicare and Medicaid Services (CMS), further protect against payments for items and services furnished or ordered by excluded parties. If you participate in federally funded health care programs, you must take the following steps to determine whether your employees and contractors are excluded individuals or entities:

- Screen all employees and contractors to determine whether any of them have been excluded. Providers are required to comply with this obligation as a condition of enrollment as a Medicare or Medicaid provider.
- Search the U.S. Department of Health and Human Services (HHS) Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE), the U.S. General Services Administration's (GSA) web-based System for Award Management (SAM) Exclusion Database and the LDH Adverse Action website located at https://adverseactions.ldh.la.gov/SelSearch, or HHS-OIG LEIE website at http://www.oig.hhs.gov to capture exclusions and reinstatements that have occurred since the last search. You can search the website by individual or entity name.
- Immediately report to the respective state Medicaid Agency any exclusion information discovered.

In addition, to comply with Magellan's fraud, waste and abuse programs, your responsibility is to:

- Check each month to ensure that you, your employees, directors, officers, partners or owners with a 5 percent or more controlling interest and subcontractors are not debarred, suspended or otherwise excluded under the U.S. Department of Health and Human Services (HHS) Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE), the U.S. General Services Administration's (GSA) web-based System for Award Management (SAM) Exclusion Database, HHS-OIG LEIE at http://www.oig.hhs.gov, the SAMS at https://www.sam.gov/SAM and the LDH Adverse Action website located at https://adverseactions.ldh.la.gov/SelSearch.

- Immediately notify Magellan in writing of the debarment, suspension or exclusion of you, your employees, subcontractors, directors, officers, partners or owners with a 5 percent or more controlling interest.

Disclosure Requirements

Medicaid providers are required to disclose the following information regarding:

1. the identity of all individuals and entities with an ownership or control interest of 5% or greater in the provider including information about the provider's agents and managing employees in compliance with 42 CFR 455.104.
2. certain business transactions between the provider and subcontractors/wholly owned suppliers in compliance with 42 CFR 455.105; and
3. including you the provider, the identity of any individual or entity with an ownership or control interest in the provider or disclosing entity, or who is an agent or managing employee of the provider group or entity that has ever been convicted of any crime related to that person's involvement in any program under the Medicaid, Medicare, or Title XX program (Social Services Block Grants), or XXI (State Children's Health Insurance Program) of the Social Security Act since the inception of those programs in compliance with 42 CFR 455.106.

How to Report Suspected Cases of Fraud, Waste and Abuse

Reports made to Magellan can be submitted via one of the following methods:

- Special Investigations Unit Hotline: 1-800-755-0850
- Special Investigations Unit Email: SIU@MagellanHealth.com
- Corporate Compliance Hotline: 1-800-915-2108
- Compliance Unit Email: Compliance@MagellanHealth.com

Magellan's responsibility

Magellan's responsibility to you is to implement and regularly conduct fraud, waste and abuse prevention activities that include:

- Extensively monitoring and auditing provider utilization and claims to detect fraud, waste and abuse.
- Actively investigating and pursuing fraud and abuse and other alleged illegal, unethical or unprofessional conduct.
- Reporting suspected fraud, waste and abuse and related data to federal and state agencies, in compliance with applicable federal and state regulations and contractual obligations.
- Cooperating with law enforcement authorities in the prosecution of health care and insurance fraud cases.
- Verifying eligibility for enrollees and providers.
- Utilizing internal controls to help ensure payments are not issued to providers who are excluded or sanctioned under Medicare/Medicaid and other federally funded health care programs.
- Providing individual Explanation of Benefit notices to a sample group of the enrollees who received services in a manner that complies with 42CFR§455.20 and

§433.116(e).

- Making the Magellan Provider Handbook available to network providers.

Provider Scorecard

Our philosophy

As part of our commitment to outcomes driven care and transparency, the Provider Scorecard shares measures related to the Care Management Entity statement of work for partnership in program improvement. The measures are balanced for quality process, fidelity to wraparound principles, administrative efficiency and outcomes of wraparound.

Our policy

The Provider Scorecard is a document released to the network every quarter and details each Provider's performance on key indicators. The aggregate of the provider network is compared to de-identified providers. This information is shared with providers each quarter and posted on our website.

Provider responsibility

1. Review the provider scorecard quarterly, looking for areas of strength and need for improvement. Make plans to improve your measures.
2. Participate in quality improvement activities related to the scorecard, such as all provider meetings.
3. Bring the scorecard to your staff to assist in quality improvement.
4. Ask questions for clarification, such as when your scorecard measure does not match expectations.

Magellan's responsibility

1. Publish a Provider Scorecard quarterly.
2. Publish a Provider Scorecard Manual with measure definitions, source, and targets to accompany the scorecard.
3. Trend measures over time, such as quarter over quarter, to look for patterns and consider interventions.
4. Review the Provider Scorecard(quarterly) in the monthly provider meeting, including discussion of trends and requesting feedback on drivers.
5. Submit the Provider Scorecard to the Quality Improvement Committee for oversight.

Youth Involvement

Our philosophy

Magellan strongly encourages youth to be involved in all aspects of their own care, as well as to share their ideas on how to improve services. Magellan's hope is that youth will participate and enjoy the opportunities for personal growth available through the High Fidelity Wraparound process.

- Youth should be seen as experts in their own lives and Plans of Care. They should be heavily involved in their Plan of Care, along with their family, including selecting goals and helping to decide how those goals will be achieved. When young people are actively involved in decisions, they are more likely to follow through with plan objectives and achieve positive outcomes.
- Youth involvement can improve outcomes for youth. It can help them develop relationships, acquire new skills, improve behavior, build self-confidence and more. There is great value in encouraging youth to share their opinions and ideas. This helps shape policies, programs, and services for their own care and for the broader community.
- Through group participation, youth can develop friendships and contribute to their communities. They can gain experience in decision-making.

Our policy

Magellan has the policy that there should be meaningful youth involvement in the High Fidelity Wraparound process.

Provider responsibility

- Provide opportunities for youth to have a voice in the development of the youth and family driven plan of care. The plan of care may look at development of social skills and positive support from peers.
- Provide education on potential group activities (either from High Fidelity Wraparound or other formal/informal supports) as a means of possible opportunities for youth to learn from each other, practice social skills, and make friends.
- When a youth reaches the age of majority, the provider must update all documentation to reflect their transition to adulthood and role as the decision-maker in the High Fidelity Wraparound process.

Magellan responsibility

- Magellan will support through each stage of the Wraparound Process so that youth involvement occurs throughout the youth's enrollment.
- Magellan will support through training the youth's voice in the team process, WIFI-EZ completion, gathering of their story, and inclusion of formal and natural supports.
- Magellan is responsible for growing and supporting a robust network of Youth Support Partners that directly encourage youth voice in the High Fidelity Wraparound Process.
- Magellan will encourage independent living skills for youth who are approaching age of majority.

Outcomes

Our philosophy

Our Quality Management Program assures adherence to the High Fidelity Wraparound process through oversight, fidelity measurement, continuous quality improvement and outcomes management. The principle of High Fidelity Wraparound highlighted here is outcome-based.

Our policy

To support an outcomes-based High Fidelity Wraparound process, providers must maintain training and certifications with High Fidelity Wraparound and the selected outcomes tools, be full participants in fidelity measurement and improvement and follow the values and principles of High Fidelity Wraparound. The High Fidelity Wraparound process completed with fidelity to the principles demonstrates outcomes which is why the fidelity tools, coaching, observations, and monitoring are essential to the model.

Provider responsibility

1. Educate families and youth on the principle of outcome-based, including that they drive the High Fidelity Wraparound process with their active participation in assessment, fidelity, and outcome tools.
2. Facilitate, complete, and document the Child and Adolescent Needs and Strengths (CANS) for each 90-day Plan of Care and at transition out of High Fidelity Wraparound.
3. Use the information in the CANS to identify youth and family needs and strengths, craft the plan of care, evaluate progress, and celebrate success.
4. Follow the instructions to complete the Wraparound Fidelity Index (WFI-EZ) at six months of High Fidelity Wraparound enrollment. Fidelity to the HFWA model is measured by the Wraparound Fidelity Index (WFI-EZ).
5. Ensure Caregiver and Youth complete the WFI-EZ at six months of High Fidelity Wraparound enrollment, as well as the Family Care Coordinator completion. It is important providers follow-up with the family or notify Magellan of barriers to completion.
6. Participate in the selected High Fidelity Wraparound fidelity improvement processes and activities including the acknowledgement of feedback and making plans to address improvements needed.
7. Return assessments and tools timely using the established collection process.
8. Document accurately the entire wraparound process, including the family perspectives, choices, preferences, and progress.

High Fidelity Wraparound is a short-term waiver-based process. The goal is to see successful outcomes for enrolled youth and families within 12 to 18 months.

Magellan's responsibility

1. Train providers on the requirements and timelines for performance measures, assessments, fidelity and outcomes tools.

2. Make available fidelity and outcomes tools (WFI-EZ) and supply a collection method for each tool.
3. Report on the CANS outcomes at least annually.
4. Report on Fidelity at least annually.
5. Use outcome and fidelity reports for quality improvement activities, including performance improvement plans when needed.
6. Engage providers, coaches, other stakeholders, and the Quality Improvement Committee in reviewing outcome and fidelity reports for recommendation for improving process, policy and procedure.
7. Request a case review with your team as needed to support successful outcomes.

Enrollee Rights and Responsibilities

As a Magellan provider, it is your responsibility to inform the enrollees receiving HFWA services from you about their rights and responsibilities. Magellan endorses Medicaid-approved rights and responsibilities. The list below outlines some of the information to be discussed with all Wyoming Care Management Entity enrollees. A complete list of rights and responsibilities can be found in the member handbook.

1. Enrollee rights and responsibilities.
2. Covered services.
3. Procedures to follow if a clinical emergency occurs.
4. Confidentiality, its scope and its limits.
5. Ensure current medications are updated in the Plan of Care as needed, include updates when medication changes are made and communication with the primary care physician, other relevant healthcare providers and Magellan.
6. Choice of Provider.

Several aspects of Magellan's quality improvement program are designed to facilitate adequate communication with enrollees regarding their rights and responsibilities. These include, but are not limited to, the enrollee grievance process.

Magellan has comprehensive procedures for addressing enrollee grievances regarding any aspect of service or care provided by the Magellan provider network. If a grievance is received about a provider's services, Magellan may contact the provider directly to clarify the issue and attempt to resolve the enrollee's concerns. If the enrollee is not satisfied with the grievance determination, he or she has a right to appeal the determination.

Providers are expected to participate fully in the grievance resolution process.

Inquiry and Review Process

Our philosophy

Magellan is committed to developing and maintaining a high-quality provider network.

Our policy

Magellan maintains a process for inquiry, review and action when concerns regarding provider performance are identified.

Provider responsibility

1. Actively participate and cooperate with the investigation and resolution of any identified concerns as a condition of continued participation in the Magellan provider network.

Magellan's responsibility

1. Contact you by phone or in writing to inquire about the nature of the concern and request additional information if a concern regarding quality of care or service is raised.
2. Advise you if any type of review is required.
3. Review all inquiries for adequate resolution of any performance concerns.
4. Advise you when a corrective action plan and follow-up are required.
5. Advise you of a change in the conditions of your network participation, if required.

Advise you, in writing, if any action is taken as a result of the inquiry and review process.

SECTION 4: THE QUALITY PARTNERSHIP

Provider Medicaid Enrollment

Our philosophy

Magellan complies with all the applicable State and Federal regulations and Medicaid program requirements.

Our policy

As the Wyoming Care Management Entity, Magellan must ensure all new and existing providers in the Care Management Entity network are enrolled Medicaid providers.

Provider responsibility

1. Providers must be Medicaid enrolled to provide and render services to children and adolescents eligible and enrolled in the Wyoming Care Management Entity program. Medicaid payment is made only to providers who are actively enrolled in the Medicaid Program.
2. Providers must be Medicaid enrolled with linking to the Magellan group practice. All staff or group enrollees who provide High Fidelity Wraparound and Respite services working for an agency or group practice must be Medicaid enrolled.
    a. Go to the Wyoming Medicaid Provider Enrollment website for information on how to enroll with Medicaid. To be enrolled, you must complete an enrollment application and a Provider Agreement. In addition, certain providers are required to submit proof of licensure and/or certification. These requirements apply to both in-state and out-of-state providers.
    b. To complete a Medicaid enrollment application, you must first obtain a National Provider Identifier.
    c. To enroll as a Medicaid provider linked to the Magellan group practice, contact Medicaid/EqualityCare Provider Relations department at 1-800-251-1268 or complete an online application from the Medicaid/EqualityCare website.
    d. After your enrollment application has been approved, a welcome letter will be sent to you. If your application is not approved, a notice including the reasons for the decision will be sent. No medical provider is declared ineligible to participate in the Medicaid Program without prior notice.
    e. You must notify Medicaid of updated provider information: If any information listed on the original enrollment application subsequently changes, you must notify Medicaid in writing 30 days prior to the effective date of the change. Changes that would require you to notify Medicaid include, but are not limited to, the following:
        i. Current licensing information, facility or name changes,
        ii. New ownership information,
        iii. New telephone number, physical, correspondence or payment address change,
        iv. New email address or
        v. Taxpayer Identification Number.

3. The provider is responsible for adhering to applicable State and Federal regulations and the Medicaid provider requirements. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements.
4. Review the Center for Medicare and Medicaid Services manual to ensure that you are in compliance with Medicaid record keeping and access requirements.

Magellan's responsibility

1. Ensure all new and existing providers in the Care Management Entity network are enrolled Medicaid providers.
2. Verify the provider's Medicaid enrollment is current and active.

Provider Exclusion from Federally or State-Funded Programs

Our philosophy

Magellan promotes provider compliance with all applicable federal and state laws on provider exclusion. This includes taking appropriate action on individuals and entities appearing on the U.S. Department of Health and Human Services through the Office of Inspector General List of Excluded Individuals/Entities, the U.S. General Services Administration's web-based system for award management exclusion database and/or state-specific exclusion lists from participating in federally funded healthcare programs.

Our policy

Consistent with federal and state requirements, any individual or entity excluded from participation in federally or state-funded contracts and programs cannot participate in any federally or state-funded healthcare program. Magellan's policy is that upon notification of sanction or exclusion status from Wyoming's Medicaid Fiscal Agent and action will be taken on the affected provider's participation status up to and including termination. Compliance will monitor the list monthly.

Magellan's responsibility

1. Act up to and including network termination upon notification from Wyoming's Medicaid Fiscal Agent of a sanction or exclusion.

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Appendix A: Family Care Coordinator Timelines and Requirements

Magellan of Wyoming
HFWA Provider Requirements & Timelines
All work to be done in Electronic Health Record

Legend

Application: Goals and Activities for days 1-7

First Prior Authorization: Assessments, Crisis Prevention Planning, 1st Child & Family Team, 1st Plan of Care
Days 8-52, Units: FCC=80, FSP=52, YSP=44

Implementation: Working with the family and team
Days 53-discharge, Units: TBD by Plan of Care

Transition to Discharge; Setting the family up for success.
Days TBD, Units: TBD by Plan of Care

Content provided by National Wraparound Initiative, Magellan Healthcare

Phase 1: Engagement and team preparation.				
National Wraparound Initiative Task and Goal	Wraparound Activity	Information	Documentation	Timeline
Eligibility and Application	Referral and Application to CME for HFWA	When a referral comes to Magellan the care worker contacts guardian for a verbal choice of provider then sends the FCC a notification to meet with youth and family to begin enrollment. Or:	Referral Form Builder & Provider of Choice	48 hrs. or the family will be encouraged to choose a different FCC/Agency
		If provider completes the referral with family, have them choose a provider and fill out the Choice of Provider (Contact an Independent Assessor on the Magellan website and set up CASII/ESCII and begin to gather information for the initial CANS, ACE). Submit the referral and Choice of Provider Custom Assessment via email in electronic health record (EHR).	Contact Note	Contact family within 3 business days of notification (7-calendar day application). Document this contact in a Contact/Service note. The contact service note is to be uploaded to the electronic health record within 14 business days. The 3 business day contact is documented by selecting the “Contact Family within 72 hours” drop down in the “Select Purpose” dropdown box.
		Agency/provider responds to Magellan via email that they accept or decline the referral and contacts the family.	Contact Note	

		Magellan authorizes 7 days for the application period (from the FCC's acceptance) for the FCC: Medicaid eligibility is confirmed with the family (call IVR 800-251-1268 and verify via date of birth and SS#) – if no Medicaid notify Magellan via email. Family meets with the Independent Assessor. FCC adds Independent Assessors to the team to give access to the member's record in EHR.	CASII/ESCII	Beginning of the 7-day application authorization Contact Note must be documented during the 7 day application period and uploaded to the electronic health record within 14 business days of contact.
		1. Fill out the Intake Form, Custody Tab, Language Tab, School Tab and Review the Demographics Tab.	Intake Form, Custody, Language, School, and Review the Demographics	Within the 7 calendar days
Eligibility and Application	Referral and Application to CME for HFWA	2. If the family is interested in adding an FSP or YSP to their team indicate who will be added at enrollment on the Choice of Provider Custom Assessment.	Choice of Provider	Within the 7 calendar days
		3. Fill out the Intake Form Consent, Rights and Responsibilities, Freedom of Choice Custom Assessments with the family.	Intake Form Consent, Rights and Responsibilities, Freedom of Choice	Document in Contact Note and upload to EHR within 7 calendar days. The note needs to be in the EHR before an invoice can be sent.
		4. Help family get Level of Care from a Qualified Mental Health Professional (see LOC). Upload the LOC to the Documents Hub of the member's record in EHR.	Level of Care	Document in Contact Note and upload contact note to EHR within 14 business days.
		5. If the youth is not in the custody of their parent, submit proof of legal guardianship in the Documents Tab.	Proof of legal guardianship	Within the 3 business days

		6. Any needed Release of Information forms (kept in an agency's files and uploaded to the electronic health record).	Release of Information	Document in Contact Note and upload to electronic health record within 14 business days. Add any team members that releases are obtained to the team members tab and upload corresponding Release to the "Documents" tab in the electronic health record.
		7. If youth have a current Medicaid number, FCC submits the documents through EHR. In the subject line of the email submission, please indicate "B waiver Referral". In the body of the email, please include the Client ID number.		Within 7 calendar days
		8. If no current Medicaid number submit the application and the Medicaid financial application via EHR. Remember to use the placeholder Medicaid ID number (N + zeros, e.g., N0000000). In the subject line of the email submission, please indicate "C waiver Referral". In the body of the email, please include the Client ID number.		Within 7 calendar days
		Once completed forms and applications are submitted to Magellan, eligibility is determined.		Contact Note must be documented during the 7 day application period and uploaded to the EHR within 14 business days.
1.2. Orient the family. GOAL: To orient the family to the wraparound process.	Orient the family and youth to wraparound.	Begin HFWA process during the application process. Do a contact note for any attempted contact. Best practice is to put in Notes in a timely manner.	Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.

1.2. Orient the family. GOAL: To orient the family to the wraparound process.	Address legal and ethical issues.	It's important to understand that the minimum is not the standard, rather a starting point. The standard is to give the family the best possible HFWA.	Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
	Address legal and ethical issues.	HFWA minimums: FCC contact with youth and caregiver at least two (2) times per month. This can include the CFT meeting or phone contact for a minimum of 8 minutes. All member- generated information identified as the contact (letters, e-mails, or information entered over the web or by any other means) must be entered in the contact note. All C waiver Youth must have YFT provided by an FSP or YSP at least one time each calendar quarter. If only minimums contacts are achieved, discuss with CFT and family if HFWA is appropriate.	Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.

		All YFT must be documented in the POC and contact notes of the service provider who delivers the youth and family training.	Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		If provider is out on vacation or is sick, you or another certified HFWA provider (Back-up FCC) will still need to meet the minimum contact and set up support for the family and reflect what will occur in a contact note. Address mandatory reporting and your policy for making reports as well as going over with the family on how they can recognize and report abuse, neglect, and exploitation.	Contact Note Notify Magellan to ensure the backup FCC has been added to the Team page and authorizations reflect the change.	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
1.3. Stabilize crises and urgent needs. GOAL: To address pressing needs and concerns so that family and team can give their attention to the wraparound process.	Get information from referral about immediate crisis or urgent needs.	If you do a band-aid plan, this could become your first crisis plan or it could be a note.	Either the Plan of Care Crisis Plan and Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
	Ask youth and family and youth about immediate crisis concerns.	If you do a band-aid plan, this could become your first crisis plan or it could just be a note.	Either the Plan of Care Crisis Plan and Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
	If necessary, formulate a response for immediate stabilization.	If you do a band-aid plan, this could become your first crisis plan or it could just be a note.	Either into the Plan of Care Crisis Plan and Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.

1.4. Facilitate conversations with family and youth/child. GOAL: To explore individual and family strengths, needs, culture, and vision and to use these to develop a document that will serve as the starting point for planning.	Prepare the family for the assessments	If the family chooses an FSP and/or YSP may begin to work with them. If the family wants to add an FSP later then a new POC and Choice of Provider Custom Assessment will need to be submitted via Electronic Health Record at that time.	Choice of Provider Custom Assessment	Total of 46 days to complete the Assessment, Crisis Planning, the first Child and Family Team Meeting and write up the Plan of Care.
		If eligible, youth is enrolled and do the assessments, Family Story, ACEs, CANS	Family Story, ACE, CANS	Days 1-17
1.4. Facilitate conversations with family and youth/child. GOAL: To explore individual and family strengths, needs, culture, and vision and to use these to develop a document that will serve as the starting point for planning.	Prepare the family for the assessments	At a minimum, the FCC, will contact the child/youth and family at least two (2) times per month throughout wraparound. This can include in person meetings, telehealth, CFTs or phone calls (minimum of 8 minutes).	Contact Notes	Note: this authorization period will be populated through development of a "Magellan Administrative POC." Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
	Explore strengths, needs, culture, and vision with child/youth and family.	Gather info and complete the Family Story in the Summary of the Family Interview	Family Story	By day 7
		Have the family complete the ACE survey.	Adverse Childhood Experience (ACE)	By day 7

1.4. Facilitate conversations with family and youth/child. GOAL: To explore individual and family strengths, needs, culture, and vision and to use these to develop a document that will serve as the starting point for planning.	Explore strengths, needs, culture, and vision with child/youth and family.	Have a conversation with the family about the Primary Care Physician, Clinical Evaluator, and emergency contact. Discuss with the PCP any health-related concerns.	Populate in the Intake Form and in the Plan of Care	By Day 11
		Complete the CANS after the Family Story and use it to explore ideas with the family and possibly update the Family Story	Child CANS	By Day 17
		Find out if the family has a primary care provider (PCP = doctor) and discuss the benefits	Populate in the Intake Form and in the Plan of Care	By Day 30
		Do a note for each task that you complete as well as every contact you make including the Family Story itself.	Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.

Phase 2: Initial Plan Development				
2.1 Prepare family for Behavior Exploration	Gather Information regarding the Crisis	Use a Behavior Exploration sheet to help gather information regarding the Crisis. This can be obtained from your supervisor or coach	Behavior Exploration	By Day 25
		Complete contact notes	Contact Notes	Documentation must be completed prior to the Crisis Meeting and Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
2.2 Create a Crisis Plan to support the stabilization of family functioning	Complete a Crisis Team Meeting	Gather the people who know the Crisis best – brainstorm options for each level (Prevention – Early Intervention – Crisis - de-escalation – Follow Through) and the family will choose the best options for them	Crisis Plan	Preferably between days 7-14 of the authorization
		Any contacts made should be documented in a Note	Contact Notes	Documentation must be completed prior to the Crisis Meeting and Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
2.3 Write up the Crisis Plan	Write up the Crisis Plan	Take the information provided by the Crisis Team and write up the Crisis Plan.	Crisis Plan in the Plan of Care	Preferably between days 7-14 of the authorization
		With the family take that plan and create reminders and things that will help them follow it. This is often called a “refrigerator plan” but it could be reminder on the mirror, sticky notes, etc.	Crisis Plan in the Plan of Care	Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.

2.4 Necessary meeting preparation	Solicit participation, orient team members.	Complete progress notes for all the contacts or attempted contacts (phone, email, texts), list them on the progress note as contacted	Contact Notes	Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
To ensure a successful first meeting	Arrange meeting logistics.	Schedule the first Child and Family Team Meeting. Arrange with the family where it will be, what time and who will invite the team members. Make sure to include the FSP and YSP if they are part of the team.		Begin this process as you are contacting people for the Crisis Meeting
2.3. Develop an initial plan of care at a Child and Family Team Meeting GOAL: To create a team process that gets multiple perspectives and builds trust and shared vision among team members, while maximizing family voice and choice	Describe and document strengths.	Hold the first Child and Family Team (CFT) in a place that meets the family's needs		Preferably hold the Child and Family Team Meeting within Days 12-19
	Team Process.	Have the Child and Family Team (CFT) create ground rules including confidentiality and the decision-making process	List in the Team Meeting Tab	Preferably write up the Plan of Care between days 19-25
	Create team Mission.	Create with the Child and Family Team (CFT) the mission statement and document it on POC	Document it on POC in the Team Preferences of the Vision Tab	Preferably write up the Plan of Care between days 19-26
	Describe and prioritize needs/goals.	Use SMART goals - what does the family want to change to meet their dream or vision	Document on the POC in the Mission Tab	Preferably write up the Plan of Care between days 19-27
	Select Strategies and assign Tasks.	Make sure it is clear who is responsible for the outcome – support for actions listed in the Tasks. Take time for good brainstorming and facilitate the family making the final decision on what they will be working on.	Document on the POC in the Needs	Preferably write up the Plan of Care between days 21-28

Complete necessary Documentation	Complete documentation and logistics.	Remember, all requests for billable units should be documented in the Tasks within the Plan of Care. Within each task, specify who is responsible for ensuring completion of each task. If the responsible person is a High-Fidelity Wraparound service provider, include the total number of units requested for this task for the 90-day timeframe.	Make all edits to the current version of the Plan of Care. Once edits are complete, create a copy and email to WYClinical if you are requesting Prior Authorization (PA) or a service change. Include the Client ID number in the body of the email submission.	Submit this information on the 60th day but no earlier. This will give the clinical team 14 days to review and give a Prior Authorization (PA)
		Upload the Plan of Care signature page with signatures of all participating team members in the Documents Hub of the member's record.		
		Add to the Child and Family Team Meeting	Team Meetings tab	Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.

Phase 3: Implementation				
GOAL: To Implement the initial plan of care, monitoring completion of strategies and tasks and their success in meeting need and achieving outcomes in a manner consistent with the wraparound principles.	Debriefing with family and team.	Write a note indicating the level of family and team satisfaction with process so far. Make any necessary adjustments according to feedback.	Contact Note	Prior Authorizations are given for 90 days Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
	Support and motivate family/team.	Continue to write notes for each contact and care coordination activity.	Contact Note	Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		Use of the Transition Asset Tool Custom Assessment can help motivate the family and team as they see the progress being made.	Contact Note	
GOAL: To Implement the initial plan of care, monitoring completion of strategies and tasks and their success in meeting need and achieving outcomes in a manner consistent with the wraparound principles.	Monitor progress celebrate success.	Celebrations, big and small, need to be documented in notes.	Plan of Care (POC)	Hold Child and Family Team meetings, best practice is to hold one as often as needed (one is needed every 90 days for a Prior Authorization to be created and must be entered 30 days before an authorization review is completed) POC is reauthorized every 90 days after the first POC authorization, if documentation is submitted within timelines. *Untimely submission of documentation will result in a gap in prior authorization (non-authorization)*
		At a minimum, the FCC, FSP, and YSP will each contact the Youth and Caretaker at least two (2) times per month throughout wraparound. This can include in-person meetings, telehealth, CFT's or phone calls (that are a minimum of 8 minutes).	Contact notes	
		The minimum is based on when a family is ready to be discharged from High Fidelity Wraparound. There should be more contact at the beginning of the process.	Contact notes	

		Continue to hold CFT meetings, best practice is to hold one as often as needed but at least every 30 days. Each time there is a meeting:	Contact notes	CFT Meetings should be documented in the Team Meeting Sections of the Team Tab in the Electronic Health Record. Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		• Update the current version of the Plan of Care	Update the current Plan of Care with updates to what each team member completed during the process. Include any changes to the plan to support the Youth and Family towards transition.	
GOAL: To Implement the initial plan of care, monitoring completion of strategies and tasks and their success in meeting need and achieving outcomes in a manner consistent with the wraparound principles.	Monitor progress celebrate success.	• Update the Crisis Plan by updating information	Update the Crisis plan by any changes that occurred within the last 3 months or indicate a review has been completed by updating the Crisis Plan Start date	Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		• Have all team members sign off on the POC and upload a POC signature page in the Documents Hub of the member's record	Plan of Care (POC)	
		• Enter Team notes in the Team Meeting	Team Meetings	
		• Provide family and team copies of POC and all relevant documentation		

		The Seattle Children's Hospital is available for Primary Care Physicians consultations		
3.3. Maintain team cohesiveness and build trust. GOAL: To monitor team satisfaction and "buy-in" to the process, and build team cohesiveness and trust	Implementation Planning Process	With plan Prior Authorizations		
		• Complete a Transition Asset Tool with the family	Transition Asset Tool = Custom Assessment	Must be submitted within 30 days of Plan of Care submission.
		• Complete the Child and Adolescent Needs and Strengths (CANS) with the family.	Child and Adolescent Needs and Strengths (CANS) = Licensed Assessment	
		• Both should help to inform the Plan of Care (POC)/Crisis Plans and needs for immediate interventions	Plan of Care (POC)	
		Do notes for every contact and care coordination activity done with/for the youth, family, and team	Contact Notes	Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
3.3. Maintain, team cohesivenessand build trust. GOAL: To monitor team satisfaction and "buy-in" to the process, and build team cohesiveness and trust	Maintain awareness of team members' satisfaction and "buy-in".	If a youth is going to be placed outside the home, please request a case review with the clinical team and update the Custody Tab. As a youth is placed outside the home your responsibility is to coordinate care between the CFT and the placement facility. Please update the POC with the CFT's efforts at coordination and document all contact in a note.	Custody Tab	Within 24 hours of Out of Home placement, Youth need to be discharged at the latest by 120 days if still Out of Home and out of community. When the youth is returning to the community and HFWA Within 5 days of receiving the information.

		When youth return to the community, the youth's FCC must submit a new Child and Adolescent Service Intensity Instrument (CASII)/ Early Childhood Service Intensity Instrument (ESCII) and Level of Care (LOC) assessment. Coordinate Independent Assessor availability and add the Independent Assessor (IA) to the Teams page in the EHR. Upload the Level of Care (LOC) to the Documents Hub of the member's record. Email WYClinical to notify of these updates once complete. Also, remember to update the Custody Tab to reflect the youth's return to community. Enter a progress note.	Child and Adolescent Service Intensity Instrument (CASII), Early Childhood Service Intensity Instrument (ESCII), Level of Care (LOC) Custody Tab	Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		When youth leave or return home, hold a Child and Family Team (CFT) to talk about this transition and the best way to support the youth and family. Document these updates in the current version of the Plan of Care (POC).	Updated Plan of Care (POC) and Contact Note	
	Address issues of team cohesiveness and trust.	If a significant event occurs that could affect a member's safety, document the event under the Critical Incident tab in the EHR. Follow all prompts for mandatory reporting.	Critical Incident Report (CIR)	As soon as you have knowledge of the incident. In the case of suspected abuse, neglect, abandonment, or exploitation, immediate action is required. Within 5 days of the CFT Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		Have a CFT or Crisis Meeting to address any issues that came up with the incident report and update the current version of the POC. If a crisis plan update is required, please update the crisis plan date as well. Do progress notes for every contact and care coordination activity done with/for the youth and family	Updated Plan of Care (POC), Contact Note and Team Meeting Note	

3.4. Complete documentation.	Complete documentation.	Review all the required documentation	Family Story, Plan of Care (POC), Crisis Plan, Transition Plan	Monthly
		Keep track and request reviews with CME clinical team whenever there is:	Plan of Care (POC)	As Needed
		• OOH placement	Custody Tab	As soon as you know
		• Change to timeline for return home		
		• Lengths of stay (total enrollment span) beyond 12 months in High Fidelity Wraparound (HFWA)		
		• Before youth turn 18 years old, and any other time as necessary when additional support is needed.		
		Talk to the family about completing the Wraparound Fidelity index (WFI-EZ) and the Family Care Coordinator (FCC), Family Support partner (FSP) complete a WFI-EZ.	Wraparound Fidelity index (WFI-EZ)	At 6 months
		The Child and Adolescent Service Intensity Instrument (CASII)/Early Childhood Service Intensity Instrument (ESCII) and Level of Care (LOC) are due annually. Check the dates for when they were conducted as it may not match entry to HFWA. You will not receive prior authorization beyond the expiration date of these clinical eligibility assessments.	CASII/ECSII And Level of Care	Annually

Phase 4: Transition				
4.1. Plan for end of formal wraparound. GOAL: To finalize transition out of formal wraparound in a way that is consistent with the wraparound principles.	Create a discharge plan.	Purposeful transition plan is considered throughout the process, and you use the Transition Asset Tool Custom Assessment to inform the POC.	Transition Asset Tool and the POC	Average time working with a family and supporting their development is 20 units per month total = 6 hours monthly of HFWA or working towards transition 1.5 hours per week is considered an average With every Plan of Care (POC)submission
	Create a discharge crisis plan.	This should include a list of community- based resources the family is familiar with using with contact information and go to people listed.	Discharge/Crisis Plan	Within 5 days of discharge
	Modify wraparound process to reflect transition.	At discharge, update the Family Story, Plan of Care (POC), Crisis Plan, Child Adolescent Needs and Strengths (CANS). Enter a contact note.	Family Timeline, Plan of Care, Crisis Plan, Child Adolescent Needs and Strengths (CANS)	To be completed by the day of the Discharge
4.2. Create a "commencement" GOAL: To celebrate commencement from formal wraparound.	Document the team's work.			
	Celebrate success.	Highlight the family's successes and celebrations	Send an email to WyQuality@MagellanHealth.com	
4.3. Follow-up with the family	Check in with family.	Develop a plan for following up with youth and family after formal HFWA ends.	Contact Note in your files	Recommended 3, 6, and 9 months post.
		Please let the family know that Magellan will be sending a link to and online Satisfaction Survey	Contact Note in your files	Recommended 3, 6, and 9 months post.

Appendix B: Family Support Partner Timelines and Requirements

Magellan of Wyoming
HFWA Family Support Partner Requirements & Timelines

Legend

Application: Goals and Activities for days 1-7

First Prior Authorization: Assessments, Crisis Prevention Planning, 1st Child & Family Team, 1st Plan of Care
Days 8-52, Units: FCC=80, FSP=52, YSP=44

Implementation: Working with the family and team
Days 53-discharge, Units: TBD by Plan of Care

Transition to Discharge; Setting the family up for success.
Days TBD, Units: TBD by Plan of Care

Content provided by National Wraparound Initiative, Magellan Healthcare

Phase 1: Engagement and team preparation.				
National Wraparound Initiative Task and Goal	Wraparound Activity	Information	Documentation	Timeline
Eligibility and Application	Referral and Application to CME for HFWA	Not Applicable	Not Applicable	Not Applicable
1.2. Orient the family. GOAL: To orient the family to the Wraparound process.	Orient the family and youth to Wraparound.	In face-to-face conversations or via approved telehealth The FSP explains their role and Wraparound from their perspective with/to the youth/family. The FSP listens without bias or judgement, they do not jump in to fix. FSP + family discuss family's comfort with advocating for child and need for coaching and support from FSP. FSP explains boundaries of their role, organizes family's documents, helps create a binder, box or folder for family to be used during Wraparound process.	Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
	Address legal and ethical issues.	FSP reviews all consent and release forms with the family and youth, answers questions, and explains options and their consequences.	Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.

	Address legal and ethical issues.	FSP discusses relevant legal and ethical issues (e.g., mandatory reporting, confidentiality) Informs family of their rights (For Example: FSP can help them prepare for court appearances and, when invited, may attend to provide support to the family.)	Obtains necessary consents and release forms before the first team meeting. Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP can help them prepare for court appearances and, when invited, may attend to provide support to the family.	Obtains necessary consents and release forms before the first team meeting. Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP discusses any evaluation, data collection, or research activities associated with the Wraparound initiative including how the family's participation might benefit them or others.	Obtains necessary consents and release forms before the first team meeting. Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
1.3. Stabilize crises and urgent needs. GOAL: To address pressing needs and concerns so family and team can focus on the Wraparound process.	Elicit information from referral about immediate crisis or urgent needs.	FSP participates in discussions regarding stabilization of immediate concerns to ensure that the plan is individualized and realistic for the family. These may include crises stemming from a lack of basic needs	Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.

		(e.g., food, shelter, utilities such as heat or electricity).		
	Ask youth and family and youth about immediate crisis concerns.	FSPs help define the nature of the family's immediate concerns by listening carefully and encouraging the family to speak frankly. The FSP can ask about the signs that a crisis is likely to occur and learn what has been done by the family before so that strategies that have worked are included in the plan and those that have failed in the past are not repeated.	Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP work with the family helps identify reasonable alternatives, possible natural supports, and share what they know about resources in their communities that may give respite, food, shelter, clothing, and other necessities to help the family stabilize.	Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		The FSP may help the family define crisis or safety concerns from their own experiences. FSP helps clarify for the family how other team members may view potential crisis concerns including events that could trigger a report for abuse or	Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.

		neglect. FSP helps communicate the family's perspective regarding potential crisis to the team members. FSP encourages family members to identify both the formal and natural supports that have worked well to resolve crisis in the past and may look at what it would take to mend bridges of past natural supports. FSP should not put themselves in the role of the person to resolve or call when in crisis.		
		FSP offers hope and helps calm and decrease the family's anxiety and fears of the unknown, when appropriate, by sharing their experiences.	Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
	If immediate response is necessary, formulate a response for immediate stabilization.	FSP helps ensure the family feels the planned response for immediate intervention and/or stabilization can be readily implemented when it is needed. FSP may assists the family in expressing any concerns they might have about the immediate intervention and/or crisis stabilization plan.	Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.

1.4. Facilitate conversations with family and youth/child. GOAL: To explore individual and family strengths, needs, culture, and vision and to use these to develop a document that will serve as the starting point for planning.	Prepare the family for the Assessments	FSP works with the facilitator to summarize the strengths, needs, culture and vision of the family unit and individual family members. The Family Support Partner reviews the document with the family to make sure the family completely understands the document and that it really reflects their view of themselves, their strengths, and the challenges they face. (May be done with FCC)	Contact Note	Total of 46 days to complete the Assessment, Crisis Planning, the first Child and Family Team Meeting Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
	Explore strengths, needs, culture, and vision with child/youth and family.	Have a conversation with the family about the Primary Care Physician, Clinical Evaluator, and emergency contact. Discuss with the PCP any health-related concerns.	Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP becomes aware of individuals who could be members of the family's Wraparound team including those who might provide support even though they cannot be physically present.	Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP through discussions about the strengths and gifts of potential team members as well as any risks associated with their involvement, the FSP helps the family decide who they would like on their team.	Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.

		The family could ask the Family Support Partner to help them invite some individuals to be on their team and explain to them what their responsibilities would be.	Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP acts as a role model by educating system representatives on Wraparound's principle of family voice and choice and helping them apply this principle to their work on the team in the context of their agency's mandates.	Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP may act as a bridge builder encouraging understanding and collaboration between the family and their team members.	Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.

Phase 2: Initial Plan Development				
2.1 Prepare family for Behavior Exploration	Gather Information regarding the Crisis	FSP contributes to crisis/safety plan development by encouraging the family to draw on their past experiences and knowledge of conditions such as environments, people, health issues, or other circumstances that could trigger a crisis or safety situation.	Contact Note	By Day 25 Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP may offer suggestions based on how they or other families have used a crisis plan.	Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP helps the teamwork with the family to think about the future and what may happen that would require the use of a crisis/safety plan.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
2.2 Create a Crisis Plan to support the stabilization of family functioning	Complete a Crisis Team Meeting	FSP needs to explain to the family and the team the specific responsibilities of their role and limitations imposed on them regarding responding to crisis situations.	Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP strongly encourages the family and the team to talk with the child or youth to understand what are likely to be the most effective strategies to avoid or de-escalate a potential crisis.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.

		FSP actively questions proposed responses to crisis to ensure that the crisis/safety plan includes solutions the family will use (i.e., alternatives to calling the police) and is something that the family truly feels can benefit them during a crisis and that they can follow in times of high stress.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP makes sure the family has a copy of the crisis/safety plan at the end of the meeting and that they have a realistic plan for where to keep it so they can find and use it when necessary.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
2.3 Review the Crisis Plan	Review Crisis Plan	FSP reviews the initial written plan with the family to make sure that the family understands the plan, that it accurately reflects what the family has said (preferably in their own words) and what they expect from those responsible for implementing it.	Crisis Plan in the Plan of Care Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP helps the family strategize about how to work with their team to modify anything in the plan that they are not comfortable with.	Crisis Plan in the Plan of Care Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP helps the family use tracking procedures provided by the team and develop their own method of organizing and preserving their family's important papers and plans, so they are available for future use.	Crisis Plan in the Plan of Care Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.

2.4 Necessary meeting preparation	Solicit participation, orient team members.	With permission from the family, FSP attends the initial care planning meeting. Before the meeting, the FSP should have a conversation with the family about where they would like the FSP to sit (next to, across from) to offer the best means of communication and support that feels comfortable for the family.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
2.4 Necessary meeting preparation	Solicit participation, orient team members.	FSP offers support to the family by encouraging family member(s) to: • Participate in constructing the ground rules so that they are relevant and individualized. • Express strengths, visions, and needs. • Describe the family's cultural, spiritual, and moral beliefs. • Contribute to the development of strategies they feel are realistic; and • Speak up and say "no" when suggestions are made that they do not agree with.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP ensures the family's perspective is visible and heard by asking questions of the family to be sure they are comfortable with the plan as it evolves.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP helps other team members understand and feel comfortable with the principle of family voice and choice.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.

		FSP agrees to take responsibility for follow up tasks that are compatible with their role description and expectations.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
2.3. Develop an initial plan of care at a Child and Family Team Meeting GOAL: To create a team process that elicits multiple perspectives and builds trust and shared vision among team members, while maximizing family voice and choice	Create opportunities to support the family	By sharing their own experience (relevant self-disclosure) FSP may help the team gain some insight into the family's situation so they can think "outside the box" and be creative in developing a practical plan.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		The Family Support Partner helps the family decide if the plan is likely to be workable for them. They do this by asking them questions like: • "Is the plan flexible enough to meet your changing needs?" • "Does the plan incorporate the natural supports you need?" • "Do you feel your voice has been heard?" • "Does the plan incorporate the formal and clinical services you need?" • "Is the financing of services and supports realistic?"	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
	Arrange meeting logistics.	FSP collaborates with the FCC and the family to make sure that all meetings are held in places and at times comfortable and convenient for the family.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.

		FSP, in collaboration with the FCC and family, may send out meeting notices and reminders, and, when necessary, identifies the need for travel, childcare, translators, or other supports for participants.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		Before the meeting, FSP works with the FCC and family to create an agenda and consider if/what refreshments might be required and how to get them.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
	Describe and document strengths.	Drawing on prior discussion, the FSP works with the family to see how their strengths, team strengths, and community strengths can be used to help address their needs with the goal of assuring natural supports are developed and used to sustain the family goal.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
	Team Process.	FSP helps the family express changes in their vision of the future to their team.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
	Create team Mission.	FSP makes sure that the team mission incorporates the family's and the child/youth's perspectives, abilities, and preferences.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP makes sure the family understands that their Wraparound team's mission may need to be revised as changes occur in their child and family.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.

	Describe and prioritize needs/goals.	FSP helps the family to determine their priorities and express them to the team.	Contact Notes	Preferably write up the Plan of Care between days 19-25 Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP helps the family to understand that needs not immediately addressed will be attended to once the greatest needs are taken care of.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP helps the family to learn the phases of the Wraparound process. Attention is paid to understanding the distinction between needs, traditional services as an attempt to meet those needs, and individualized, natural supports and resources.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
	Select Strategies and assign Tasks.	FSP helps the family express their views about all the goals identified in their plan of care. They encourage the family to talk about how well the goals meet their needs and priorities.	Contact Notes	Preferably write up the Plan of Care between days 19-26 Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP makes sure the family considers how workable and realistic the plan is for them and raises any concerns they have.	Contact Notes	Preferably write up the Plan of Care between days 19-27

				Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP helps the family to actively participate in choosing how progress on their goals will be tracked and measured.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		The family partners help the family define how its members will be involved in collecting data and working with the team to understand what it means.	Contact Notes	Preferably write up the Plan of Care between days 21-28 Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.

Phase 3: Implementation				
GOAL: To Implement the initial plan of care, monitoring completion of strategies and tasks and their success in meeting needs and achieving outcomes in a manner consistent with the Wraparound principles.	Debriefing with family and team.	FSP supports plan implementation by carrying through on the action steps they have agreed to take on.	Contact Note	Prior Authorizations are given for 90 days Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
	Support and motivate family/team.	FSP mentors and coaches the family in their journey towards self-empowerment and independence.	Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP provides support as needed, to follow through on action steps without taking over. Some examples are: • Accompanying family members to meetings with the school, court appearances, and other meetings as requested. • Inviting family members to support groups, training, and other group family activities. • Encouraging family members to contact their care coordinator, teacher, physician, or other provider as questions or concerns emerge. • Cheering the family on as they complete each significant stage of activity. • Helping the family monitor implementation of their plan.	Contact Note	

		FSP can practice communication techniques with family if necessary and help work any concerns or barriers of the family about conversations with any team members or providers.	Contact Note	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
GOAL: To Implement the initial plan of care, monitoring completion of strategies and tasks and their success in meeting need and achieving outcomes in a manner consistent with the Wraparoundprinciples.	Monitor progress celebrate success.	FSP checks in (between meetings as define in POC) with the family to see if they are following through on tasks and keeping track of other's actions they agreed to monitor.	Plan of Care (POC) Contact Note	Attend Child and Family Team meetings, best practice is to attend one as often as needed (one is needed every 90 days for a Prior Authorization to be created and must be entered 30 days before an authorization review is completed. POC is reauthorized every 90 days after the first POC authorization, if documentation is submitted within timelines.
		FSP may provide additional support to family members and their informal supports if needed.	Contact notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
GOAL: To Implement the initial plan of care, monitoring completion of strategies and tasks and their success in meeting need and achieving outcomes in a manner	Monitor progress celebrate success.	FSP encourages the team to present data in ways that make it easy for the family to understand what is being measured and what it means.	Contact notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.

consistent with the Wraparound principles.		FSP encourages the family to ask questions and provide their own views on progress in order to be an active participant with the team.	Contact notes	
		FSP highlights the family's accomplishments and acknowledges what team members have done to facilitate achieving goals.	Contact notes	
		FSP remembers to acknowledge small steps along the way.	Contact notes	
3.3. Maintain, team cohesiveness and build trust. GOAL: To monitor team satisfaction and "buy-in" to the process, and build team cohesiveness and trust	Consider New Strategies	FSP goes over the plan each time they visit or speak by phone with the family. They discuss what is working and what may not be working.	Contact notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP encourages the family to request a team meeting whenever they feel the need to adjust the plan - such as when there are frequent crises.	Contact notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP assists and supports the family in bringing updates back to their team to identify barriers and select strategies that may work better.	Contact notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP encourages the family to discuss their feelings and commitment to the evolving plan and to tell their team what they are experiencing and thinking.	Contact notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		Complete notes for every contact and activity done with/for the youth, family, and team as specified in the Plan of Care.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.

3.3. Maintain, team cohesivenessand build trust. GOAL: To monitor team satisfaction and “buy-in” to the process, and build team cohesiveness and trust	Maintain awareness of team members’ satisfaction and “buy-in”.	FSP acts as a collaborative advocate by being non-adversarial and coaching the family to find ways of keeping the conversation and approaches honest and respectful even in difficult moments. Because they are peers with similar experience, Family Support Partners can ease family members’ fears, listening (without passing judgment) to what they are saying, and assuring them that they have a voice on their team.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP may need to help the family bring their concerns, dissatisfactions, or conflicts to the surface. In such cases, FSP explores ways to communicate with the team that the family feels are safe and can lead to resolution with other team members.	Contact Notes	
		FSP collaborates with team members to maintain their confidence with the process and help them stay engaged, use the plan, adapt it when needed, and continue to develop better ways to communicate with the family, understand and meet their needs.	Contact Notes	
		FSP can make use of available information (e.g., WFI-EZ documents, CANS, informal chats, team feedback, surveys) to assess team members’ satisfaction with and commitment to the team process and plan. They share this information with the team as appropriate.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.

	Address issues of team cohesiveness and trust.	FSP must model how to frame and reframe an issue to facilitate collaboration, being patient, and being strengths-based all through the Wraparound process. By reminding the team of the meaning of the Principles of Wraparound the family partner can help the team examine how their actions are building trust, cohesiveness, and collaboration to achieve shared goals.	Contact Notes	Document all Critical Incident Reports in the Electronic Health Record Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP encourages the family or team members to bring issues into the open where they can get supports to resolve conflicts quickly (nothing about the family without the family)	Contact Notes	
3.4. Review documentation.	Complete documentation.	FSP reviews updates to the written plan with the family to make sure that the family understands the plan, that it accurately reflects what the family has said (preferably in their own words) and what they expect from those responsible for implementing it.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP helps the family strategize about how to work with their team to modify anything in the plan that they are not comfortable with.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP completes contact notes and other documentation according to requirements.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP helps the family to use tracking procedures provided by the team or to develop their own method (such as a binder or folder or storage box) of organizing and		

		preserving their family's important papers and plans.		
		FSP participates in evaluating the implementation of Wraparound such as collecting data, interviewing families, participating in data analysis, and reporting results to the team, community, families, and funding sources.		

Phase 4: Transition				
4.1. Plan for end of formal Wraparound. GOAL: To finalize transition out of formal Wraparound in a way that is consistent with the Wraparound principles.	Create Transition Plan	FSP helps the family to look back on their Wraparound experience, identify what they have learned, review their plan, and determine if the outcomes they hoped for were achieved.	Contact Notes	Average time working with a family and supporting their development is 20 units per month total = 6 hours monthly of HFWA or working towards transition 1.5 hours per week is considered an average Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
	Create a discharge crisis plan.	FSP checks the family's comfort level with the cessation of formal Wraparound and the time frame in which it will occur.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP supports the family in self-advocacy if time frames do not work for them.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP talks with the family about what graduating from Wraparound will mean for them and how they can manage to maintain whatever gains were made.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP helps the family acknowledge their own level of self-empowerment and identify the specific strategies the family is able to use to advocate for their child, use natural supports and services, or get help in a crisis.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.

		FSP supports creating a post-transition or after-care plan in a format the family can use.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP can give the family a file or binder of community and state resources and places they could use in the future.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP encourages the family to join a family-run organization and participate in family activities in the community where they can receive ongoing peer support and provide support to others if they are ready.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
	Create a post-transition crisis management plan	FSP can encourage the family to call a team meeting when they need it, create their own agendas, and to facilitate their own team meetings.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP makes sure the family has a crisis plan they can implement.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP makes sure family members know who to contact and how to contact people quickly if a crisis occurs.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
GOAL: To plan a purposeful transition out of formal Wraparound in a way that is consistent with the Wraparound principles and	Document the team's work.	At the time of transition, the family assumes responsibility for advocating for themselves.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.

that supports the youth and family in maintaining the positive outcomes achieved in the Wraparound process.		FSP may help the family assume the facilitation of their own team post formal Wraparound. The family may call on the FSP to help them refresh their skills when difficulties arise.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
GOAL: To ensure that the cessation of formal Wraparound is conducted in a way that celebrates successes and frames transition proactively and positively.	Document the team's work.	FSP, as part of the team, ask the family what kind of commencement they would like and how they want to celebrate.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP participates in planning this event to make sure this is the family's time in the sun.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
		FSP makes sure the family has collected all its important plans and papers in an organized way, so they have ready access to them in the future.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
	Celebrate success.	FSP encourages the family to participate in the commencement celebration. If the family does not participate, the Family Support Partner finds a way to acknowledge the family's success and bring closure to their relationship.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.
GOAL: To ensure that the family is continuing to experience success after	Check in with the family.	FSP may create a plan to stay connected by phone or face-to-face meetings on an individual basis	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.

Wraparound and to provide support if necessary		FSP's connection with family organizations in the community can give rise to opportunities for them to see and connect with Wraparound graduates through newsletters, support group meetings, invitations to special events, conferences, volunteering or employment in the family movement or system of care, or joining workgroups, taskforces, advisory groups, and governing bodies.	Contact Notes	Document in Contact Note and upload to EHR within 14 business days. The note needs to be in the EHR before an invoice can be sent.

Appendix C:
How to Request Prior Authorizations

Reviewed 11/24

High Fidelity Wraparound
Request for Prior Authorization

Magellan manages the Prior Authorization process for all High Fidelity Wraparound enrollees, regardless of waiver eligibility of the youth. This supports the intent of the Medicaid waivers, to offer High Fidelity Wraparound as the model for targeted case management and not simply an insurance benefit. Our process connects Family Care Coordinators with the family as the first point of contact in the eligibility process.

High Fidelity Wraparound Referral and initial Prior Authorization

1. There is no wrong door to refer potential enrollees to High Fidelity Wraparound. Verify any Medicaid Number used for this process is active for youth at time of referral. To submit a referral, call 1-855-883-8740 or 1-307-459-6162 for our Care Worker, or email WYClinical@MagellanHealth.com.
    a. Complete the referral form either in the electronic health record and email to WYClinical@MagellanHealth.com via Fidelity EHR or online https://www.magellanofwyoming.com/providers/providers-connection-corner/ Please note, submission of referral through www.MagellanofWyoming.com results in a time delay, and response is not immediate (for provider-driven referrals).
    b. Family Care Coordinators should complete a Choice of Provider Custom Assessment in Fidelity EHR with the guardian including guardian signature, ensure that the youth Social Security Number has been entered into the Intake Form and notify WYClinical of the Custom Assessment completion via email to WYClinical@MagellanHealth.com.
2. Magellan outreaches family to get a verbal choice of provider if the Choice of Provider Custom Assessment is not already in the member record.
    a. Magellan notifies Family Care Coordinator/Agency of the family's choice via email.
3. Agency must respond to Magellan via email within 48 hours that it either accepts or declines the referral for High Fidelity Wraparound. The email must include the following:
    a. A confirmation of their acceptance (or decline)
    b. The name of the Family Care Coordinator and his/her contact information
    c. In the event the chosen Family Care Coordinator/Agency does not respond to Magellan within a 48-hour period, the family will be encouraged to choose a different Family Care Coordinator/Agency.
4. Magellan authorizes seven days for High Fidelity Wraparound application period from the date of the Family Care Coordinator's confirmation.
5. Family Care Coordinator contacts the family **within 72 hours** of Magellan's notification to confirm Medicaid eligibility. The first meeting is scheduled during this first contact. Family Care Coordinator will document this first contact in a Contact/Service note.

a. Note: If there is a problem with Medicaid eligibility, the Family Care Coordinator must notify Magellan immediately via email to WYClinical@MagellanHealth.com. *Move to next step ONLY after Medicaid eligibility is confirmed.* All applications for Family Care Coordination come to Magellan for Prior Authorization and quality approval. Youth who do not currently have Medicaid but are applying to the Care Management Entity for High Fidelity Wraparound, will need to be approved by the state through the C waiver application process, once Magellan has verified documents have been filled out completely. ***Please submit all High Fidelity Wraparound applications to WYClinical@MagellanHealth.com via the electronic health record. Ensure all supplemental documentation has been uploaded to the Documents tab of the member record. Please note: High Fidelity Wraparound application documents should be completed in the electronic health record in lieu of paper forms. Please be sure to capture the guardian's signature for each required application form (via electronic signature either in the electronic health record or an emailed signature which includes audit trail of name of signer and date of signature) or a wet signature uploaded into the electronic health record.***

b. For C waiver applications, please include the Wyoming Medicaid Financial Application with other application documents. It should be uploaded to the Documents tab of the member's electronic health record. Please do not submit the Wyoming Medicaid Financial Application directly to Wyoming Medicaid.

c. Family Care Coordinator should call Magellan's Care Worker at 1-855-883-8740 or 307-459- 6162 when assistance is needed to select an Independent Assessor (IA), in order to complete the CASII/ECSII https://www.magellanofwyoming.com/youth-and-families/find-a-provider/.

6. Family Care Coordinator will assist the family with the Level of Care. This must be completed by a Qualified Mental Health Professional – anyone licensed who can attest to or provide a valid mental health diagnosis. Prior to submitting the Level of Care assessment to Magellan, please ensure all assessment questions have been answered by the Qualified Mental Health Professional if applicable. Also, please ensure the Level of Care assessment includes the Qualified Mental Health Professional's credentials, license number, and date of signature. Level of Care assessments completed by provisionally licensed Qualified Mental Health Professionals must include the name, signature, credentials, license number, and date of signature for the original signee's supervisor.
7. Family Care Coordinator will initiate the High Fidelity Wraparound application in Fidelity EHR.
    a. Complete all application Custom Assessments and guardian signatures within the electronic health record. Confirm all application documents are complete by accessing the Family Care Coordinator Intake Checklist in the electronic health record. Required documents include the following:
        i. Intake form tab of the member record
        ii. Choice of Provider Custom Assessment with guardian's signature
            1. If a family wants to add a Family Support Partner or Youth Support

Partner to the team at enrollment, that provider name must be included on the Choice of Provider Custom Assessment.

2. For all C waiver referrals, the Youth and Family Training service provider must be included on the Choice of Provider Custom Assessment.
3. Freedom of Choice Custom Assessment with guardian's signature
4. Family Rights and Responsibilities Custom Assessment with guardian's signature
5. CASII/ESCII Custom Assessment signed by Independent Assessor
6. Release of Information with guardian's signature
7. Intake Form consent with guardian's signature
8. Custody tab entry documenting whether the youth is in a Home and Community-based placement or an Out of Home placement at the time of application
9. CASII/ESCII 1-day add form (if C waiver application)
10. Medicaid Financial Application (if C waiver application)

b. Application Reminders:
   i. The CASII/ECSII instruments are Custom Assessments that must be completed by the Independent Assessor (IA). You will need to talk with the family about their choice of Independent Assessor and document this choice on the Choice of Provider Custom Assessment initially submitted with the referral. Magellan will grant the selected IA time-limited access to the record for completion of the CASII/ESCII assessment.
   ii. Paper copies of Release of Information forms are supplied by each provider and should be uploaded in the Documents tab of the member record. Providers also have the electronic option of either using the "Has Authorization to Release Information" radio button within the "Edit Team Member Details" feature within Fidelity EHR or the Consent to Release on MagellanofWyoming.com.

8. Family Care Coordinator will submit a fully completed application and clinical eligibility assessments within the first seven days of the application authorization (see note in step 5) to Magellan as stated above. **As a reminder, invoice submissions for the seven-day application authorization {CPT code H0032} do not require a Prior Authorization. These invoices should be submitted directly to Magellan at WYProvider@MagellanHealth.com. Please document your contact with the youth and family during the seven-day application authorization in a Contact/Service note before submitting your invoice to Magellan.**
9. Begin an initial CANS Licensed Assessment and ACE survey Custom Assessment with the youth and family.
   a. *Note – there is currently no wait list for C waiver. When a wait list is necessary, wait times vary and are not at the discretion of Magellan. Magellan will notify providers when changes to wait list occur.
   b. If families have a need for the C waiver and will be on the wait list, direct them to email Brenda Stout at brenda.stout1@wyo.gov for their status on the wait list. Magellan will not be able to provide information until the state sends a funding

notification for a youth on the C waiver wait list.

10. Upon approval of a High Fidelity Wraparound application, Magellan will notify referral source, guardian and Family Care Coordinator of enrollment into High Fidelity Wraparound and initiate a Prior Authorization for 46 days. In that time period, the following needs to occur:
    a. Meet to start team building. Work with the family to complete assessments and documentation needed for prior authorization
    b. Complete Family Interview located under the Family Timeline tab in the electronic health record. If this is your first time, get High Fidelity Wraparound coach approval before sending to Magellan.
    c. Complete Adverse Childhood Experiences Survey (ACES) Custom Assessment.
    d. Complete Child and Adolescent Needs and Strengths (CANS) Licensed Assessment.
    e. Complete a crisis plan with the family. Document the Crisis Plan within the Current version of the Plan of Care in the electronic health record and save
    f. Plan for the first Child and Family Team meeting. Please note, the CANS Licensed Assessment, ACES survey, and Family Story MUST be completed prior to the first Child and Family Team meeting and initial Plan of Care development.
    g. Complete Contact/Service notes in the member record. Ensure there are a minimum of two required Family Care Coordinator contacts documented with the youth and their caregiver, per month, via the family's preferred means of contact. For continued prior authorization of auxiliary services, e.g. Family Support Partner, Youth Support Partner, Youth and Family Training, Respite, groups, please document all associated contact with the youth and family in a Contact/Service note to obtain continued prior authorization.
    h. For C waiver youth, create a Need/Strategy/Task within in the Plan of Care which documents the individualized need for Youth and Family Training, a mandatory service for all C waiver youth.
    i. Complete the initial Plan of Care and submit to WYClinical@MagellanHealth.com via the electronic health record. Be sure to include the guardian's signature on your Plan of Care submission. *Ensure all assessments and documentation listed above are complete in the electronic health record prior to submitting the Plan of Care for Prior Authorization review.

Important Notes

Magellan will not extend the initial application period beyond seven days. This time is not billable to Wyoming Medicaid. If it takes longer than seven days to complete the application, Level of Care and initial CASII/ECSII, the agency will have to make its own business decision about the days beyond seven as these will not be reimbursed.

When no evidence of engagement occurs in the first 30 days of referral submission and Magellan does not receive an application and accompanying documents, the application process for the referred youth will be closed at Magellan's discretion.

Enrollment Notification Guidelines

1. Respond in a timely manner to any communication from Magellan about High Fidelity Wraparound application submissions so the process does not stall. The Family Care Coordinator will receive an automated enrollment notification email after Magellan has processed a complete application submission. Magellan will issue this notification within 14 days of application submission. The enrolled family will receive an enrollment letter with a link for the Family and Youth Guide via U.S. Mail. A copy of the enrollment letter will be saved in the Documents tab of the member's electronic health record.
2. Family Care Coordinators who have completed all application documents and made sure the CASII score (20-26) and Level of Care assessment meet criteria should confidently move forward working with the family. Magellan will approve all **completed** B waiver applications which meet clinical eligibility for enrollment. As a reminder, Magellan defers to the state for all C waiver clinical and financial eligibility determinations.
3. Follow the guidelines in the Timelines and Requirements document, see the Provider Handbook for further guidance on facilitation of High Fidelity Wraparound. Contact your program director, supervisor or coach with any questions.

Requests for Continuous Prior Authorizations after High Fidelity Wraparound Enrollment

1. To initiate a request for continuous Prior Authorization, the Family Care Coordinator should complete the Plan of Care in the electronic health record. Then submit an update routine Plan of Care to WYClinical@MagellanHealth.com using the electronic health record email function. Requests for prior authorization may be submitted up to 30 days before the last covered day of the existing prior authorization.

2. Magellan will review Prior Authorization requests within a 14-day timeframe to ensure all documentation reflects the individualized needs of each youth and family. It is the provider's responsibility to ensure all required documentation is fully completed, as this 14-day time period begins with a complete request.

3. Magellan will confirm the service authorization request is for a youth with active Medicaid. If Medicaid has lapsed, Magellan will notify the Family Care Coordinator and ask the Family Care Coordinator to support the youth's guardian in contacting the Medicaid Customer Service Center for more information. If all required documentation for a service authorization request has not been submitted **prior** to the last covered date of the current Prior Authorization timeframe, Magellan will issue a Non-Authorization. **This could potentially result in a gap between Prior Authorization timeframes, until all required documentation has been submitted to Magellan for review. It is the responsibility of the provider, not Magellan or Wyoming Medicaid, to submit complete and timely Prior Authorization requests.**

4. Once a request for Prior Authorization has been reviewed and approved, Magellan will communicate the details of the Prior Authorization to Wyoming Medicaid's fiscal agent. These details include the Prior Authorization date span, CPT code, and number of units authorized. **Note, Magellan will continue to be responsible for review of the Plan of Care and all other supplemental documentation required to make a review and prior authorization decision, throughout the duration of the youth's High Fidelity Wraparound enrollment.**

Helpful Hints

- If you feel there is a discrepancy in your authorization listings, contact us at WYClinical@MagellanHealth.com.
- If you note prior authorizations are present in the electronic health record but not showing in the Wyoming Medicaid portal, please create a Provider Resource Center ticket.
- Contact Magellan directly if there are extenuating circumstances that prevent these steps from being followed.
- Magellan has 14 days to review all Prior Authorization requests. Providers are encouraged to submit documentation no more than 30 days in advance of the last covered day, to account for this processing time.
- You may make a one-time request per Prior Authorization, for administrative authorization extension of up to 14 calendar days. Please submit these requests via the Provider Resource Center.. Requests MUST be submitted prior to the last covered day of the existing Prior Authorization. Please document the rationale for your request within the Provider Resource Center submission.
- You may request additional units before the last covered day of the existing Prior Authorization through the Provider Resource Center. Please ensure all supplemental documentation is in the member record in the electronic health record, e.g. updated Plan of Care, Contact/Service notes, etc. Should Magellan require additional information, a case review with the requesting provider may be scheduled.
- Late submission of documentation may result in a gap between Prior Authorization spans.

Preparation for Plan of Care submission checklist:

- Verify the youth has active Medicaid eligibility through Wyoming Medicaid.
- Confirm a valid Level of Care assessment is saved to the Documents tab of the member's electronic health record.
- Confirm a valid CASII/ESCII Custom Assessment is in the member's electronic health record.
- Confirm Family Interview has been completed, to include a signature page uploaded to the Documents tab of the member's electronic health record.
- Confirm CANS Licensed Assessment has been completed within 30 days of the submission date to request new prior authorization.
- Confirm Team Meeting Minutes have been updated within the last 30 days of a 90-day prior

authorization.

- Confirm a new Transition Readiness Custom Assessment has been completed within 30 days of the submission date to request new prior authorization. Transition Readiness Custom Assessments are due at a minimum of every 90 days per the waiver requirement.
- Confirm Core Assessments have been completed within the last 90 days.
- Confirm Contact/Service notes document a minimum of 2 contacts per month between the Family Care Coordinator and the youth and/or caregiver.
- Confirm a Crisis Plan has been fully completed and includes all 4 phases of a crisis event (Prevention, Early Intervention, Crisis, Follow Through) and Action Steps for each phase.
- Confirm Custody information has been completed within the electronic health record. Ensure all signatures are completed by the legal guardian documented under Custody.
- Confirm that the Clinical Evaluator, Primary Care Physician, and Level of Engagement have been completed and are reflected on the Crisis Plan.
- Confirm the Plan of Care has been signed by the guardian and Family Care Coordinator. Other High Fidelity Wraparound service providers, such as a Family Support Partner, etc. may also provide signatures.
    - If signatures are not captured electronically, confirm a Plan of Care Signature Page has been uploaded to the Documents tab of the member record. Confirm the signature page includes a current date and printed name for all signatures. Note, a youth in custody of Department of Family Services requires Plan of Care signature by the identified Department of Family Services caseworker. Should an alternate Department of Family Services caseworker need to sign documents submitted for prior authorization, the alternate caseworker's name should be documented on the Teams page of the member's electronic health record.
- Confirm Youth and Family Training is included for all C-Waiver youth and documented within the Plan of Care and Choice of Provider form.
- If requesting Group Family Support Partner or Group Youth Support Partner, confirm the following has been completed: updated Choice of Provider, Plan of Care Tasks includes group curriculum and units, Plan of Care documents the individualized need for the group service and curriculum.