Connecticut Medical Assistance Program
Policy Transmittal 23-31

Provider Bulletin 2023-55
July 2023

Andrea Barton Reeves, Commissioner

Effective Date: July 1, 2023
Contact: Erica.Garcia@ct.gov

TO: All Providers

RE: New Medicaid Coverage of Targeted Case Management for Integrated Care for Kids (InCK) in New Haven

Effective for dates of service July 1, 2023, and forward, the Department of Social Services (DSS) will add coverage and reimbursement for targeted case management (TCM) services for the Integrated Care for Kids (InCK), in New Haven under the Connecticut Medical Assistance Program (CMAP) under HUSKY A, B, C and D.

The initial program is being operated as a part of the InCK, a federal program being implemented by DSS to provide services for individuals under age 21 and pregnant and postpartum individuals up to one year after pregnancy who are eligible for Medicaid and the Children's Health Insurance Program. DSS is partnering with Clifford Beers of New Haven as the Local Lead Organization to provide oversight over InCK.

Applicable Members

HUSKY Health members will be eligible for a needs assessment that will determine individual Service Integration Level (SIL), if they are:

- Under the age of 21 years old.
- Reside in New Haven (06510 and 06511 zip codes only).
- Currently pregnant or less than one year postpartum.

The needs assessment will examine medical and social drivers of health status and behavioral health needs. HUSKY Health members, who are determined to be SIL 2 or SIL 3 will be eligible for InCK services.

After initial assessments, reassessments must occur at least annually to continue TCM services and individuals assessed to be SIL 3 must be reassessed every six months as long as reassessment determines the person remains at a SIL 3 level.

Provider Qualifications

DSS will enroll providers that meet the following qualifications: the provider entity must: (1) be able to deliver services in New Haven, (2) comply with timely service requirements. (3) have experience providing community-based care coordination services and (2) designate one or more dedicated care coordinator supervisors to provide regular supervision and oversight of care coordinators. InCK supervisors must have either a master's degree in a human service or related field with at least one year's full-time equivalent experience providing care coordination or a bachelor's degree in a human service or related field with at least three years' full-time equivalent experience providing care coordination in the New Haven, Connecticut area.

Enrollment

Programs interested in participating as an InCK provider can begin enrolling as a billing provider effective with dates of service on and after July 1, 2023.

InCK provider programs must enroll online via the enrollment Wizard on the CMAP Web site:

www.ctdssmap.com. Eligible providers should select "Provider" and then "Provider Enrollment" from the Home page to access the enrollment Wizard. InCK providers are encouraged to read all instructions prior to proceeding with the online enrollment process. Programs should gather all data required prior to beginning the enrollment process, as an incomplete application cannot be saved. In addition, an application remaining idle for more than 20 minutes will disconnect the provider from the enrollment Wizard.

Once the online application is submitted, providers should take note of the Application Tracking Number (ATN). Once the application has been submitted, the provider should download a copy of the completed application for record keeping purposes. The ATN will allow providers to track the status of their enrollment application by selecting "Provider Enrollment Tracking" from the provider main menu on the www.ctdssmap.com Web site Home page.

Successfully enrolled programs will receive both a Welcome and PIN letter to set up their Secure Web Account. The setup of a secure Web account allows the provider access to multiple on-line functionalities to maintain an updated enrolled provider file, in addition to multiple functionalities such as eligibility verification and claim submission.

Gainwell Technologies, the Fiscal Agent for the Department of Social Services, will provide an enrollment workshop to assist providers with the online enrollment process, application tracking, and initial Secure Web Account set-up.

Services Covered

All services reimbursed under InCK must be provided by an eligible enrolled provider organization. Covered services include:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
    - taking client history;
    - identifying the individual's needs and completing related documentation; and
    - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

    - As part of the comprehensive assessment, an initial comprehensive assessment of needs is performed, which includes a determination of whether each individual risk-stratifies to Service Integration Level (SIL) 1, in which case further InCK TCM services after the assessment are not provided; SIL 2, which reflects a moderate level of need and corresponds to a moderate intensity of InCK TCM services provided, as tailored to each person's needs in the care plan; or SIL 3, which reflects a high level of need and corresponds to a higher level of InCK TCM services provided, as tailored to each person's needs in the care plan.

- After the initial assessment, reassessments occur at least annually for individuals at SIL 1 and SIL 2 and every six months for individuals at SIL 3 but may be performed more frequently based on the individual's needs, including to the extent necessary to capture changes in the person's needs.

- As part of the comprehensive assessment, development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that specifies the goals and actions to address the medical, social, behavioral, educational, and other services needed by the individual; Referral and related care coordination activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and
- Monitoring and follow-up activities: activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one quarterly monitoring.
- Type of Monitoring and Follow-Up Activities: Monitoring and follow-up activities include making necessary adjustments in the care plan and related changes in the services performed by the provider, which may be performed by staff face-to-face, telehealth, or telephone contact with the individual; by chart review; by case conference; by collateral contact with individuals, family members, providers, legal representatives, or other persons or entities for the benefit of the Medicaid member; or any combination thereof. The care plan must be reviewed every 90 days and adjusted if needed.

Billing

All participating InCK Providers must enroll as an InCK Provider through the Connecticut Medical Assistance Program (CMAP). After enrollment, InCK Providers must bill care coordination services under the Integrated Care for Kids Targeted Case Management Provider type to receive the monthly payment from Medicaid for providing services to eligible individuals. Billing codes for services are as follows:

Code	Modifier	Procedure Code Description
T2023		SIL 2: Targeted case management; per month
T2023	TG	SIL 3: Targeted case management; per month

Supplemental Guidance

DSS has developed additional guidance and may develop additional guidance in the future, which is posted to the DSS InCK webpage (available at https://portal.ct.gov/DSS/Health-And-Home-Care/InCK/Integrated-Care-for-Kids). This includes guidance on training; minimum services/contacts required to be able to bill for services, documentation requirements, billing procedures; technology requirements and additional topics. Providers must comply with this, and all other guidance issued by DSS.

Gainwell Technologies will be offering a Claim Submission Workshop in the future for Providers new to the Connecticut Medical Assistance Program or those seeking additional guidance for successful claim submission.

Accessing the Fee Schedules

The updated fee schedules can be accessed and downloaded by going to the CMAP Web site: www.ctdssmap.com. From this Web page, go to "Provider", then to "Provider Fee Schedule Download", scroll to the bottom of the page and click on "I Accept", then select "Integrated Care for Kids Targeted Case Management" fee schedule. To access the CSV file, press the control key while clicking the CSV link, then select "Open".

Posting Instructions:

Policy transmittals can be downloaded from the Web site at www.ctdssmap.com.

Distribution:

This policy transmittal is being distributed to providers of the CMAP by Gainwell Technologies.

Responsible Unit:

For Questions Related to InCK Covered Services: DSS Division of Health Services, Medical Policy: erica.garcia@ct.gov

Date Issued: July 2023

Integrated Care for Kids
Provider Supplemental Guidance

Connecticut Department of Social Services (DSS)

July 2023

Version 1.0

Table of Contents

1. Overview

Integrated Care for Kids (InCK) is a service delivery and payment model that is being implemented by the federal Center for Medicare and Medicaid Services (CMS) Innovation Center. The purpose of the model is to reduce expenditures and improve the quality of care for children and young adults through prevention, early identification, and treatment of behavioral health needs. As of 2023, there are seven participants in the model, including Connecticut. Connecticut's InCK program is known as CT InCK.

The Connecticut Department of Social Services (DSS), which is Connecticut's state Medicaid agency, selected Clifford Beers of New Haven to serve as a lead-organization that is implementing CT-InCK. CT-InCK is a care management program available to children under 21 years of age covered by HUSKY Health CT as well as pregnant and postpartum individual covered by HUSKY Health CT. This program is being initially piloted in zip codes 06510 and 06511 within New Haven, Connecticut and pending results, the program may be further expanded throughout a broader geographic area, potentially ultimately including the entire state of Connecticut. This provider manual describes key components of the program in more detail, but a high level, the CT InCK model of care encompasses:

- Intensive care coordination for children and families with complex health needs
- An alternative payment model (APM) that provides a per member per month (PMPM) payment adjusted for the intensity of a beneficiary needs
- Technology platforms to streamline information for participating healthcare providers

Since this program is being initially piloted in the specified zip codes (06510 and 06511) within New Haven, this guidance may be periodically updated as the program implementation moves forward.

2. Service Model

CT InCK brings together families, local community-based service providers, health providers, and schools to make sure families get the care that they need. CT InCK supports families, community-based providers, educators, and health providers to better understand and support all children's health needs, especially those who have complex or chronic medical, behavioral health, and social needs. The CT InCK service model is designed to provide care coordination to children and families to create a strength-based circle of care and support with families at the center informing their care needs.

Consistent with the guidelines of the federal program, CT InCK will be assessing whether eligible individuals fall into three "service integration levels" (SILs): SIL 1, SIL 2, and SIL 3. SILs are meant to reflect the intensity of health and social needs among eligible members. Where possible,

using Medicaid claims and Department of Children and Families data, individuals will be assigned a preliminary SIL level.

From there, a needs assessment, called a *HealthJourney,* will be completed for these individuals to confirm or adjust the initial SIL level. The *HealthJourneys* will be completed by an Intensive Care Coordinator (ICC) assigned to the individual; the individual can exercise choice at any point should they wish to make a change in their assigned ICC. Community Health Organizers (CHOs) will engage individuals without claims history to complete a *HealthJourney*, which will determine a SIL level.

For individuals determined to be at a SIL 2 or SIL 3 level, the ICC will coordinate care based on the individual needs of the child and family. if individuals wish to change their ICC at this or any point, they can exercise such choice. The ICC will organize access to all services and will help to coordinate care for members to develop an integrated care plan that includes physical, behavioral, community and social supports, education, and other services. ICCs will also oversee and coordinate care planning team meetings, referrals and care that will include the following:

- Provide basic needs support such as food, housing, employment, and infant supplies
- Assist members to determine their physical and mental health needs and how to access care
- Identify local support networks
- Support members in advocacy for their health needs
- Support members in advocacy of their child's education and other healthcare and social needs

With the consent of the individual and/or their family/representative, care plans will be shared among care planning team providers to ensure the individual receives unduplicated supports and services. See the policy transmittal **{I would insert the name of the PB otherwise providers may experience a difficult time locating it)** for more information on length of services and frequency of assessments. See **Appendix A** for a visual representation of how individuals will move through the program during the pilot phase of implementation.

3. Technology

CT InCK will require utilization of two technology platforms, Unite Us and ZaneNet/MayJuun. Providers must be fully trained on these platforms (see training section) and must use the two platforms in providing services through this program.

Zane Networks and MayJuun technology platform (ZaneNet/MayJuun) will be used by participating provider organizations to support the *HealthJourney* process. The *HealthJourney* Portal, supported by ZaneNet/MayJuun, is a secure platform where InCK Providers can send *HealthJourney* (Needs Assessment) links to families' mobile devices or email. This portal houses the pre-engagement module that allows CT InCK providers to manage the members assigned to

their organization, assign individual ICCs to a member, and track their initial outreach to families. The *HealthJourney* portal also allows for staff to track the completion of *HealthJourneys*, and to view results.

The Care Home or Operational Data Hub (ODH), also run by ZaneNet/MayJuun, is a secure care management platform that CT InCK providers must use. Care Home is where care coordinators track members' progress through the intensive care coordination model. The Care Home houses members' plans of care, encounter information, care team, and contact information.

Unite Us technology will provide CT InCK providers access to a wide range of social need providers in New Haven and will be used to make and track closed-loop referrals. Referral sources include organizations providing support for food, housing, and other basic needs.

4. Documentation

CT InCK Providers will be required to document each instance of face-to-face, telehealth, telephonic encounter, consultation, care planning team meetings, and cross-organization care coordination within the *HealthJourney* Portal and Care Home platform. Documentation must meet DSS guidelines for billing to include date, time, location, members present, care plan goals addressed and progress of the member.

5. Intervention Overview Grid

The CT InCK Intervention Overview, available in **Appendix B**, outlines elements of the InCK Model and identifies required and suggested guidelines for aspects of the CT InCK model. Items noted in red are required components of the model, per CMS and state requirements. All other items outlined are suggested guidelines, estimates and recommendations for InCK providers.

6. Training

To support a consistent service delivery, CT InCK has created a set of trainings for participating providers. The table in **Appendix C** describes these trainings, indicating when such trainings should occur, who on the team should participate on these trainings, and if any trainings are optional for providers. For certain specified trainings, participating organizations can attest that they deliver such trainings to staff members; these trainings are noted accordingly.

7. Additional Billing Information

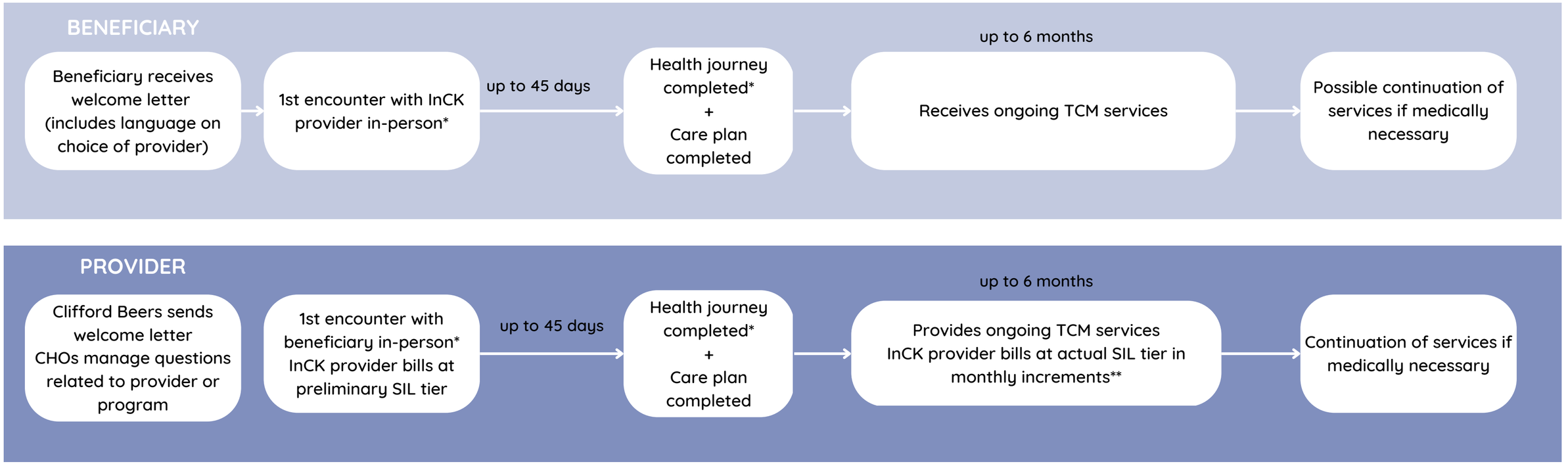
CT InCK is designing a payment process that does NOT require any ICD-10 coding as a principal diagnosis to process claims for payment. However, CT InCK is requiring that InCK Providers include relevant ICD-10 Z codes on the claim. Social Determinates of Health (SDOH)-related Z codes ranging from Z55-Z65 are the ICD-10-CM encounter reason codes used to document

SDOH data (e.g., housing, food insecurity, transportation, etc.). SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age.[1]

This particular design set up - is to ensure payment as we consider program requirements for Z-codes. Z-codes add value in terms of understanding what is happening administratively with the program and to help to improve quality, care coordination, and experience of care for members.

[1] https://www.cms.gov/files/document/zcodes-infographic.pdf

Appendix A: Service Flow - Pilot Phase



*encounter and health journey with SIL 1 may be conducted virtually

**Manual reviews of care plans to determine if:
(1) cases are resolved or
(2) if services need to continue before the 6 months

Appendix B: InCK Overview

Domain	No Claims	SIL 1	SIL 2	SIL 3
HealthJourney	Annually	Annually	Annually	Every 6 months
Goal of CT InCK Intervention	Focus on outreach to enroll in CT InCK: verify contact and demographics, consent/opt out, refer to ASO Member Engagement to id PCP, HealthJourney, refer v Unite Us	Focuses on basic, preventive care and active surveillance for developing needs and functional impairments	The CT InCK Intervention Overview outlines elements of the InCK Model and identifies required and suggested guidelines by Service Integration Level (SIL) for aspects of the CT InCK model that InCK provider organizations and Intenstive Care Coordinators need to follow. Items in red signify what is required by CMS and the CT InCK Model and the responibiilty of the InCK Provider and ICC. Items in black identify guidelines, estimates and recommndations for the InCK Provider.	Focuses on child-centered care planning, intensive care coordination, and home and community-based services
Assignment of Member to InCK Provider	CHO	If member stratified as a SIL 1 is part of a family unit with an individual stratified at a SIL 2 or SIL 3 assigned to an ICC, that ICC will be responsible for completing HealthJourney for SIL 1 members.	InCK Provider/ICC	InCK Provider/ICC
SIL Criteria	All members without claims for previous 12 months	Includes entire target population stratified at a SIL 1 until otherwise stratified higher	Includes members with needs involving ***more than one service type*** and who exhibit a ***functional symptom or impairment***	Includes children who meet **Level 2** criteria who are ***currently*** , or are at ***imminent risk*** *of being, placed* ***outside the home*** .
InCK Provider Role	None	HealthJourney only for SIL 1's within a family unit assigned to an ICC	Single Point of Contact/Outreach & engagement/Legal/ HealthJourney Assessment/care plans/closed-loop referrals/care coordination/care planning team meetings and any other ICC services	Single Point of Contact/Outreach & engagement/Legal/ HealthJourney Assessment/care plans/closed-loop referrals/care coordination/care planning team meetings and any other ICC services
CHOs Role	Single Point of Contact for member	If SIL 1 is within a family unit assigned to an ICC, CHO will be Single Point of Contact for ICC. If member is stratified at a SIL 1 and not part of a family unit, assignment to be determined	Single Point of Contact for ICC	Single Point of Contact for ICC
Caseload **(specific caseload sizes are to be determined during demonstration: numbers in table are for illustrative purposes only)**	400 members/year/CHO (7 CHOs)	35 annually	13 annually	6 annually
Intervention	Community Health Organizer acts as the connector to services and resources	x	Intensive Care Coordination	Intensive Care Coordination
	Outreach via Phone only	Outreach via Phone only	Initial Outreach via Phone, required to complete initial face-to-face visit	Initial Outreach via Phone, required to complete initial face-to-face visit
	HealthJourney	HealthJourney only	HealthJourney	HealthJourney
	Crisis/Safety Plan - urgent/emergent needs	Crisis/Safety Plan - urgent/emergent needs	Crisis/Safety Plan - urgent/emergent needs	Crisis/Safety Plan - urgent/emergent needs
	Warm Transfer to CHN to identify a PCP	Warm Transfer to CHN to identify a PCP	Shared Care Plans (Tailored plan specific to individual need and includes family vision, needs statements, care plan needs and benchmarks (which include strategies), team meeting materials and documentation, transition plans, etc.	Shared Care Plans (Tailored plan specific to individual need and includes family vision, needs statements, care plan needs and benchmarks (which include strategies), team meeting materials and documentation, transition plans, etc.
	BH referral if needed	BH referral if needed	Care Planning Team Meetings with member, family and care team within 60 days of care plan development	Care Planning Team Meetings with member, family and care team within 60 days of care plan development
	N/A	N/A	Engage existing PCP, Bx Health Practioner, OBGyn, Dentist. If member does not have existing providers, provide warm-transfer to CHN to identify a PCP; warm-transfer to Benecare to identify a dentist, if needed conduct referral for BH and ObGYN care provider.	Engage existing PCP, Bx Health Practioner, OBGyn, Dentist. If member does not have existing providers, provide warm-transfer to CHN to identify a PCP; warm-transfer to Benecare to identify a dentist, if needed conduct referral for BH and ObGYN care provider.
	N/A	N/A	Engage school personnel	Engage school personnel
	Warm Transfer to Benecare to identify a dentist	Warm Transfer to Benecare to identify a dentist	Referrals and/or Engagement to SDoH agencies based on identified needs	Referrals and/or Engagement to SDoH agencies based on identified needs
	Referrals via Unite Us	Referals via Unite Us	Referrals via Unite Us	Referrals via Unite Us
Dose and Intensity of Intervention	HealthJourney (via portal sent electronically)	HealthJourney 1x/annually (via portal sent electronically), no face-to-face required, no care coordination required	Encounters = 11 hours/month (includes face-to-face, telephonic, consultation, care planning team meetings, cross-organization care coordination and documentation (per member)). Estimated 2 face-to-face visits per month.	Encounters = 16 hours/month (includes face-to-face, telephonic, consultation, care planning team meetings, cross-organization care coordination and documentation (per member)). Estimated 3 face-to-face visits per month
Documentation	Document warm transfers and referrals as needed	Document warm transfers and referrals as needed	Document each instance of face-to-face, telehealth, telephonic encounter, consultation, care planning team meetings, and cross-organization care coordination in Zane Care Home platform	Document each instance of face-to-face, telehealth, telephonic encounter, consultation, care planning team meetings, and cross-organization care coordination in Zane Care Home platform
APM Performance Measures			1) Successful Completion of Needs Conversations: This measure is met if an InCK Provider completes Needs Conversations with 60% or greater of its attributed population. This measure is calculated by dividing the total number of completed Needs Conversations by the total number of attributed members for an InCK Provider. 2) Comprehensive Collection of Race, Ethnicity, and Language Data: This measure is met if an InCK Provider collects race, ethnicity, and language data in 75% or greater of its completed Needs Conversations. This measure is calculated by dividing the total number of InCK members with completed race, ethnicity, and preferred language demographic data by the total number of InCK members with completed Needs Conversations by an individual InCK Provider. 3) Referral Efficacy: This measure is met if 50% or greater of referrals made by an InCK Provider for attributed patients are closed. This measure is calculated by dividing the total number of closed referrals by the total number of referrals made (in aggregate across all attributed patients).	1) Successful Completion of Needs Conversations: This measure is met if an InCK Provider completes Needs Conversations with 60% or greater of its attributed population. This measure is calculated by dividing the total number of completed Needs Conversations by the total number of attributed members for an InCK Provider. 2) Comprehensive Collection of Race, Ethnicity, and Language Data: This measure is met if an InCK Provider collects race, ethnicity, and language data in 75% or greater of its completed Needs Conversations. This measure is calculated by dividing the total number of InCK members with completed race, ethnicity, and preferred language demographic data by the total number of InCK members with completed Needs Conversations by an individual InCK Provider. 3) Referral Efficacy: This measure is met if 50% or greater of referrals made by an InCK Provider for attributed patients are closed. This measure is calculated by dividing the total number of closed referrals by the total number of referrals made (in aggregate across all attributed patients).
Payment	No Payment	No Payment	PMPM based on monthly report of total SIL2 & SIL3. Initial monthly payment based on preliminary risk score (claims data and DCF data). An ICC is required to cmplete an initial face-to-face visit and complete a Health Journey and subsequent care plan within 45 days of the initial face-to-face in order to secure second monthly payment for SIL and SIL 3 members.	PMPM based on monthly report of total SIL2 & SIL3. Initial monthly payment based on preliminary risk score (claims data and DCF data). An ICC is required to cmplete an initial face-to-face visit and complete a Health Journey and subsequent care plan within 45 days of the initial face-to-face in order to secure second monthly payment for SIL and SIL 3 members.

red text=requirement

Appendix C: Training Requirements

Required or Optional	Provider Can Attest to Providing Training?	Module Title	Training Topic	Additional Detail	TIME/Hrs	Who Completes Training?	Timing to Complete Training
Required	No	CT InCK: A Demonstration Project of CMS/CMMI	CT InCK 101	Model Overview	2.00	ALL (ICC, Sup, Mngr	Prior to Member Engagement
			Best Practices Framework - overview	Trauma-Informed Anti Racist Practices for Race & Health Equity	1.50	ALL (ICC, Sup, Mngr	Prior to Member Engagement
				ACEs - Adverse Childhood Experiences		ALL (ICC, Sup, Mngr	Prior to Member Engagement
				Care Coordination Models		ALL (ICC, Sup, Mngr	Prior to Member Engagement
				NCQA Standards for Person-Centered Medical Home Model		ALL (ICC, Sup, Mngr	Prior to Member Engagement
				Wraparound Philosophy and Practices - overview		ALL (ICC, Sup, Mngr	Prior to Member Engagement
		Population Health Components	Service Integration Components	Risk Stratification: Needs Assessment Tools and Processes	2.00	ICC & Supervisor	Prior to Member Engagement
				Service Integration Levels (SILs) - Integrated Care		ICC & Supervisor	Prior to Member Engagement
		Population Health Components	Intensive Care Coordination Model	Part 1: Member Engagement & Assessment/*HealthJourney*Portal	10.00	ICC & Supervisor	Prior to Member Engagement
				Part 2: Member Care Coordination/Care Home (ODH) Portal	10.00	ICC & Supervisor	Prior to Member Engagement
		Technology	Data/Documentation	Part 3: Wraparound Integrated Care Coordination Practice*	36.00	ICC	Prior to Member Engagement
				Part 4: Unite Us - Referrals	1.00	ICC & Supervisor	Prior to Member Engagement
			InCK Providers in HUSKY Health CT	CMAP: Part 1 - Application (3 hrs) Part 2 - Coding/Billing (3 hrs)	6.00	Manager/Supervisor	Within 60 Days of CMAP Enrollment
				APM Model	1.50	Manager/Supervisor	Within 60 Days of CMAP Enrollment
				Compliance - Privacy and Documentation	2.00	ALL (ICC, Sup, Mngr	Prior to Member Engagement
		Measuring Effectiveness	Provider Performance	Quality Assurance & Quality Improvement	2.50	Manager/Supervisor	Within 90 Days of CMAP Enrollment
				Provider Performance Measures	1.00	Manager/Admin	Within 90 Days of CMAP Enrollment
	Yes	Wraparound		*Wraparound 2 Day Overview	16.00	ICC	Prior to Member Engagement
				Crisis Planning (Intake & Care Plan)	8.00	ICC	Prior to Member Engagement
				Needs and Benchmarks (Care Plan/Team)	4.00	ICC	Prior to Member Engagement
				Transition Planning	4.00	ICC	Prior to Member Engagement
				Team Meeting Facilitation	4.00	ICC	Prior to Member Engagement
		Additional Trainings		Wraparound 2 Hour Overview	2.00	Supervisor	Prior to Member Engagement
				ICC Supervisor CT InCK Overview (optional)	7.00	Supervisor	Prior to Member Engagement
				Trauma-Informed Care/Practices	8.00	ICC & Supervisor	Within 1 year of CMAP Enrollment
				Anti-Racism (DEI-B)	8.00	ICC & Supervisor	Within 1 year of CMAP Enrollment
				PCMH/PCMH+ Care Coordination (CYSHCN)	4.00	ICC & Supervisor	Within 1 year of CMAP Enrollment
				ACEs and/or N.E.A.R. Science	2.50	ICC & Supervisor	Within 1 year of CMAP Enrollment
				Motivational Interviewing	16.00	ICC & Supervisor	Within 1 year of CMAP Enrollment
				Mental Health 1st Aid (Adults/Youth)	8.00	ICC & Supervisor	Within 1 year of CMAP Enrollment
				Mandatory Reporter Training	2.00	ICC & Supervisor	Prior to Member Engagement
				Elder Abuse & Mandatory Reporting	2.00	ICC & Supervisor	Prior to Member Engagement
Optional	N/A	Additional Trainings		Strengths-Based Approach (Asset Development)	4.00	ICC & Supervisor	Within 1 year of CMAP Enrollment
				Strengths Based Documentation - WrapCT	3.00	ICC & Supervisor	Within 1 year of CMAP Enrollment
				Engaging Families - WrapCT	3.00	ICC & Supervisor	Within 1 year of CMAP Enrollment
				Conflict Resolution -WrapCT	3.00	ICC & Supervisor	Within 1 year of CMAP Enrollment
				Health Equity	3.00	ALL (ICC, Sup, Mngr	Within 2 years of CMAP enrollment
				Psychological 1st Aid	4.00	ICC & Supervisor	Within 2 years of CMAP enrollment
				Community Resliency	3.00	ALL (ICC, Sup, Mngr	Within 2 years of CMAP enrollment
				Community Organizing (Health-Related)	8.00	ALL (ICC, Sup, Mngr	Within 2 years of CMAP enrollment