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DESCRIPTION OF LIMITATIONS

1. Eff. 4-1-93 — Inpatient Hospital Services. Prior authorization is required for services provided outside the state by non-border status providers in non-emergency circumstances, for transplant services and for ventilator dependent services. Other professional services that require prior authorization outside the hospital, often require prior authorization when provided in a hospital.

Other limitations include, but are not limited to: circumstances for private room accommodations; restrictions on non-therapeutic sterilizations; requirements for separate billing of independent professional services; and restrictions to avoid duplicative and unnecessary payments.

2.a. Outpatient Hospital Services. Prior authorization restrictions apply to these services as required by the area of service.

2.b. Rural Health Clinic Services. Services provided by rural health clinics are subject to the same prior authorization requirements and other limitations as applied to covered services in the Medical Assistance Program.

2.c. Eff. 10-1-91 — Federally Qualified Health Centers. Prior authorization and other limitations required for various medical disciplines as described in HSS 107, Wis. Admin. Code are applicable.

2.d. Eff. 10-1-91 — Health Center Ambulatory Services. Prior authorization and other limitations required for various medical disciplines as described in HSS 107, Wis. Admin. Code are applicable.

4.a. Nursing Facility Services. Prior authorization is required for rental or purchase of a specialized wheelchair. Levels of service required are stipulated by the recipient's plan of care, subject to guidelines described in HSS 107.09(3).

4.c. Family Planning Services. Sterilization procedures require prior authorization and informed consent as mandated under federal regulations.

4.b. EPSDT Other Services, continued.

4. School Based Services

School Based Services (SBS) are services that are listed in an eligible student's Individualized Education Program (IEP) that are coverable under one or more of the service categories described in Section 1905(a) of the Social Security Act, and that are necessary to correct or ameliorate defects or physical or mental illnesses or conditions discovered by an EPDST screen.

Service providers shall be licensed under the applicable State practice act or comparable licensing criteria by the State Department of Public Instruction, and shall meet applicable qualifications under 42 CFR Part 440. Identification of defects, illnesses or conditions and services necessary to correct or ameliorate them is done by practitioners qualified to make those determinations within their licensed scope of practice, either as a member of the IEP team or by a qualified practitioner outside the IEP team. Eligible individuals may obtain covered services from any person qualified to perform the services required, who undertakes to provide the services.

Covered services include physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR 440.110. Covered services also include nursing services coverable under 42 CFR §440.80, and 42 CFR §440.60 ordered by a licensed physician and performed by a registered nurse or licensed practical nurse, nursing services provided on a restorative basis under 42 CFR §440.130 (d), including services delegated in accordance with the Nurse Practice Act to individuals who have received appropriate training from a registered nurse; personal care services (as known as attendant care services) coverable and performed by individuals qualified under 42 CFR §440.167; psychological, counseling, and social work services performed by licensed practitioners within the scope of practice as defined under state law and coverable as medical or other remedial care under 42 CFR §440.60 or rehabilitative services under 42 CFR §440.130. Assessments are covered as necessary to assess or reassess the need for medical services in a child's treatment plan and must be performed by any of the above licensed practitioners within the scope of practice.

The state has established controls to prevent duplicate services and assure continuity of care when a child receives services from both SBS providers and Medicaid Health Maintenance Organizations (HMOs) or fee-for-service providers. HMOs are responsible for managing medical services for recipients receiving SBS when recipients are in HMOs. SBS and HMO providers are required to sign Memorandums of Understanding setting standards, policies and procedures to avoid duplication of services and coordinate care. Where a child served within the Medicaid fee-for-service system receives SBS, SBS providers are required to document the regular contracts between schools and community providers as appropriate for each child but at least annually. Medicaid monitors service coordination and ensures duplicate services are not provided through prior authorization.

Physical therapy can be provided by physical therapy assistants, aides, and interns under the direction of a qualified physical therapist. Occupational therapy can be provided by occupational therapy assistants, aides, and interns under the direction of a qualified occupational therapist. Speech language services for individuals with speech, hearing, and language disorders can be provided by a speech language pathology assistant and interns under the direction of a qualified speech language pathologist. Audiology can be provided by audiology assistants, interns, and interpreters under the direction of a qualified audiologist.

When services are provided under the direction of a licensed therapist, the licensed must:

- see the beneficiary at the beginning of and periodically during treatment;
- is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts under State law;
- has continued involvement in the care provided, and reviews the need for continued services throughout the treatment;
- assume professional responsibility for the services provided under his/her direction and monitors the need for continued services;
- spend as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- ensure that individuals working under his/her direction have contact information to permit them direct contact with the supervising therapist as necessary during the course of treatment; and
- maintain documentation supporting the supervision of services and ongoing involvement in the treatment.

5.a. Eff. 4-1-93 Physician's Services. The Department imposes some payment and benefit limitations on some specific physician services. Many of these limitations are based on quantity and frequency, diagnoses, provider specialty, or the place the service is provided. In addition, some procedures require prior authorization and/or a second surgical opinion. Examples of physician services in each of these areas are listed below:

Services with Quantity and Frequency Limitations - Services with quantity and frequency limitations include: evaluation and management visits in the office, outpatient clinic and inpatient hospital nursing home; routine foot care; specific injections; weight alteration programs; fetal monitoring; clozapine management, and multiple surgeries performed on the same day.

Services with Diagnosis Limitations - Services with diagnosis limitations include: certain injections, routine foot care and application of Unna boots.

Services with Provider Specialty Limitations - Provider specialty limitations are imposed on physicians providing obstetric and pediatric services, and those performing evoked potentials testing.

Services with Place of Service Limitations - Place of service limitations are imposed on medication management in the home and on critical or prolonged care provided in the emergency department.

Services that Require Prior Authorization - To insure that a procedure is medically necessary, to demonstrate that the procedure is not primarily cosmetic or for the convenience of the recipient, to assure that the procedure is not experimental in nature, and to allow the Department to determine the treatment is the most cost-effective available, the provider must obtain prior authorization for the following categories of procedures:

1) Surgical or other medical procedures of questionable medical necessity but deemed by the Department to be essential to correct conditions that cause significant impairment to the recipient's interpersonal adjustments or employability;

2) Surgical procedures or medical procedures that the Department deems redundant, outdated or marginally effective;

3) Transplants;

4) Sterilizations (to conform with federal and state regulations and limitations);

5) Temporomandibular surgery.

Second Surgical Opinion - Elective surgeries that require the recipient obtain a second surgical opinion include but are not limited to: cataract extraction; cholecystectomy; hemorrhoidectomy; diagnostic D & C procedures; inguinal hernia repair; hysterectomy; joint replacement, hip or knee; tonsillectomy/adenoidectomy; varicose vein surgery.

5.b. Eff. 10-1-91 Dental Services. The same prior authorization and other limitations required under item #10 and 12.b. apply.

6.a. Eff. 7-1-90 Podiatry Services. Prior authorization is required for electric bone stimulation. Maintenance care is limited to once per 61 day period under certain conditions. For other service limitations, see s. HSS 107.14(3), Wis. Admin. Code. All orthopedic and orthotic services, including repairs, orthopedic and corrective shoes and supportive devices, services correcting "flat feet," and treatment of subluxation of the foot are not covered.

6.b. Eff. 1-1-93 Vision Care Services. (Optometry) Prior authorization is required for certain types of lenses and frames, antiseikonic services, prosis crutch services, low vision services, certain ophthalmological services and vision training. Frames, lenses and replacement parts must be obtained through the volume purchase plan provider, unless prior authorized. Anti-glare coating, spare eyeglasses and sunglasses, and services provided primarily for convenience or cosmetic reasons are not covered.

6.c.
Eff.
3-1-86

Chiropractic. Prior authorization is required for services beyond the initial visit and 20 spinal manipulations per spell of illness. Consultations are not covered.

6.d
Eff.
4-1-93

Other Practitioners

Services of licensed pharmacists, pharmacy interns and pharmacy technicians acting within the scope of their practice under state law to administer COVID-19 vaccines. Pharmacy interns or pharmacy technicians are working under the supervision of a licensed pharmacist.

Pharmacies are qualified providers of COVID-19 vaccinations per the HHS COVID-19 PREP Act Declaration and authorizations.

Other Nurse Practitioners and Clinical Nurse Specialist Services.

Included are other primary care nurse practitioner and clinical nurse specialist services not covered under item #23. Services are subject to limitations imposed on specific disciplines within the scope of practice of the nurse. These services include medical services delegated by a licensed physician through protocols, pursuant to the requirements set forth in the Wisconsin Nursing Act and the guidelines set forth by the medical examining board and the board of nursing. Other practitioner services are subject to the same limitations imposed on physician services under item #5 to enable the Department to monitor and regulate the following: medical necessity, cost, frequency and place of service.

Medication management includes in-home administration of medications other than those given intravenously, prefilling syringes for self injection when the recipient is not capable, setting up medications for self-administration, and programming dispensers. Instructing the recipient may be covered when provided in conjunction with these activities but not covered if it is the only activity.

Pharmacists.

Licensed pharmacists may administer vaccines, including the H1N1 and COVID-19 vaccines, as authorized and permitted by the State of Wisconsin Pharmacy Examining Board, within their scope of practice and to the extent permitted by Wisconsin law.

Allow licensed and enrolled pharmacists to furnish services within their professional scope of practice and in accordance with state law.

Eff. 7-1-95

Clozapine Management. Clozapine Management is a covered service when all of the following conditions are met:

- a physician has prescribed clozapine,
- the recipient is currently taking clozapine or has taken it within four weeks,
- the dispensing pharmacy has received prior authorization for clozapine,
- the provider of clozapine management has received prior authorization for that service.

Providers of clozapine management work under the general supervision of a physician or a pharmacist and include Medicaid-certified, licensed pharmacies and Community Support Programs (CSP). Qualified pharmacy staff include pharmacists, nurses, pharmacy technicians and others with equivalent training, knowledge and experience. Qualified CSP professional staff are designated in the approved CSP treatment plan component regarding clozapine management services.

Components of clozapine management include the following services as appropriate:

a. Ensuring the recipient has the required weekly white blood count testing. The provider may draw the blood or transport the recipient to a clinic, hospital, or laboratory to have the blood drawn, if necessary. To perform this service, the provider may travel, if necessary, to the recipient's residence or other places in the community where the recipient is available.

b. Ensuring the blood test results are reported in a timely fashion to the pharmacy dispensing the recipient's clozapine.

c. Ensuring abnormal blood test results are reported to the physician who prescribed the recipient's clozapine.

d. Ensuring the recipient receives medications as scheduled, ensuring the recipient stops taking medication when the blood test is abnormal, if so ordered by the physician, and receives any physician-prescribed follow-up care to ensure that the recipient's physical and mental well-being are maintained.

e. Making arrangements for the transition and coordination of the use of clozapine and clozapine management services between different care locations.

f. Maintaining appropriate records.

State: Wisconsin

6.d. Other practitioners, continued

Medication Therapy Management Services Performed by a Pharmacist

The Medication Therapy Management (MTM) benefit consists of services that are provided by qualified, licensed pharmacists to members in order to optimize the therapeutic outcomes of a recipient's medications and reduce costs. These services are delivered in a face-to-face setting. This benefit is voluntary and is available for members in Wisconsin Medicaid, BadgerCare Plus, and SeniorCare programs.

Wisconsin will reimburse enrolled pharmacies for Comprehensive Medication Review and Assessment (CMR/A) – These are comprehensive interventions between providers and members. They involve an in-depth, interactive review of the member's medication regimen, health history and lifestyle.

1. A member may be eligible for this service if the member meets at least one of the following criteria:
    - Is taking four or more medications used to treat or prevent two or more chronic conditions.
    - Has diabetes.
    - Has recently been discharged from the hospital or a long term care setting.
    - Has experienced health literacy issues.
    - Was referred by a prescriber due to issues that are impacting the member's health.
    - Meets other criteria as defined by the Department.
2. The provider must be certified by a Department-approved certification program before providing a CMR/A.
3. Providers must have a private or semi-private area in which to conduct the CMR/A.
4. One initial Comprehensive Medication Review and Assessment (CMR/A) and three follow-up assessments are reimbursable per member, per rolling year.

Providers may receive Department approval to exceed annual limits for the CMR/As for children who are EPSDT-eligible and for members who demonstrate medical need.

State: Wisconsin

6.d. Other Practitioners, continued.

A. Behavioral Treatment Services provided by licensed practitioners.

Licensed practitioners furnish treatment services for autism spectrum disorder (ASD) and other related conditions that cause persistent, clinically significant impairment in social communication, behavioral interaction, and/or other areas of functional development that manifest as atypical behavior patterns that interfere with the member's safety and effective functioning in the home and community. Treatment is directly furnished by a licensed practitioner within their scope of practice under state law or by a non-licensed practitioner under the supervision of a licensed practitioner within their scope of practice as allowed under state law. Services are authorized in the home, community, or provider's office.

B. Components of Behavioral Treatment provided by licensed practitioners

1. Assessment

Assessment services are covered for the purposes of treatment planning for an individual diagnosed with a condition for which behavioral treatment services have been proven effective. Both initial and follow-up assessments are covered.

Initial assessments must be performed by a licensed professional within their scope of practice. Allowable providers are the behavioral treatment licensed supervisor and the focused treatment licensed supervisor, both of which are described in "Section D – Provider Qualifications."

Follow-up assessments may be performed by a licensed professional or by a treatment therapist under the direction of a licensed professional. Allowable providers are the behavioral treatment licensed supervisor, the focused treatment licensed supervisor, the behavioral treatment therapist, and the focused treatment therapist, all of which are described in "Section D – Provider Qualifications."

State: Wisconsin

6.d. Other Practitioners, continued.

B. Components of Behavioral Treatment provided by licensed practitioners, continued.

2. Comprehensive Treatment (EPSDT only)

Comprehensive treatment targets acquisition of a broad base of skills with an emphasis on the primary deficits of autism spectrum disorder or other related conditions (communicative, social, emotional, and adaptive functioning). It entails a high degree of intensity. In addition, caregiver training is an essential feature of this approach.

ForwardHealth reimburses the following services:

a. Comprehensive adaptive behavior treatment by protocol
b. Comprehensive adaptive behavior treatment with protocol modification
c. Comprehensive treatment family adaptive behavior treatment guidance
d. Group adaptive behavior treatment by protocol
e. Group adaptive behavior treatment with protocol modification

Comprehensive treatment may be performed by a licensed professionals or by treatment therapists or treatment technicians under the direction of a licensed professional. Allowable providers are the behavioral treatment supervisor, the behavioral treatment therapist, and the behavioral treatment technician. Allowable providers are described in greater detail in "Sectional D – Provider Qualification."

3. Focused Treatment

The goals of focused treatment are the reduction of specific challenging behaviors, with development of replacement behaviors, as well as discrete skill acquisition. ForwardHealth reimburses the following services:

a. Focused adaptive behavior treatment by protocol
b. Focused adaptive behavior treatment with protocol modification
c. Focused treatment family adaptive behavior treatment guidance
d. Group adaptive behavior treatment by protocol
e. Group adaptive behavior treatment with protocol modification

Focused treatment may be performed by licensed professionals or by treatment therapists or treatment technicians under the direction of a licensed professional. Allowable providers are the focused treatment licensed supervisor, the behavioral treatment licensed supervisor, the behavioral treatment therapist, the focused treatment therapist, and the behavioral treatment technician. Allowable providers are described in greater detail in "Section D – Provider Qualifications.:

State: Wisconsin

6.d. Other Practitioners, continued

C. Additional Benefit Information

1. Prior Authorization

All behavioral treatment comprehensive treatment or focused treatment services provided directly by or under the supervision of a licensed practitioner must be authorized by the Department in advance of their provision to the member.

Behavioral identification assessment and follow-up assessment services require prior authorization by the Department only in certain circumstances, as outlined in the ForwardHealth provider policy manual.

2. Limits

Focused or comprehensive treatment services must be medically necessary for the member as determined by ForwardHealth through the prior authorization process.

D. **Provider Qualifications and Training**

Wisconsin requires all providers who provide behavioral treatment services to Medicaid members to enroll as a behavioral treatment provider. Only licensed practitioners may enroll as a billing provider for behavioral treatment services. Providers should enroll in the specialty listed below that best matches level of training and experience.

1. Behavioral Treatment Licensed Supervisor – billing and rendering provider.
2. Behavioral Treatment Therapist – rendering provider only.
3. Behavioral Treatment Technician – rendering provider only.
4. Focused Treatment Licensed Supervisor – billing and rendering provider.
5. Focused Treatment Therapist – rendering provider only.

State: Wisconsin

7. Home Health Care Services. Covered services include: skilled nursing services, home health aide services, medical supplies, equipment and appliances, and therapy and speech pathology services which the agency is certified to provide. Home health services may take place in any setting in which normal life activities take place.

Similar to Medicare, a visit may be of any duration, with prior authorization required after 30 visits of any combination of RN, LPN, home health aide or therapy services, including medication management. Skilled nursing and therapy services are available for recipients who require less than eight hours of a day with home health aide services provided up to 24 hours a day as the recipient's condition requires. Various limitations apply based on appropriate nursing practices, state licensure, and Medicare/Medicaid certification requirements.

Medication management includes administration of medications other than those given intravenously, prefilling syringes for self-injection when the recipient is not capable, setting up medications for self-administration, and programming dispensers. Instructing the recipient may be covered when provided in conjunction with these activities but not covered if it is the only activity.

State: Wisconsin

6.d. Other Practitioners. continued

Certified Professional Midwife services.

Certified professional midwife services are a covered service when provided by a qualified provider acting within their scope of practice in accordance with state law to engage in the practice of midwifery. "Practice of midwifery" means providing maternity care during the antepartum, intrapartum and postpartum periods.

Effective 3-1-96

Other Practitioners, continued

Treat-in-Place/No Transport services provided by licensed EMS personnel including Emergency Medical Responders (EMRs), Emergency Medical Technicians (EMTs), and Paramedics.

Effective 01-01-2023

Medical Supplies and Equipment.

The Department requires prior authorization or imposes payment and benefit limitations for the repair, modification, rental, or purchase of most medical supplies and equipment to enable the Department to monitor and regulate the following: cost, frequency, place where the recipient receives the service, and recipient's medical diagnosis or fundamental conditions under which the items will be reimbursed. These medical supplies and equipment include, but are not limited to: durable medical equipment, disposable supplies, hearing aid and related materials, and orthoses.

i. Disposable Medical Supplies are health care related items with limited life expectancy that are consumable or disposable, or cannot withstand repeated use by more than one individual, and are required to address an individual medical disability, illness or injury.
ii. Equipment and appliances are items that are primarily and customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable. State Medicaid coverage of equipment and appliances is not restricted to the items covered as durable medical equipment in the Medicare program.

The following are not covered:
Items that are not primarily medical in nature, are not proven to be therapeutically effective, or do not contribute to the improvement of a recipient's medical or functional condition; and items or features that are primarily for a recipient's comfort and convenience.

Effective 1-1-92

State: Wisconsin

7.d. Physical, Occupational and Speech Therapy and Audiology Provided by a Medical Rehabilitation Facility.

The prior authorization requirements and other limitations are described below in item #11.

Effective 3-1-86

8. Private Duty Nursing.

Prior authorization is required for all private duty nursing services. These services may be provided only if the recipient requires 8 or more hours of skilled nursing services a day.

Effective 1-1-92

9. Clinic Services.

All prior authorization requirements for services apply as appropriate. Second surgical opinions also apply (see #5 above).

Effective 3-1-86

9. Dental Services.

Dental services are limited to the basic services within each of the following categories: diagnostic services, preventative services, restorative services, endodontic services, periodontic services, fixed and removable prosthodontic services, oral and maxillofacial surgery services, and emergency treatment of dental pain. The following are examples of services not covered:

Effective 3-1-96

10. Dental Services. (Continued)

Eff. 10-1-95 dental implants and transplants; services for cosmetic purposes; overlay and duplicate dentures; precious metal crowns; professional visits; drug dispensing; adjunctive periodontal services; alveoplasty and stomoplasty; and non-surgical temporomandibular joint therapy. Several services are provided only in specified circumstances or as referred through a HealthCheck (EPSDT) screen. For other limitations and a listing of those services requiring prior authorization, see the WMAP Dental Provider Handbook, Part B.

11. Physical Therapy and Related Services. Prior authorization is required for physical and occupational therapies, and speech language pathology after 35 treatment days per spell of illness. A spell of illness means a condition characterized by a demonstrated loss of functional ability to perform daily living skills, caused by a new disease, injury or medical condition or by an increase in the severity of a pre-existing medical condition. Servces for recipients who are hospital inpatients or receiving therapy through a home health agency are not subject to this requirement. For audiology, prior authorization is required for speech and aural rehabilitation.

Eff. 3-1-06

Physical therapists provide physical therapy services, occupational therapists provide occupational therapy services, and speech-language pathologists provide speech, hearing and language services. Physical therapists are certified under s. DHS 105.27 and meet the requirements of 42 CFR 440.110 (a). Occupational therapists are certified under s. DHS 105.28 and meet the requirements of 42 CFR 440.110 (b). Speech language pathologists are certified under s. DHS 105.30 and meet the requirements of 42 CFR 440.110 (c). Those who provide services under the direction of the listed therapists are physical therapist assistants, who are certified providers under ch. DHS 105.27, and occupational therapy assistants, who are certified providers under s. DHS 105.28.

12. Prescribed Drugs.

1. Drugs and drug products covered by MA include legend and non-legend drugs and supplies listed in the Wisconsin Medicaid drug index, which are prescribed by a licensed provider acting within the scope of the provider's practice or when a physician delegates prescribing authority to a licensed pharmacist through a collaborative practice agreement in accordance with state law.

2. Drugs excluded from coverage include drugs determined to be "less than effective by the FDA, drugs not covered by a federal rebate agreement, experimental drugs or other drugs that have no medically accepted indications, and other items as enumerated in Wisconsin Administrative Code, such as personal hygiene items, cosmetic items, and common medicine chest items.

3. To be a covered service, an over-the-counter drug shall have a signed federal rebate agreement and be listed in the Wisconsin Medicaid drug index. General categories of OTC drugs that are covered include the following: antacids, analgesics, insulins, contraceptives, cough preparations, ophthalmic lubricants, iron supplements for pregnant women, and other, medically necessary, cost-effective drug products, including some non-legend products that previously had legend drug status.

4. Prescribed drugs that are not covered outpatient drugs (including drugs authorized for import by the Food and Drug Administration during drug shortages) are eligible for FFP when determined to be medically necessary.

12.a. Prescribed drugs, continued.

Prior Authorization

1. Prescription drugs may be subject to prior authorization by DHFS to ensure that drugs are prescribed and dispensed appropriately.

2. DHFS determines which prescription drugs may require prior authorization by reviewing the drug(s) for the following: safety; potential for abuse or misuse; narrow therapeutic index; and high cost when less expensive therapeutically equivalent alternatives are available.

3. DHFS will convene a Prescription Drug Prior Authorization Committee comprised of at least two physicians, two pharmacists, and one advocate for Medicaid recipients to review the pertinent scientific literature and make prior authorization recommendations to the Department.

4. As enumerated in Wisconsin Administrative Code, all Schedule III and IV stimulant drugs as listed in the Wisconsin Medicaid Drug Index; enteral and parenteral nutrition products; fertility drugs used for treatment of a condition not related to fertility; impotence drugs used for treatment of a condition not related to impotence; drugs that have been demonstrated to entail substantial cost or utilization problems for the MA program; and drugs produced by a manufacturer that has not signed a federal rebate agreement but which are medically appropriate and cost effective treatment for a recipient's condition as certified by the prescribing provider are subject to prior authorization.

5. To provide economies and efficiencies in the Medicaid program, the state applies the same prior authorization requirements and supplemental rebate provisions utilized in the Medicaid program to its state-sponsored portion of SeniorCare.

State Wisconsin

12.a. Prescribed drugs, continued.

6. Prior authorization programs for covered outpatient drugs provide for a response within 24 hours of a request for prior authorization and for the dispensing of a 72-hour supply of medications in emergency situations.

7. A drug use review program, including prospective and retrospective drug utilization review, has been implemented, in compliance with federal law.

8. Claims management is electronic, in compliance with federal law.

9. The state is in compliance with section 1927 of the Social Security Act. The state will cover drugs of manufacturers participating in the federal rebate program. The state is in compliance with reporting requirements for utilization and restrictions to coverage. Pharmaceutical manufacturers may audit utilization data. The unit rebate amount is confidential and may not be disclosed for purposes other than rebate invoicing and verification.

10. The state will participate in a multi-state pooling program that will negotiate supplemental rebates in addition to federal rebates provided for in Title XIX. This multi-state pooling program is known as the Optimal PDL $olution (TOP$). TOP$ rebate agreements will be separate from the federal rebates. TOP$ supplemental rebates received by the state in excess of those required under the federal drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the federal rebate agreement.

11. A TOP$ rebate agreement for drugs provided to the Medicaid program, effective 10/01/2013, has been authorized by CMS.

12. Pursuant to 42 USC 1396r-8, the state is establishing a preferred drug list with prior authorization requirements for drugs not included on the preferred drug list.

13. Effective July 1, 2024, CMS has authorized the State of Wisconsin to enter into value/outcomes-based contracts with manufacturers on a voluntary basis. The conditions of the value/outcomes-based contract would be agreed upon by both the state and manufacturer. These contracts will be executed on the model agreement entitled “Value-Based Supplemental Rebate Agreement” submitted to CMS and authorized for use beginning 7/1/2024.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Agency _Wisconsin__

MEDICAID PROGRAM: REQUIREMENTS RELATING TO
COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D.

The following excluded drugs are covered:

☑ (a) agents when used for weight loss
Drugs covered by the program are outlined on the Wisconsin Medicaid Drug Search Tool found on the state's website.

☐ (b) agents when used to promote fertility (see specific drug categories below)

☑ (c) agents when used for the symptomatic relief cough and colds

☑ (d) prescription vitamins and mineral products, except prenatal vitamins and fluoride

☑ (e) nonprescription drugs

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency Wisconsin

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

☐ (f) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)

12.b. Dentures. Prior authorization is required.

12.c. Prosthetic devices. Prior authorization is required for most prostheses, hearing aids, and other medical equipment in the Wisconsin Durable Medical Equipment and Supplies indices, except for certain opthalmological prostheses. Prior authorization also is required for most items not in the indices.

12.d. Eyeglasses. When frames and lenses services are provided by the same provider, prior authorization is required to exceed the following limitations in a 12 month period: one original pair; one unchanged prescription replacement pair; and one replacement pair with a documented changed prescription meeting Department criteria. Tinted lenses, occupational frames, certain glass and lens types, and frames and other vision materials not obtained through the volume purchase plan also require prior authorization. Anti-glare coating, spare eyeglasses and sunglasses, and services provided primarily for convenience or cosmetic reasons are not covered.

State: Wisconsin

13.d. Rehabilitative Services

Psychosocial Rehabilitation Services:

The rehabilitative service (or services) described below is a:

☒ Program (encompasses several rehabilitative services)

Identify and describe the program and each service component of the program.

☒ Psychosocial Rehabilitation Services Program

Description: Psychosocial rehabilitation services are provided to members to better manage the symptoms of their behavioral health issues, to increase their independence, to achieve effective levels of functioning in the community and at home, and to reduce the incidence and duration of institutional care members might otherwise need. Psychosocial rehabilitation services are recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. Psychosocial rehabilitation services are provided in an individual, family, or group setting within the community, including a member's home.

Service Components:

- **Screening and Assessment**

Describe: Screening and assessment services include completion of initial screens and assessments, comprehensive assessments, and ongoing screens or assessments. These screens and assessments are used to determine member need for psychosocial rehabilitation services and assess treatment needs that will be addressed through the development of an appropriate treatment plan. Criteria for screens and assessments are appropriate to the member's age and presenting condition(s). The amount and duration of this service is determined on a case by case basis through the person-centered assessment and planning process.

Allowable Practitioners: Licensed Psychiatrists, Licensed physicians, Licensed physician assistants, Licensed psychologists, Licensed nurse practitioners, Licensed advanced practice nurse prescribers, Licensed practical nurses, Licensed registered nurses, Licensed independent clinical social workers, Licensed professional counselors, Licensed marriage and family therapists, Licensed occupational therapists, Certified social workers, Certified advance practice social workers, Certified independent social workers, Certified alcohol and drug abuse counselors, Certified occupational therapy assistants, Certified rehabilitation counselors, Master's level professional, Clinical Student/Resident, Bachelors level professional, Psychosocial rehabilitation technician

State: Wisconsin

13.d. Rehabilitative Services, continued.

Psychosocial Rehabilitation Services, continued:

- **Diagnostic Evaluations**

  Describe: Diagnostic evaluations are exams necessary to appropriately diagnose a member's mental health disorder, substance use disorder, or related health condition. Diagnostic evaluations do not include central nervous system assessments or evaluations for autism, developmental disabilities, or learning disabilities. The amount and duration of this service is determined on a case by case basis through the person-centered assessment and planning process.

  Allowable Practitioners: Licensed Psychiatrists, Licensed physicians, Licensed physician assistants, Licensed psychologists, Licensed nurse practitioners, Licensed advanced practice nurse prescribers, Licensed registered nurses, Licensed independent clinical social workers, Licensed professional counselors, Licensed marriage and family therapists, Licensed occupational therapists, Certified social workers, Certified advance practice social workers, Certified independent social workers, Master's level professional, Clinical Student/Resident

- **Service Planning**

  Describe: Service planning includes development and update of a written plan detailing psychosocial rehabilitation services that will be provided or arranged for the member. Service planning is a person-centered planning process conducted as a collaboration between the healthcare practitioner and the member. Service planning actively engages and empowers the member, ensuring that the plan reflects the member's needs and preferences. Service planning is culturally and age appropriate. The amount and duration of this service is determined on a case by case basis through the person-centered assessment and planning process. The service plan must be updated at least every six months.

  Allowable Practitioners: Licensed Psychiatrists, Licensed physicians, Licensed physician assistants, Licensed psychologists, Licensed nurse practitioners, Licensed advanced practice nurse prescribers, Licensed practical nurses, Licensed registered nurses, Licensed independent clinical social workers, Licensed professional counselors, Licensed marriage and family therapists, Licensed occupational therapists, Certified social workers, Certified advance practice social workers, Certified independent social workers, Certified alcohol and drug abuse counselors, Certified occupational therapy assistants, Certified rehabilitation counselors, Master's level professional, Clinical Student/Resident, Bachelors level professional, Psychosocial rehabilitation technician

- **Service Facilitation**

  Describe: Service facilitation includes coordination and monitoring activities to ensure the member receives those services identified in the service plan and has access to other necessary services. Service facilitation is culturally and age appropriate. The amount and duration of this service is determined on a case by case basis through the person-centered assessment and planning process.

State: Wisconsin

13.d. Rehabilitative Services, continued.

Psychosocial Rehabilitation Services, continued:

Allowable Practitioners: Licensed Psychiatrists, Licensed physicians, Licensed physician assistants, Licensed psychologists, Licensed nurse practitioners, Licensed advanced practice nurse prescribers, Licensed practical nurses, Licensed registered nurses, Licensed independent clinical social workers, Licensed professional counselors, Licensed marriage and family therapists, Licensed occupational therapists, Certified social workers, Certified advance practice social workers, Certified independent social workers, Certified alcohol and drug abuse counselors, Certified occupational therapy assistants, Certified rehabilitation counselors, Master's level professional, Clinical Student/Resident, Bachelors level professional, Psychosocial rehabilitation technician

- **Medication Management**

Describe: Medication management includes identification of target symptoms, prescription of medication to alleviate identified symptoms, administration of medication, medication checks and evaluations of the medication regimen, monitoring symptoms, supporting the member and the member's family in establishing a medication regime, and educating the member and the member's family regarding their medications. Medication management includes services related to both medical and psychotropic medications. The amount and duration of this service is determined on a case by case basis through the person-centered assessment and planning process.

Allowable Practitioners: Licensed Psychiatrists, Licensed physicians, Licensed physician assistants, Licensed psychologists, Licensed nurse practitioners, Licensed advanced practice nurse prescribers, Licensed practical nurses, Licensed registered nurses, Licensed independent clinical social workers, Licensed professional counselors, Licensed marriage and family therapists, Licensed occupational therapists, Certified social workers, Certified advance practice social workers, Certified independent social workers, Certified alcohol and drug abuse counselors, Certified occupational therapy assistants, Certified rehabilitation counselors, Master's level professional, Clinical Student/Resident, Bachelors level professional, Psychosocial rehabilitation technician

- **Physical Health Monitoring**

Describe: Physical health monitoring includes evaluations of the impact a member's mental health or substance abuse issues have on his or her physical health; identification of medical conditions present; training the member and the member's family to identify, monitor, and manage physical health conditions in collaboration with primary care providers; and supporting access to treatment for medical conditions. The amount and duration of this service is determined on a case by case basis through the person-centered assessment and planning process.

State: Wisconsin

13.d. Rehabilitative Services, continued.

Psychosocial Rehabilitation Services, continued:

Allowable Practitioners: Licensed Psychiatrists, Licensed physicians, Licensed physician assistants, Licensed psychologists, Licensed nurse practitioners, Licensed advanced practice nurse prescribers, Licensed practical nurses, Licensed registered nurses, Licensed independent clinical social workers, Licensed professional counselors, Licensed marriage and family therapists, Licensed occupational therapists, Certified social workers, Certified advance practice social workers, Certified independent social workers, Certified alcohol and drug abuse counselors, Certified occupational therapy assistants, Certified rehabilitation counselors, Master's level professional, Clinical Student/Resident, Bachelors level professional, Psychosocial rehabilitation technician

- **Peer Support**

Describe: Peer support services link members with peer specialists who serve as advocates, mentors, facilitators, and role models. Peer support services build formal and informal supports to instill confidence, provide assistance in developing goals, and rebuild the abilities of members to meet their chosen goals. Peer specialists demonstrate techniques in recovery and provide ongoing recovery and resiliency support. Peer specialists attend treatment team and crisis plan development meetings, promote members' use of self-directed recovery tools, and inform members about community and natural supports and how to utilize these in the recovery process. Peer specialists deliver peer support services under the direction of a qualified health care practitioner. The peer support services are identified in a person-centered assessment and are specified in the member's service plan. The amount and duration of this service is determined on a case by case basis through the person-centered assessment and planning process.

Allowable Practitioners: Certified Peer Specialists

- **Community Living Functional Restoration**

Describe: Community Living Functional Restoration addresses specific functional needs that result from the member's mental health or substance abuse disorder and impede the member's ability to live independently in the community. Functional needs are identified in a person-centered assessment and services to address them are specified in the member's service plan. Service providers do not complete tasks necessary for successful community living for the member; rather, service providers assist the member in becoming more independent in accomplishing these tasks. Services are provided using motivational, psychoeducational, and cognitive-behavioral strategies to address mental health and/or substance use disorders.

Eff. 10-1-96

13.d Mental Health Crisis Intervention Services

Mental Health Crisis Intervention (MHCI) services are a coordinated system of mental health services that provides an immediate response to assist a person experiencing a mental health crisis. "Crisis" means a situation caused by an individual's apparent mental disorder:

- that results in a high level of stress or anxiety for the individual, for the persons providing care for the individual or for the public, and
- that cannot be resolved by the available coping methods of the individual or by the efforts of those providing ordinary care or support for the individual.

An initial assessment and referral to services, if appropriate, either over the telephone or face-to-face is available to any recipient contacting a MHCI provider. Additional crisis linkage, follow-up and stabilization services are available only to recipients determined to be in crisis. Services are described in a response plan or a crisis plan for individuals known to require periodic crisis intervention, and are approved by a psychiatrist or a licensed psychologist. Interventions are designed to relieve the recipient's immediate distress, reduce the risk of escalation, reduce the risk of physical harm to the recipient or others, resolve the crisis and improve individual and family coping skills, coordinate the involvement of other resources needed to respond to the crisis and assist the recipient to make the transition to the least restrictive level of care required. Services may be provided in the office setting, over the telephone, in the home or in the community. Services to individuals residing in a hospital or nursing facility are limited to development of the response plan or crisis plan and those services required to assist the recipient to transition to the least restrictive level of care required, but may not duplicate the hospital's or nursing facility's discharge planning activities. Services may be provided directly to the recipient or to others involved with the recipient when such intervention is required to address the recipient's crisis. Services for individuals receiving Medicaid Community Support Program (CSP) services are allowed when:

- The crisis intervention program has a formal arrangement with the CSP to provide crisis services to CSP enrollees.
- The crisis intervention services are delivered according to a crisis plan developed by the crisis intervention program *and* the CSP.
- The crisis intervention services do not duplicate CSP services.

Substitute page received 3-7-97

While MHCI services are available in each county, agencies providing Medicaid MHCI services must be certified by the Department's Division of Supportive Living certification standards which include staff qualifications, supervision requirements, service standards and requirements for a coordinated emergency mental health services plan. Services must be available 24 hours a day, 7 days a week.

Services billed and reimbursed as MHCI services may not also be billed and reimbursed as another MA service, such as hospital outpatient services, community support program services, day treatment services, outpatient psychotherapy services or case management services. Room and board costs are not covered under MHCI services. Services that are primarily social or recreational are not covered under MHCI services.

Substitute page received 3-7-97

13.d Rehabilitative Services, continued.

Enhanced Mobile Crisis Services

Enhanced mobile crisis services are specialized mental health crisis intervention services that provide rapid in-person community-based mobile crisis intervention by a team of at least two Medicaid providers trained in trauma-informed care practices, de-escalation strategies and harm reduction techniques. Enhanced mobile crisis services include individual assessment, de-escalation, and crisis resolution. Enhanced mobile crisis services may also include follow up interventions for a period up to 72 hours after the initial response, including additional mobile crisis intervention and referral to or arrangement for any additional behavioral health services which are necessary to reduce symptoms and connect the member to ongoing supports and services. All services are provided outside of a hospital, psychiatric residential treatment facility, or nursing facility. Enhanced mobile crisis services are available to members 24 hours a day, 7 days a week, every day of the year.

Services billed and reimbursed as enhanced mobile crisis services may not also be billed and reimbursed as another mental health crisis intervention service. Wisconsin will only claim increased FMAP for mobile crisis services that meet the requirements as described in section 1947(b) and 1947 (d)(2).

Allowable Practitioners

The enhanced mobile crisis team must include one behavioral health professional able to conduct an assessment within their scope of practice under state law. At least one practitioner must deliver services in-person. Additional practitioners can provide services in-person or via telehealth.

Practitioners eligible to provide enhanced mobile crisis services, include: Licensed psychiatrists, licensed physicians, licensed physician assistants, licensed psychologists, licensed nurse practitioners, licensed advanced practice nurse prescribers, licensed practical nurses, licensed registered nurses, licensed independent clinical social workers, licensed professional counselors, licensed marriage and family therapists, licensed occupational therapists, certified social workers, certified advance practice social workers, certified independent social workers, certified alcohol and drug abuse counselors, certified occupational therapy assistants, certified rehabilitation counselors, certified peer specialists, Master's level professionals, clinical student/resident, Bachelor's level professional, psychosocial rehabilitation technician / paraprofessionals, certified parent peer specialist, recovery coaches, other paraprofessionals, licensed emergency medical services professionals, certified emergency medical services professionals

- Licensed emergency medical services professionals shall be licensed in the state of Wisconsin and must complete all required training for mobile crisis intervention practitioners.
- Certified emergency medical services professionals shall be certified in the state of Wisconsin and must complete all required training for mobile crisis intervention practitioners.

For all other allowable behavioral health practitioners, refer to Attachment 3.1-A, section 13.d, page 8i thru 8x, for provider qualifications.

State: Wisconsin

13.d. Rehabilitative Services, continued.

Psychosocial Rehabilitation Services, continued:

Services provided to minors focus on restoring integration and interaction with the minor's family, school, community, and other social networks. Services include assisting the minor's family to actively restore the minor's ability to live in the community through the management of mental health or substance use disorders. Services that are designed to assist the family must be directly related to the assessed needs of the minor. The amount and duration of this service is determined on a case by case basis through the person-centered assessment and planning process.

Allowable Practitioners: Licensed Psychiatrists, Licensed physicians, Licensed physician assistants, Licensed psychologists, Licensed nurse practitioners, Licensed advanced practice nurse prescribers, Licensed practical nurses, Licensed registered nurses, Licensed independent clinical social workers, Licensed professional counselors, Licensed marriage and family therapists, Licensed occupational therapists, Certified social workers, Certified advance practice social workers, Certified independent social workers, Certified alcohol and drug abuse counselors, Certified occupational therapy assistants, Certified rehabilitation counselors, Master's level professional, Clinical Student/Resident, Bachelors level professional, Psychosocial rehabilitation technician

- **Recovery Management**

Describe: Recovery management services include psychoeducation, behavioral tailoring, development of a recovery action plan, and recovery and/or resilience training. Services focus on improving the member's engagement in treatment and management of their recovery progress. Services are provided using motivational, psychoeducational, and cognitive-behavioral strategies. Services can be provided with a mental health or substance abuse focus. The amount and duration of this service is determined on a case by case basis through the person-centered assessment and planning process.

Allowable Practitioners: Licensed Psychiatrists, Licensed physicians, Licensed physician assistants, Licensed psychologists, Licensed nurse practitioners, Licensed advanced practice nurse prescribers, Licensed practical nurses, Licensed registered nurses, Licensed independent clinical social workers, Licensed professional counselors, Licensed marriage and family therapists, Licensed occupational therapists, Certified social workers, Certified advance practice social workers, Certified independent social workers, Certified alcohol and drug abuse counselors, Certified occupational therapy assistants, Certified rehabilitation counselors, Master's level professional, Clinical Student/Resident, Bachelors level professional, Psychosocial rehabilitation technician

State: Wisconsin

13.d. Rehabilitative Services, continued.

Psychosocial Rehabilitation Services, continued:

- **Psychotherapy**

  Describe: Psychotherapy includes individual and family psychotherapy to treat an individual who is mentally ill or has medically significant emotional or social dysfunctions. The treatment is a planned and structured program based on information from a differential diagnostic examination and directed at the accomplishment of specified goals. The treatment goals may include removing, modifying, or retarding existing symptoms, mediating disturbed patterns of behavior, and promoting positive personal growth and development by enhancing the ability to adapt and cope with internal and external stresses. The amount and duration of this service is determined on a case by case basis through the person-centered assessment and planning process.

  Allowable Practitioners: Licensed Psychiatrists, Licensed physicians, Licensed psychologists, Licensed nurse practitioners, Licensed advanced practice nurse prescribers, Licensed independent clinical social workers, Licensed professional counselors, Licensed marriage and family therapists, Certified social workers, Certified advance practice social workers, Certified independent social workers, Clinical Student/Residents

- **Substance Abuse Counseling**

  Describe: Substance abuse counseling includes individual substance abuse counseling and intervention, family counseling, and group counseling. Services are provided to ameliorate negative symptoms from substance abuse and to restore effective function in persons with substance abuse dependency or addiction. The amount and duration of this service is determined on a case by case basis through the person-centered assessment and planning process.

  Allowable Practitioners: Licensed Psychiatrists, Licensed physicians, Licensed psychologists, Certified alcohol and drug abuse counselors, Clinical Student/Resident

- **Crisis Intervention**

  Describe: Crisis intervention includes intervention by psychosocial rehabilitation staff to assess and manage a member crisis and prevent hospitalization. The amount and duration of this service is determined on a case by case basis through the person-centered assessment and planning process.

  Allowable Practitioners: Licensed Psychiatrists, Licensed psychologists, Licensed registered nurses, Licensed independent clinical social workers, Certified social workers, Certified advance practice social workers, Certified independent social workers, Certified rehabilitation counselors, Bachelors level professional, Psychosocial rehabilitation technician

State: Wisconsin

13.d. Rehabilitative Services, continued.

Psychosocial Rehabilitation Services, continued:

Assurances

☒ The State assures that all rehabilitative services are provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual in accordance with section 1902(a)(10)(A)(i) of the Act.

☒ The State assures that rehabilitative services do not include and FFP is not available for any of the following in accordance with section 1905(a)(13) of the Act.

a. educational, vocational and job training services;
b. room and board;
c. habilitation services;
d. services to inmates in public institutions as defined in 42 CFR §435.1010;
e. services to individuals residing in institutions for mental diseases as described in 42 CFR§435.1010;
f. recreational and social activities; and
g. services that must be covered elsewhere in the state Medicaid plan.

Additional Benefit Information

☒ Benefits or Services are provided with limitations on amount, scope or duration or with authorization requirements.

Member Eligibility:

A member who is eligible for psychosocial rehabilitation services has a need for comprehensive behavioral health services beyond what is offered by outpatient behavioral health services. Eligible members are impaired in the basic areas of everyday functioning and may have varying degrees of need and acuity throughout their recovery. All members must be assessed by the psychosocial rehabilitation program to determine their needs.

Authorization:

The psychosocial rehabilitation program must develop a service plan for each member that is updated as needed and at least every six months. The member will only receive psychosocial rehabilitation services identified in their individualized service plan.

State: Wisconsin

13.d. Rehabilitative Services, continued.

Psychosocial Rehabilitation Services, continued:

Provider Qualifications

Psychosocial rehabilitation services are provided by a psychosocial rehabilitation program. A psychosocial rehabilitation program is an entity that employs licensed and non-licensed health professionals. Services are provided by or overseen by a licensed professional within the scope of his or her practice under state law. All psychosocial rehabilitation programs must be certified by Wisconsin's State Medicaid Agency and enrolled as a Medicaid provider in Wisconsin.

Individual practitioners are not eligible for direct reimbursement of psychosocial rehabilitation services. These practitioners must act as staff within a psychosocial rehabilitation program. Practitioners acting as staff for a psychosocial rehabilitation program include:

- Licensed psychiatrists – Psychiatrists shall be licensed in Wisconsin to practice medicine and surgery and shall have completed 3 years of residency training in psychiatry in a program approved by the American Medical Association or the Accreditation Council for Graduate Medical Education. The above licensure requires:
    i. Verified documentary evidence of graduation from a medical or osteopathic school approved by the Medical Examining Board. The board recognizes as approved those medical or osteopathic schools recognized and approved at the time of the applicant's graduation therefrom by the American osteopathic association, or the liaison committee on medical education, or successors. If an applicant is not a graduate of a medical school approved by the board, but is a graduate of a medical school recognized and listed as such by the world health organization of the united nations, such applicant shall submit verified documentary evidence of graduation from such school and also verified documentary evidence of having passed the examinations conducted by the educational council for foreign medical graduates or successors, and shall also present for the board's inspection the originals thereof, and if such medical school requires either social service or internship or both of its graduates, and if the applicant has not completed either such required social service or internship or both, such applicant shall also submit verified documentary evidence of having completed a 12 month supervised clinical training program under the direction of a medical school approved by the board.

13.d. Rehabilitative Services, continued.

Psychosocial Rehabilitation Services, continued:

Provider Qualifications, continued

ii. A verified certificate showing satisfactory completion by the applicant of 12 months' postgraduate training in a facility approved by the board. The board recognizes as approved those facilities and training programs recognized as approved at the time of the applicant's service therein by the council on medical education of the American medical association, or the American osteopathic association, or the liaison committee on graduate medical education, or the national joint committee on approval of pre-registration physician training programs of Canada, or successors. If an applicant is a graduate of a foreign medical school not approved by the board and if such applicant has not completed 12 months' postgraduate training in a facility approved by the board, but such applicant has had other professional experience which the applicant believes has given that applicant education and training substantially equivalent, such applicant may submit to the board documentary evidence thereof. The board will review such documentary evidence and may make such further inquiry including a personal interview of the applicant as the board deems necessary to determine that such substantial equivalence in fact exists. The burden of proof of such equivalence shall lie upon the applicant. If the board finds such equivalence, the board may accept this in lieu of requiring that applicant to have completed 12 months' postgraduate training in a program approved by the board.

iii. A verified statement that the applicant is familiar with the state health laws and the rules of the department of health services as related to communicable diseases.

- Licensed physicians – Physicians shall be licensed in Wisconsin to practice medicine and surgery and shall possess knowledge and experience related to mental disorders of adults or children, be certified in addiction medicine by the American Society of Addiction Medicine, be certified in addiction psychiatry by the American Board of Psychiatry and Neurology, or otherwise be knowledgeable in the practice of addiction medicine. The above licensure requires:

13.d. Rehabilitative Services, continued.

Psychosocial Rehabilitation Services, continued:

Provider Qualifications, continued

i. Verified documentary evidence of graduation from a medical or osteopathic school approved by the Medical Examining Board. The board recognizes as approved those medical or osteopathic schools recognized and approved at the time of the applicant's graduation therefrom by the American osteopathic association, or the liaison committee on medical education, or successors. If an applicant is not a graduate of a medical school approved by the board, but is a graduate of a medical school recognized and listed as such by the world health organization of the united nations, such applicant shall submit verified documentary evidence of graduation from such school and also verified documentary evidence of having passed the examinations conducted by the educational council for foreign medical graduates or successors, and shall also present for the board's inspection the originals thereof, and if such medical school requires either social service or internship or both of its graduates, and if the applicant has not completed either such required social service or internship or both, such applicant shall also submit verified documentary evidence of having completed a 12 month supervised clinical training program under the direction of a medical school approved by the board.

ii. A verified certificate showing satisfactory completion by the applicant of 12 months' postgraduate training in a facility approved by the board. The board recognizes as approved those facilities and training programs recognized as approved at the time of the applicant's service therein by the council on medical education of the American medical association, or the American osteopathic association, or the liaison committee on graduate medical education, or the national joint committee on approval of pre-registration physician training programs of Canada, or successors. If an applicant is a graduate of a foreign medical school not approved by the board and if such applicant has not completed 12 months' postgraduate training in a facility approved by the board, but such applicant has had other professional experience which the applicant believes has given that applicant education and training substantially equivalent, such applicant may submit to the board documentary evidence thereof. The board will review such documentary evidence and may make such further inquiry including a personal interview of the applicant as the board deems necessary to determine that such substantial equivalence in fact exists. The burden of proof of such equivalence shall lie upon the applicant. If the board finds such equivalence, the board may accept this in lieu of requiring that applicant to have completed 12 months' postgraduate training in a program approved by the board.

State: Wisconsin

13.d. Rehabilitative Services, continued.

Psychosocial Rehabilitation Services, continued:

Provider Qualifications, continued

iii. A verified statement that the applicant is familiar with the state health laws and the rules of the department of health services as related to communicable diseases.

- Licensed physician assistants – Physician assistants shall be licensed in Wisconsin. The above licensure requires:
  - i. Proof of successful completion of an educational program accredited and approved by the committee on allied health education and accreditation of the American Medical Association, the commission for accreditation of allied health education programs, or its successor agency.
  - ii. Proof of successful completion of the national certifying examination.
  - iii. Proof that the applicant is currently certified by the national commission on certification of physician assistants or its successor agency.

- Licensed psychologists – Psychologists shall be licensed in Wisconsin and be listed or have met the requirements for listing with the National Register of Health Service Providers in Psychology or have a minimum of one year of supervised post-doctoral clinical experience directly related to the assessment and treatment of individuals with mental disorders or substance-use disorders. The above licensure requires:
  - i. Official transcripts of graduate training, properly attested to by the degree granting institution and submitted by the institution directly to the Psychology Examining Board.
  - ii. Documentation of any additional relevant education and appropriate experience.
  - iii. The "Supervised Psychological Experience" form which has been filled out by a psychologist who has firsthand knowledge of the applicant's experience relating to psychology.
  - iv. The "Nature of Intended Practice of Psychology" form.
  - v. Evidence of successful completion of an examination on the practice of psychology approved by the board.
  - vi. Proof of successful completion of the written examination on the elements of practice essential to the public health, safety or welfare.
  - vii. For applicants with doctoral degrees in psychology from universities outside the United States and Canada, as required by the board, documentation of additional supervised experience in the United States and documentation of English proficiency.

State: Wisconsin

13.d. Rehabilitative Services, continued.

Psychosocial Rehabilitation Services, continued:

Provider Qualifications, continued

viii. Verification of the applicant's licensure in all states or countries in which the applicant has ever held a license.

ix. For applicants who have a pending criminal charge or have been convicted of a crime, all related information necessary for the board to determine whether the circumstances of the pending criminal charge or conviction are substantially related to the duties of the licensed activity.

x. For applicants licensed in another state, proof of completion of continuing education requirements.

- Licensed nurse practitioners – Nurse practitioners shall be licensed in Wisconsin as a registered nurse, certified in Wisconsin as a nurse practitioner, and possess 3,000 hours of supervised clinical experience. The above certification requires:
  - i. Proof of certification by a national certifying body as a nurse practitioner
  - ii. Successful completion of a master's degree in nursing or a related health field granted by a college or university accredited by a regional accrediting agency approved by the board of education in the state in which the college or university is located

- Licensed advanced practice nurse prescribers – Advance practice nurse prescribers shall be licensed in Wisconsin as a registered nurse and certified in Wisconsin as an advance practice nurse prescriber. The above certification requires:
  - i. Proof of certification by a national certifying body as a nurse practitioner, certified nurse-midwife, certified registered nurse anesthetist or clinical nurse specialist
  - ii. Successful completion of a master's degree in nursing or a related health field granted by a college or university accredited by a regional accrediting agency approved by the board of education in the state in which the college or university is located
  - iii. Documented evidence of at least 45 contact hours in clinical pharmacology/therapeutics within 3 years preceding the application for a certificate to issue prescription orders
  - iv. Successful completion of a jurisprudence examination for advanced practice nurse prescribers

State: Wisconsin

13.d. Rehabilitative Services, continued.

Psychosocial Rehabilitation Services, continued:

Provider Qualifications, continued

- Licensed practical nurses – Licensed practical nurses shall be licensed in the state of Wisconsin. The above licensure requires:
    i. Completion of two years of high school or its equivalent.
    ii. Age of 18 years or older.
    iii. Proof of either of the following:
        - Graduation from a school of practical nursing.
        - Evidence of general and professional educational qualifications comparable to those required in this state at the time of graduation.
    iv. Successful completion of the national council licensure examination (NCLEX)

- Licensed registered nurses – Licensed registered nurses shall be licensed in the state of Wisconsin. The above licensure requires:
    i. Proof of graduation from a high school or its equivalent.
    ii. Proof of either of the following:
        - Graduation from a school of practical nursing.
        - Evidence of general and professional educational qualifications comparable to those required in this state at the time of graduation.
    iii. Successful completion of the national council licensure examination (NCLEX)

- Licensed independent clinical social workers – Licensed independent clinical social workers shall be licensed in the state of Wisconsin and shall possess at least 3,000 hours of supervised clinical experience where the majority of clients are children or adults with mental disorders or substance use disorders. The above licensure requires:
    i. A certificate of professional education, signed and sealed by the chancellor, dean or registrar of the school from which the applicant has graduated with a master's or doctoral degree in social work with a concentration in clinical social work, including completion of supervised clinical field training. In lieu of supervised clinical field training, applicants may submit an affidavit indicating that they have completed 1,500 hours of supervised clinical social work experience in not less than one year within a primary clinical setting, which includes at least 500 hours of supervised face-to-face client contact.

13.d. Rehabilitative Services, continued.

Psychosocial Rehabilitation Services, continued:

Provider Qualifications, continued

ii. Verification that the school or program which awarded the social work degree was accredited by, or a pre-accreditation program, of the Council on Social Work Education (CSWE) at the time the applicant graduated from the program or school, or that a degree awarded by a foreign institution of higher learning has been determined by the CSWE to be equivalent to a program accredited by the CSWE. If the applicant's education was not received in English, the applicant must demonstrate proficiency in English by achieving a score of 550 (or 213 on the computer-based exam) or above on the Test of English as a Foreign Language (TOEFL) or an equivalent score on an equivalent examination.

iii. An affidavit that the applicant, after receiving a master's or doctoral degree and after receiving certification as an independent social worker, has completed at least 3,000 hours of clinical social work practice in no less than 2 years, including at least 1,000 hours of face-to-face client contact and including DSM diagnosis and treatment of individuals, under the supervision of a supervisor approved by the social worker section.

- An applicant who after receiving a master's or doctoral degree in social work and completing any portion of the applicant's 3,000 hours of supervised clinical social work practice outside of Wisconsin in no less than 2 years may be given credit for those hours provided they included at least 1,000 hours of face-to-face client contact, or a proportionate number thereof, and also included DSM diagnosis and treatment of individuals, completed under the supervision of a supervisor acceptable to the social worker section.

iv. Verification of successful completion of the examination approved by the section, or verification that the applicant is a board certified diplomat (BCD) of the American Board of Examiners in clinical social work.

v. Verification of the applicant's credential in all jurisdictions in which the applicant has ever been credentialed.

vi. All pertinent information relating to any convictions or pending charges for all crimes and any traffic offenses which did or could result in revocation or suspension of the applicant's driver's license.

13.d. Rehabilitative Services, continued.

Psychosocial Rehabilitation Services, continued:

Provider Qualifications, continued

- Licensed professional counselors – Licensed professional counselors shall be licensed in the state of Wisconsin and shall possess at least 3,000 hours of supervised clinical experience where the majority of clients are children or adults with mental disorders or substance use disorders. The above licensure requires:
    - i. A certificate of professional education, signed and sealed by the chancellor, dean or registrar of the school from which the applicant has graduated with an approved degree.
        - An applicant who does not have a master's or doctoral degree in professional counseling shall be considered for licensure as a professional counselor upon the professional counselors section's receipt of a complete description of the academic program which the applicant proposes as the equivalent of a master's or doctoral degree in professional counseling. The professional counselors section may request additional information as necessary to complete the evaluation of the applicant's academic program.
    - ii. Verification that the institution which awarded the degree was a regionally accredited college or university, or accredited by the commission for accreditation of counseling and related educational programs (CACREP), or the council on rehabilitation education (CORE) at the time the applicant graduated from the school, or that a degree awarded by a foreign institution of higher learning has been determined by the National Board for Certified Counselors (NBCC) or by another organization approved by the section to be equivalent to a degree from a program accredited by CACREP. If the applicant's education was not received in English, the applicant must demonstrate proficiency in English by achieving a score of 550 (or 213 on the computer-based exam) or above on the Test Of English as a Foreign Language (TOEFL) or an equivalent score on an equivalent examination.
    - iii. An affidavit from the applicant that the applicant has, after receiving a master's or doctoral degree, completed the required period of supervised practice under the supervision of a person qualified to supervise the applicant's practice.
    - iv. Verification of successful completion of an examination required by the section.
    - v. Verification of the applicant's credential in all jurisdictions in which the applicant has ever been credentialed.

State: Wisconsin

13.d. Rehabilitative Services, continued.

Psychosocial Rehabilitation Services, continued:

Provider Qualifications, continued

vi. If the applicant has been convicted of a crime, or of a traffic offense which did or could result in the suspension or revocation of his or her driver's license, or the applicant has such charges pending against him or her, the applicant has disclosed all information necessary for the section to determine whether the circumstances of the pending charge or conviction are substantially related to the duties of the practice under the license.

vii. An applicant may submit, but is not required to submit, evidence of certification by a professional organization.

- Licensed marriage and family therapists – Licensed marriage and family therapists shall be licensed in the state of Wisconsin and shall possess at least 3,000 hours of supervised clinical experience where the majority of clients are children or adults with mental disorders or substance use disorders. The above licensure requires:
    i. For those providers without clinical membership in the American association for marriage and family therapy:
        - A certificate of professional education, signed and sealed by the chancellor, dean or registrar of the regionally accredited college or university or other accredited institution from which the applicant has graduated with a master's or doctoral degree in marriage and family therapy.
            - An applicant who does not have a master's or doctoral degree in marriage and family therapy must present a certificate of professional education signed and sealed by the chancellor, dean or registrar of the school from which the applicant has graduated with a master's or doctoral degree in a field substantially equivalent to marriage and family therapy, together with satisfactory evidence of having completed education equivalent to a master's or doctoral degree in marriage and family therapy.

State: Wisconsin

13.d. Rehabilitative Services, continued.

Psychosocial Rehabilitation Services, continued:

Provider Qualifications, continued

- An applicant who has a master's or doctoral degree in marriage and family therapy from a program which was not accredited by the commission on accreditation for marriage and family therapy education (COAMFTE) of the American association for marriage and family therapy must submit satisfactory evidence of having completed education equivalent to a master's or doctoral degree in marriage and family therapy from a program accredited by the commission on accreditation for marriage and family therapy education of the American association for marriage and family therapy, or that a degree awarded by a foreign institution of higher learning has been determined by an organization approved by the section to be equivalent to a degree from a program accredited by COAMFTE. If the applicant's education was not received in English, the applicant must demonstrate proficiency in English by achieving a score of 550 (or 213 on the computer-based exam) or above on the Test Of English as a Foreign Language (TOEFL) or an equivalent score on an equivalent examination.

▪ An affidavit that the applicant has completed at least 3000 hours of marriage and family therapy practice in no less than 2 years, including at least 1000 hours of supervised face-to-face client contact.

▪ Verification of successful completion of an examination required by the section

▪ Verification of the applicant's credential in all jurisdictions in which the applicant has ever been credentialed.

▪ All pertinent information relating to any convictions or pending charges for all crimes, and any traffic offenses which did or could result in revocation or suspension of the applicant's driver's license.

ii. For providers who have been admitted to clinical membership in the American association for marriage and family therapy, licensure will be considered for following the section's review of documentation of the individual's clinical membership submitted directly to the section from AAMFT. Those applicants shall also submit:

▪ An affidavit that the applicant has completed at least 3000 hours of marriage and family therapy practice in no less than 2 years, including at least 1000 hours of supervised face-to-face client contact.

State: Wisconsin

13.d. Rehabilitative Services, continued.

Psychosocial Rehabilitation Services, continued:

Provider Qualifications, continued

- Verification of successful completion of an examination required by the section.
- Verification of the applicant's credential in all jurisdictions in which the applicant has ever been credentialed.
- All pertinent information relating to any convictions or pending charges for all crimes, and any traffic offenses which did or could result in revocation or suspension of the applicant's driver's license.

- Licensed occupational therapists – Licensed occupational therapists shall be licensed in the state of Wisconsin. The above licensure requires:
  i. Evidence that the applicant is certified as an occupational therapist or occupational therapy assistant by the national board for certification in occupational therapy; and that the applicant has completed an occupational therapist educational program, or an occupational therapy assistant educational program.
  ii. Written verification from the national board for certification in occupational therapy that the applicant has passed the examination required by this chapter.

- Certified social workers – Certified social workers shall be certified in the state of Wisconsin. The above certification requires:
  i. A certificate of professional education, signed and sealed by the chancellor, dean or registrar of the school from which the applicant has graduated with a bachelor's, master's or doctoral degree in social work.
  ii. Verification that the school or program which awarded the social work degree was accredited by, or a pre-accreditation program, of the Council on Social Work Education (CSWE) at the time the applicant graduated from the program or school, or that a degree awarded by a foreign institution of higher learning has been determined by the CSWE to be equivalent to a program accredited by the CSWE. If the applicant's education was not received in English, the applicant must demonstrate proficiency in English by achieving a score of 550 (or 213 on the computer-based exam) or above on the Test of English as a Foreign Language (TOEFL) or an equivalent score on an equivalent examination.
  iii. Verification of successful completion of an examination required by the section.
  iv. Verification of the applicant's credential in all jurisdictions in which the applicant has ever been credentialed.

State: Wisconsin

13.d. Rehabilitative Services, continued.

Psychosocial Rehabilitation Services, continued:

Provider Qualifications, continued

v. All pertinent information relating to any convictions or pending charges for all crimes and any traffic offenses which did or could result in revocation or suspension of the applicant's driver's license.

- Certified advance practice social workers – Certified advance practice social workers shall be certified in the state of Wisconsin. The above certification requires:
  - i. A certificate of professional education, signed and sealed by the chancellor, dean or registrar of the school from which the applicant has graduated with a master's or doctoral degree in social work.
  - ii. Verification that the school or program which awarded the social work degree was accredited by, or a pre-accreditation program, of the Council on Social Work Education (CSWE) at the time the applicant graduated from the program or school, or that a degree awarded by a foreign institution of higher learning has been determined by the CSWE to be equivalent to a program accredited by the CSWE. If the applicant's education was not received in English, the applicant must demonstrate proficiency in English by achieving a score of 550 (or 213 on the computer-based exam) or above on the Test of English as a Foreign Language (TOEFL) or an equivalent score on an equivalent examination.
  - iii. Verification of successful completion of an examination required by the section.
  - iv. Verification of the applicant's credential in all jurisdictions in which the applicant has ever been credentialed.
  - v. All pertinent information relating to any convictions or pending charges for all crimes and any traffic offenses which did or could result in revocation or suspension of the applicant's driver's license.

- Certified independent social workers – Certified independent social workers shall be certified in the state of Wisconsin. The above certification requires:
  - i. A certificate of professional education, signed and sealed by the chancellor, dean or registrar of the school from which the applicant has graduated with a master's or doctoral degree in social work.

State: Wisconsin

13.d. Rehabilitative Services, continued.

Psychosocial Rehabilitation Services, continued:

Provider Qualifications, continued

ii. Verification that the school or program which awarded the social work degree was accredited by, or a pre-accreditation program, of the Council on Social Work Education (CSWE) at the time the applicant graduated from the program or school, or that a degree awarded by a foreign institution of higher learning has been determined by the CSWE to be equivalent to a program accredited by the CSWE. If the applicant's education was not received in English, the applicant must demonstrate proficiency in English by achieving a score of 550 (or 213 on the computer-based exam) or above on the Test of English as a Foreign Language (TOEFL) or an equivalent score on an equivalent examination.

iii. An affidavit that the applicant, after receiving a master's or doctoral degree and after receiving certification as an advanced practice social worker, has obtained at least 3,000 hours of social work practice in no less than 2 years under the supervision of a supervisor approved by the social worker section.

iv. Verification of successful completion of the examination approved by the section, or verification that the applicant has obtained certification of the Academy of Certified Social Workers (ACSW) of the National Association of Social Workers.

v. Verification of the applicant's credential in all jurisdictions in which the applicant has ever been credentialed.

vi. All pertinent information relating to any convictions or pending charges for all crimes and any traffic offenses which did or could result in revocation or suspension of the applicant's driver's license.

- Certified alcohol and drug abuse counselors – Certified alcohol and drug abuse counselors shall be certified in the state of Wisconsin. The above certification requires:

  i. For substance abuse counselors-in-training:

  - Verified high school diploma, an HSED or GED.
  - Successful passage of an ethics, boundaries and jurisprudence examination developed or approved by the department.
  - Successful completion of 100 hours of specialized education in the transdisciplinary foundations in compliance with state board defined curriculum. An organized educational field experience program from an accredited school fulfills this requirement.
  - Current employment, a written offer of employment or an agreement authorizing volunteer hours at an agency providing substance use disorder treatment. The applicant's clinical supervisor shall review the education submitted and attest that the education submitted by the applicant fulfills the above requirements.

State: Wisconsin

13.d. Rehabilitative Services, continued.

Psychosocial Rehabilitation Services, continued:

Provider Qualifications, continued

ii. For substance abuse counselors without previous credentialing:

- Successful passage of the International Certification Reciprocity Consortium Alcohol and Other Drug Abuse written counselor examination.
- Verified high school diploma, an HSED or GED.
- Completion of 4,000 hours of supervised work experience performing the practice dimensions within 5 years immediately preceding the date of application. Experience in excess of 40 hours per week or 2,000 hours per year does not count in meeting the experience requirement. The 4,000 hours shall include all of the following:
  - Two thousand hours in performing the practice dimensions with patients who have a primary substance use disorder diagnosis.
  - One thousand hours in substance use disorder counseling with at least 500 hours in a one-on-one individual modality setting.
  - A minimum of 200 hours of counseling during the 12 month period immediately preceding the date of application, of which 100 hours shall have been completed using an individual modality setting.

iii. For substance abuse counselors with previous credentialing:

- An applicant for certification as a substance abuse counselor who is previously credentialed by the marriage and family therapy, professional counseling and social work examining board shall submit evidence of completing training and education in the treatment of alcohol or substance dependency or abuse.

State: Wisconsin

13.d. Rehabilitative Services, continued.

Psychosocial Rehabilitation Services, continued:

Provider Qualifications, continued

iv. For clinical substance abuse counselors:

- Successful passage of the International Certification Reciprocity Consortium Alcohol and Other Drug Abuse written counselor certification examination taken on or after June 1, 2008. If the written examination was taken before June 1, 2008, an applicant shall have either successfully passed the International Certification Reciprocity Consortium case presentation method interview on or before December 31, 2008, or have successfully retaken the written counselor certification examination on or after June 1, 2008.

- Certified peer specialists - . Certified peer specialists shall be certified in the state of Wisconsin. The above certification requires:
  i. Successful completion of a peer specialist training program using a state-approved training curriculum.
  ii. Successful completion of the Wisconsin Peer Specialist Certification Exam.

- Certified occupational therapy assistants – Certified occupational therapy assistants shall be certified in the state of Wisconsin. The above certification requires:
  i. Applicants for licensure as an occupational therapist or occupational therapy assistant shall pass the certification examination for occupational therapist or the certification examination for occupational therapy assistant of the national board for certification in occupational therapy, and shall complete an open book examination on statutes and rules governing the practice of occupational therapy in Wisconsin.

State: Wisconsin

13.d. Rehabilitative Services, continued.

Psychosocial Rehabilitation Services, continued:

Provider Qualifications, continued

- Certified rehabilitation counselors – A certified rehabilitation counselor shall be certified or eligible for certification by the national Commission on Rehabilitation Counselor certification

- Master's level professional - shall have a master's degree in an area directly related to providing mental health services, including clinical psychology, psychology, school or educational psychology, rehabilitation psychology, counseling and guidance, counseling psychology, or social work. Masters level professionals must complete orientation and training in the delivery of psychosocial rehabilitation. The psychosocial rehabilitation program will determine that masters level providers have a clean criminal background and possess the interpersonal skills, training, and experience necessary to perform their assigned functions.

- Clinical Student/Resident - shall either be enrolled in a masters degree or higher program at an accredited institution or have completed such a degree and be working toward completion of the full clinical experience requirements necessary for licensure or certification as a provider.

- Bachelors level professional - shall have at least a bachelors degree in an area of education or human services. Bachelors level professionals must complete orientation and training in the delivery of psychosocial rehabilitation. The psychosocial rehabilitation program will determine that bachelors level providers have a clean criminal background and possess the interpersonal skills, training, and experience necessary to perform their assigned functions.

- Psychosocial rehabilitation technician - shall be a paraprofessional with aptitude for the delivery of psychosocial rehabilitation services. Technicians must complete orientation and training in the delivery of psychosocial rehabilitation. The psychosocial rehabilitation program will determine that masters level providers have a clean criminal background and possess the interpersonal skills, training, and experience necessary to perform their assigned functions.

Eff. 1-1-93

Medical Day Treatment - Mental Health Service. Medical day treatment is a mental health rehabilitation service for recipients who are seriously impaired in basic areas of everyday functioning and for whom less intensive, traditional, outpatient mental health treatment is not adequate to stabilize their condition, attain their best possible functional level, or maintain their residence in the community. This service also is appropriate on a limited basis for individuals in hospitals or nursing facilities who are in transition from an institutional to a community setting. Day treatment services are necessary for the maximum reduction of a recipient's disability and for restoring a recipient to his or her best possible functional level.

Medical day treatment is a compendium of medical, mental health, occupational therapy, and other services. Specific day treatment services include individual and group occupational therapy and psychotherapy, medication management, symptom management, psychosocial rehabilitation services, and nursing services. Medical Assistance pays only for those medically-necessary services in a physician-approved plan of care, provided under the general direction of a physician.

Medical day treatment is provided by day treatment programs certified by the Department of Health and Social Services. Certification requires the following: a registered nurse or occupational therapist is on duty to participate in program planning, implementation, and coordination; the program is directed by an interdisciplinary team; a qualified professional staff person participates in all groups; and periodic evaluation is conducted of each recipient's progress in the program.

Prior authorization is required after a limited number of hours of service have been provided in a calendar year. Any occupational therapy and psychotherapy provided as part of the day treatment program are part of the day treatment benefit, are subject to day treatment limitations, and cannot be separately billed.

13.d Medical Day Treatment - Mental Health Service. (Continued)

Activities such as recreation, arts and crafts, music, exercise, socializing, and general education that may be part of a recipient's day treatment program, are non-covered services.

Eff. 1-1-93 Outpatient Psychotherapy Services. The Medical Assistance Program covers outpatient psychotherapy services necessary for the maximum reduction of a recipient's disability and for restoring a recipient to his or her best possible functional level. These services are available to recipients when prescribed by a physician prior to beginning treatment.

Evaluations, assessments and testing are provided to all recipients to determine the need for psychotherapy services or to evaluate the appropriateness of the services being provided. Treatment services include individual, group, and family psychotherapy (including such modalities as hypnotherapy and biofeedback) and collateral contacts. Psychiatric medication management may be provided by physicians or registered nurses employed by a certified clinic.

Outpatient psychotherapy services are provided under the direction of a psychiatrist or licensed psychologist who is listed or eligible to be listed in the National Register of Healthcare Providers in Psychology. These services may be performed by either such a psychiatrist or psychologist, or by an individual with a master's degree in social work, counseling, psychology, or a related discipline, who has 3000 hours of post-degree experience providing psychotherapy services and who is supervised by a provider meeting the certification requirements. Masters level providers must work in an outpatient clinic certified by the Department of Health and Social Services.

Prior authorization is required for recipients to receive services beyond an identified dollar or hourly limit in a calendar year. (This threshold also includes outpatient AODA services provided to the same recipient.) Evaluations require prior authorization after reaching an hourly limit in a two year period.

Eff. 10-1-97 Mental health services, including services provided by a psychiatrist, may be provided to an individual who is 21 years of age or older in the individual's home or in the community.

13.d. Rehabilitation Services, continued.

Residential Substance Use Disorder (SUD) Treatment Services

The service is a program (encompasses several different rehabilitative services):
Substance use disorder (SUD) treatment in a residential setting provides treatment for adults and youth to promote recovery from substance use disorder and reduce the incidence and duration of institutional care members might otherwise need. Residential SUD Treatment Services include the following services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional levels in accordance with 42 CFR 440.130(d):

- Assessment and Treatment Planning:
  Assessment and treatment planning services include completion of the initial screening, intake, comprehensive assessment, diagnosis, and treatment planning. Reassessment and updated treatment planning is required throughout the duration of services. The amount and duration of this service is determined on a case by case basis through the prior authorization process.

  Allowable Practitioners: Licensed psychiatrists, Licensed physicians, Licensed psychologists, Licensed physician assistants, Licensed nurse practitioners, Licensed advanced practice nurse prescribers, Licensed registered nurses, Licensed independent clinical social workers, Licensed professional counselors, Licensed marriage and family therapists, Certified alcohol and drug abuse counselors, Clinical Student/Resident

- Individual, group and family substance abuse counseling
  Individual, group, and family substance abuse counseling services are provided to ameliorate negative symptoms from substance abuse and to restore effective function in individuals with substance use disorder or addiction. Group counseling involves interaction among members of a group consisting of at least two patients but not more than 10 patients. Family counseling includes interaction among members of the individual's family, and must be directly related to the assessed needs of the individual. The amount and duration of this service is determined on a case by case basis through the prior authorization process.

  Allowable Practitioners: Licensed psychiatrists, Licensed physicians, Licensed psychologists, Licensed independent clinical social workers, Licensed professional counselors, Licensed marriage and family therapists, Certified alcohol and drug abuse counselors, Clinical Student/Resident

- Individual, group and family psychotherapy

Individual, group, and family psychotherapy is used to treat an individual who is mentally ill or has medically significant emotional or social dysfunctions. The treatment is a planned and structured program based on information from a diagnostic assessment and directed at accomplishing specific goals. Treatment goals may include removing, modifying, or retarding existing symptoms, mediating disturbed patterns of behavior and promoting positive personal growth and development by enhancing the ability to adapt and cope with internal and external stresses. Group psychotherapy involves interaction among members of a group consisting of at least two patients but not more than 10 patients. Family psychotherapy includes interaction among members of the individual's family, and must be directly related to the assessed needs of the individual. The amount and duration of this service is determined on a case by case basis through the prior authorization process.

Allowable Practitioners: Licensed psychiatrists, Licensed physicians, Licensed psychologists, Licensed advanced practice nurse prescribers, Licensed nurse practitioners, Licensed independent clinical social workers, Licensed professional counselors, Licensed marriage and family therapists, Certified social workers, Certified advance practice social workers, Certified independent social workers, Clinical Student/Resident

- Psychoeducation
  Psychoeducation includes the provision of information in a didactic format in either a group or individual setting that relates to health or promotes recovery. This service includes providing counseling about individual's substance abuse and/or mental health issues, skills training, and guidance about managing and coping with symptoms. The amount and duration of this service is determined on a case by case basis through the prior authorization process.

  Allowable Practitioners: Licensed psychiatrists, Licensed physicians, Licensed psychologists, Licensed physician assistants, Licensed nurse practitioners, Licensed advanced practice nurse prescribers, Licensed registered nurses, Licensed practical nurses, Licensed independent clinical social workers, Licensed professional counselors, Licensed marriage and family therapists, Certified social workers, Certified advance practice social workers, Certified independent social workers, Certified alcohol and drug abuse counselors, Clinical Student/Resident

- Medication Administration
  Medication administration includes receiving, storing, administering, and supporting the member in taking medications to treat the member's substance use disorder, mental health, and medical conditions. Medications are administered by trained staff, supervised when required, according to state policies and procedures designed to provide safe and accurate administration of medication. The amount and duration of this service is determined on a case by case basis through the prior authorization process.

Allowable Practitioners: Licensed psychiatrists, Licensed physicians, Licensed physician assistants, Licensed psychologists, Licensed nurse practitioners, Licensed advanced practice nurse prescribers, Licensed registered nurses, Licensed practical nurses, Licensed independent clinical social workers, Licensed professional counselors, Licensed marriage and family therapists, Certified social workers, Certified advance practice social workers, Certified independent social workers, Certified alcohol and drug abuse counselors, Clinical Student/Resident, Certified peer specialists, Recovery coaches, SUD technicians

- Nursing Services
  Behavioral health or medical services provided by a licensed nurse and operating within their scope of practice that supports screening, assessment, and treatment for patients. The amount and duration of this service is determined on a case by case basis through the prior authorization process.

  Allowable Practitioners: Licensed nurse practitioners, Licensed advanced practice nurse prescribers, Licensed registered nurses, Licensed practical nurses, Clinical Student/Resident

- Peer Support and Recovery Coaching
  Peer support and recovery coaching services link members with peer specialists and recovery coaches who serve as advocates, mentors, facilitators, and role models. These services provide guidance from a lived-experience perspective that promotes engagement in substance use disorder treatment and recovery systems. Peer specialists and recovery coaches support the individual in building recovery capital, making choices that promote SUD recovery, developing goals, and rebuilding the individual's ability to meet their chosen goals. These services promote the individual's use of self-directed recovery tools, and inform the individual about community and natural supports and how to utilize these in the recovery process. Peer supports and recovery coaching services are delivered under the direction of a qualified health care practitioner. The amount and duration of this service is determined on a case by case basis through the prior authorization process.

  Allowable Practitioners: Certified peer specialists, Recovery coaches

- Drug Testing
  Drug testing includes collection of samples and completion of point-of-care drug tests, including breathalyzer, at the residential SUD facility to monitor treatment compliance, reinforce treatment gains and ensure safety. Drug tests are administered by trained staff, supervised when required, according to procedures that safeguard patient rights and ensure the accuracy and integrity of test results. The amount and duration of this service is determined on a case by case basis through the prior authorization process.

  Allowable Practitioners: Licensed psychiatrists, Licensed physicians, Licensed physician assistants, Licensed psychologists, Licensed nurse practitioners, Licensed advanced

practice nurse prescribers, Licensed registered nurses, Licensed practical nurses, Licensed independent clinical social workers, Licensed professional counselors, Licensed marriage and family therapists, Certified social workers, Certified advance practice social workers, Certified independent social workers, Certified alcohol and drug abuse counselors, Clinical Student/Resident, Certified peer specialists, Recovery coaches, SUD technicians

- Treatment Coordination Services
  Treatment coordination services involve managing covered medical assistance services to meet an individual's identified health needs and assisting the individual in engaging in such services to support the individual's overall treatment and recovery. The amount and duration of this service is determined on a case by case basis through the prior authorization process.

  Allowable Practitioners: Licensed psychiatrists, Licensed physicians, Licensed physician assistants, Licensed psychologists, Licensed nurse practitioners, Licensed advanced practice nurse prescribers, Licensed registered nurses, Licensed practical nurses, Licensed independent clinical social workers, Licensed professional counselors, Licensed marriage and family therapists, Certified social workers, Certified advance practice social workers, Certified independent social workers, Certified alcohol and drug abuse counselors, Clinical Student/Resident, Certified peer specialists, Recovery coaches, SUD technicians

Provider Qualifications:
Residential SUD treatment facilities must be licensed by the state of Wisconsin as medically monitored SUD treatment services or transitional residential SUD treatment services in order to enroll as a Medicaid provider. SUD residential facilities may employ licensed and non-licensed health professionals. Services are provided by or overseen by a licensed professional within the scope of his or her practice under state law. Practitioners in SUD residential treatment facilities include:

- Licensed psychiatrists – Psychiatrists shall be licensed in Wisconsin to practice medicine and surgery and shall have completed 3 years of residency training in psychiatry in a program approved by the American Medical Association or the Accreditation Council for Graduate Medical Education.
- Licensed physicians – Physicians shall be licensed in Wisconsin to practice medicine and surgery and shall possess knowledge and experience related to mental disorders of adults or children, be certified in addiction medicine by the American Society of Addiction Medicine, be certified in addiction psychiatry by the American Board of Psychiatry and Neurology, or otherwise be knowledgeable in the practice of addiction medicine.
- Licensed physician assistants – Physician assistants shall be licensed in Wisconsin
- Licensed psychologists – Psychologists shall be licensed in Wisconsin and be listed or have met the requirements for listing with the National Register of Health Service Providers in Psychology or have a minimum of one year of supervised post-doctoral clinical experience

directly related to the assessment and treatment of individuals with mental disorders or substance-use disorders.

- Licensed nurse practitioners – Nurse practitioners shall be licensed in Wisconsin as a registered nurse, certified in Wisconsin as a nurse practitioner, and possess 3,000 hours of supervised clinical experience.
- Licensed advanced practice nurse prescribers – Advance practice nurse prescribers shall be licensed in Wisconsin as a registered nurse and certified in Wisconsin as an advance practice nurse prescriber.
- Licensed registered nurses – Licensed registered nurses shall be licensed in the state of Wisconsin
- Licensed practical nurses – Licensed practical nurses shall be licensed in the state of Wisconsin.
- Licensed independent clinical social workers – Licensed independent clinical social workers shall be licensed in the state of Wisconsin and shall possess at least 3,000 hours of supervised clinical experience where the majority of clients are children or adults with mental disorders or substance use disorders.
- Licensed professional counselors – Licensed professional counselors shall be licensed in the state of Wisconsin and shall possess at least 3,000 hours of supervised clinical experience where the majority of clients are children or adults with mental disorders or substance use disorders.
- Licensed marriage and family therapists – Licensed marriage and family therapists shall be licensed in the state of Wisconsin and shall possess at least 3,000 hours of supervised clinical experience where the majority of clients are children or adults with mental disorders or substance use disorders.
- Certified social workers – Certified social workers shall be certified in the state of Wisconsin.
- Certified advance practice social workers – Certified advance practice social workers shall be certified in the state of Wisconsin.
- Certified independent social workers – Certified independent social workers shall be certified in the state of Wisconsin.
- Certified alcohol and drug abuse counselors – Certified alcohol and drug abuse counselors shall be certified in the state of Wisconsin.
- Certified peer specialists - Certified peer specialists shall be persons with lived experience of mental illness or substance use disorders or both who have completed formal training and are certified in the state of Wisconsin.
- Recovery coaches – Recovery coaches shall be persons with lived experience in substance use disorder recovery, or those impacted by another's addiction, who have completed formal, documented training in a program acceptable to Wisconsin Medicaid that emphasizes recovery services and systems, and approaches for promoting member engagement in treatment.
- Clinical Student/Resident - Clinical students and residents shall either be enrolled in a masters degree or higher program at an accredited institution or have completed such a degree and be working toward completion of the full clinical experience requirements necessary for licensure or certification as a provider.

- SUD Technician - SUD technicians shall possess a high school diploma or equivalent and pass a criminal background check. Technicians must complete orientation and training in assigned work functions.

Assurances:
Residential SUD services, including substance abuse family counseling and family psychotherapy, that involve the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

The State assures that rehabilitative services do not include and FFP is not available for any of the following in accordance with section 1905(a)(13) of the Act. a. educational, vocational and job training services; b. room and board; c. habilitation services; d. services to inmates in public institutions as defined in 42 CFR §435.1010; e. services to individuals residing in institutions for mental diseases as described in 42 CFR§435.1010; f. recreational and social activities; and g. services that must be covered elsewhere in the state Medicaid plan.

The state assures that, through September 30, 2025, MAT to treat OUD as defined at section 1905(ee)(1) of the Social Security Act (the Act) is covered exclusively under section 1905(a)(29) of the Act.

Additional Benefit Information:
Benefits or Services are provided with limitations on amount, scope or duration or with authorization requirements.

Residential SUD treatment must be medically necessary for the member as determined through the prior authorization process. Initial service authorizations require verification that a clinically-appropriate assessment using allowable placement criteria has been performed prior to admission.

The amount, duration and scope of residential SUD treatment are established on a case by case basis through the prior authorization process. Residential SUD treatment must be medically necessary for the beneficiary as determined through the prior authorization process. Initial service authorizations require verification that a clinically-appropriate assessment using allowable placement criteria has been performed prior to admission. Authorization is required to exceed limitations in the initial service authorization plan.

13.d

Substance Use Disorder (SUD) Formerly AODA Treatment Services.

Outpatient SUD treatment services are available to recipients when such services are necessary for the maximum reduction of the recipient's disability and for restoring the recipient to his or her best possible functional level.

Outpatient SUD services include evaluations, assessments and diagnostic services to determine the need for AODA SUD service or to evaluate the appropriateness of the services being provided. The outpatient SUD treatment services include individual, group, and family SUD treatment and SUD educational programming specific to medical aspects of SUD diagnosis and treatment. Outpatient SUD services include drug testing for a member engaged in treatment at an appropriately certified treatment facility.

Medication management may be provided by physicians, or registered nurses employed by a certified clinic. Counseling services include counseling necessary to ensure the best possible level of functioning associated with methadone maintenance. All services are provided under the general direction of a physician.

These services may be performed only by the following providers: a physician; a licensed psychologist who is listed or eligible to be listed in the National Register of Healthcare Providers in Psychology; an individual with a master's degree in social work, counseling er psychology, or a related discipline, who has 3000 hours of poet-degree experience providing psychotherapy services supervised by a provider meeting the certification requirements; or an individual certified by the Wisconsin Alcoholism and Drug Abuse Counselor Certification Board as an alcohol and drug counselor II or III. Masters level providers and SUD counselors must work in outpatient clinics certified by the Department of Health and Social Services.

13.d Outpatient Substance Use Disorder (SUD) Alcohol and Other Drug Abuse (AODA) Treatment Services. (Continued)

Detoxification is not covered in a social (nonhospital) setting.

Alcohol and other drug abuse services may be provided to an individual who is 21 years of age or older in the individual's home or in the community.

Substance Use Disorder (SUD) Day Treatment.

SUD day treatment is available for recipients who are seriously impaired in basic areas of everyday functioning and for whom less intensive, traditional,_ outpatient treatment is not adequate to stabilize_ their condition or attain their best possible functional level in the community. SUD day treatment may be appropriate for individuals who have had inpatient hospital detoxification or limited inpatient hospital rehabilitation. These services are necessary for the maximum reduction of the recipient's disability and for restoring the recipient to his or her best possible functional level.

AODA SUD day treatment is a compendium of medical and AODA SUD treatment services, but Medical Assistance pays for only those services which are medic ally necessary based on a supervising physician or psychologist-approved plan of care and are provided under the general direction of a physician. Medical Assistance-covered services include individual, group, family therapy, educational programming specific to medical aspects of SUD diagnosis and treatment, and drug testing.

SUD day treatment is provided by day treatment programs certified by the Department of Health and Social Services. Certification requires that the program be directed by an interdisciplinary team; that an individual certified by the Wisconsin Alcoholism and Drug Abuse Counselor Certification Board as an alcohol and drug counselor II or III is on duty all hours in which services are provided; and that recipients are evaluated for their ability to benefit from treatment.

13.d Alcohol and Other Drug Abuse (AODA) Day Treatment. (Continued)

All AODA day treatment services must be prior authorized except for the initial three hours of assessment. A recipient may not receive outpatient AODA services during the period he or she is receiving AODA day treatment.

Activities such as recreation, arts and crafts, music, exercise, socializing and general education which may be part of the recipient's day treatment program are non-covered services by Medical Assistance.

14. Eff. 7-1-87 Services for Individuals Age 65 - In Institutions for Mental Diseases. Prior authorization and other limitations which otherwise are required for SNF or ICF care apply here. See Item #4a of this section and HSS 107.09, Wis. Adm. Code.

17. Eff. 10-1-93 Nurse Midwife Services. Nurse midwife services are subject to limitations within the scope of practice of the nurse midwife. The scope of practice is the overall management of care of a woman in normal childbirth and the provision of prenatal, intrapartal, postpartal and nonsurgical contraceptive methods and care for the mother and the newborn up to one year of age. These services include medical services delegated by a licensed physician through protocols, pursuant to the requirements set forth in the Wisconsin Nursing Act and the guidelines set forth by the medical examining board and the board of nursing. Nurse midwife services are subject to the same limitations imposed on physician services under item #5 to enable the Department to monitor and regulate the following: medical necessity, cost, frequency and place of service.

18. Eff. 7-1-88 1-1-91 Hospice Care Services. This service is provided according to federal requirements, including amendment by P.L. 101-508 (OBRA '90).

19. Eff. 10-1-97 Case Management Services.

Case Management is not available to any recipient:

a. participating in a home and community based (1915(c)) waiver program,

b. residing in an MA funded institution (e.g., hospital or nursing home), except for discharge-related case management services prior to discharge from an institutional setting,

c. in excess of one assessment or case plan per calendar year, per county, except when recipients receive prenatal care coordination,

d. in excess of one claim for ongoing monitoring per month per county except when recipients receive prenatal care coordination, or

e. enrolled in a MA-certified community support program.

Case Management does not include:

a. services which are diagnostic or therapeutic or which could be paid for by MA as any other covered benefit by certified or certifiable professionals,
b. legal advocacy by a lawyer or paralegal,
c. personal care or supportive home care,
d. client education and training, or
e. services not provided or directed towards some specific recipient.

19.b. Eff. 7-1-95 Special Tuberculosis Related Services under Section 1902(z)(2)(F)

These services are limited to those recipients with a TB-related diagnosis and include directly observed therapy, in-home monitoring of TB-symptoms, patient education and anticipatory guidance, and disposable supplies to encourage the completion of prescribed drugs.

20. Eff. 9-1-87 Extended Services for Pregnant Women

Major Categories of Service

Major categories of services are: inpatient and outpatient hospital services, physician services, laboratory and x-ray services, rural health and other clinic services, and diagnostic services. These include routine prenatal care, labor and delivery, routine post-partum care and complications of pregnancy or delivery likely to affect the pregnancy. These services are subject to the same limitations which pertain to the respective areas of service.

Eff. 1-1-93 Health Education

Health education for high risk pregnant and postpartum women (up to 60 days after delivery) is medically necessary instruction to ameliorate a pregnant woman's identified risk factors, as determined by the Department-sanctioned risk assessment. The following areas may be included:

1. education/assistance to stop smoking and to stop alcohol and addictive drug consumption;
2. education/assistance to stop potentially dangerous sexual practices;
3. lifestyle management and reproductive health;
4. education/assistance to handle environmental/ occupational hazards;
5. childbirth and parenting education.

Nutrition Counseling

Nutrition counseling for high risk pregnant and postpartum women (up to 60 days after delivery) is medically necessary nutrition instruction and guidance to ameliorate a pregnant woman's identified risk factors as determined by the Department-sanctioned risk assessment, and may include, but is not limited to, the following areas:

1. weight and weight gain;
2. biochemical and dietary factors;
3. previous and current nutrition-related obstetrical complications;
4. psychological problems affecting nutrition; and
5. reproductive history affecting nutritional status.

21. Eff. 9-1-87 Ambulatory Prenatal Care for Pregnant Women. These services are subject to the same limitations which pertain to the respective areas of service.

22. Eff. 1-1-99 Respiratory Care Services. Prior authorization of services is required for reimbursement. The recipient will have been medically dependent on a ventilator for life support for at least 6 hours per day. In addition, the recipient will meet one of the following two conditions:

- The recipient will have been so dependent for at least 30 consecutive days as an inpatient in one or more hospitals, nursing facilities, or ICF/MR, as stated in 42 CFR 440.185(a)(2).
- If the recipient has been hospitalized for less than 30 days, the recipient's eligibility for services will be determined by the Division's Chief Medical Officer on a case-by-case basis, and may include discussions with the recipient's pulmonologist and/or primary care physician to evaluate the recipient's prognosis, history of hospitalizations for the respiratory condition, diagnosis, and weaning attempts, when appropriate.

Reimbursement under the respiratory care benefit is not available for services that are part of the rental agreement for a ventilator or other necessary equipment with a durable medical equipment provider. Respite services are not covered.

23. Eff. 4-1-93 Pediatric or Family Nurse Practitioner Services. Services are subject to limitations imposed on specific disciplines within the scope of practice of the nurse. These services include medical services delegated by a licensed physician through protocols, pursuant to the requirements set forth in the Wisconsin Nursing Act and the guidelines set forth by the medical examining board and the board of nursing. Other practitioner services are subject to the same limitations imposed on physician services under item #5 to enable the Department to monitor and regulate the following: medical necessity, cost, frequency and place of service.

Medication management includes in-home administration of medications other than those given intravenously, prefilling syringes for self injection when the recipient is not capable, setting up medications for self-administration, and programming dispensers. Instructing the recipient may be covered when provided in conjunction with these activities but not covered if it is the only activity.

24. Any Other Medical Care

a. Transportation Services Non-emergency transportation by air and water ambulance requires prior authorization. Ambulance service restrictions include, but are not limited to: medical order requirements for non-emergency services, trip purpose limitations, and pick-up and destination point limitations.

Specialized motor vehicle transportation services are provided only to recipients with prescriptions documenting their inability to use common carrier transportation (such as private auto, bus, taxi). Eligibility standards are established for second attendant services. Within Department-established restrictions, unloaded mileage is a covered service utilizing specified mileage zones. Trips over a specified upper mileage limit require prior authorization.

b. Transportation for School-Based Services (SBS):

1. Transportation to School.

A child's transportation to and from a school certified as an SBS provider is a covered service only if all of the following conditions are met:

- The child receives covered SBS services identified in the child's IEP at the school on the day the transportation is provided.
- The SBS provider is financially responsible for providing the transportation.
- The child's medical need for the particular type of transportation is identified in the IEP.
- The vehicle is equipped with and the child requires a ramp or lift, an aide is present and the child requires the aide's assistance in the vehicle or the child has behavioral problems that do not require the assistance of an aide but that preclude the child from riding on a standard school bus.

Effective 1-1-98

2. Off-site transportation. A child's transportation to and from a site other than the child's "home" school is a covered service only if all of the following conditions are met:

   - The child receives covered SBS services identified in the child's IEP at the site on the day the transportation is provided.
   - The SBS provider is financially responsible for providing the transportation.
   - The transportation is either from the school to an off-site provider and back to school or to home, or is between home and a "special" school. A "special school" is a school that requires that a child have a disability in order to be enrolled, including but not limited to the Wisconsin School For The Deaf or the Wisconsin School For The Visually Handicapped, as defined in ch. PI 12, Wis. Adm. Code.

Effective 1-1-98

c. Care and Services provided in a Christian Science Sanatoria. Services are covered only to the extent that they are the equivalent of the inpatient services furnished by a hospital or skilled nursing facility.

d. Nursing Facility Services for Recipients Under 21 Years of Age. The plan of care and independent medical review provide bases for authorization and payment amount.

e. Non-Emergency Out-of-State Treatment. Prior authorization is required for all non-emergency out-of-state procedures unless the provider has been granted border status.

24.f. Eff. 2-25-94 Personal Care Services. Prior authorization is required for personal care services after a limited number of hours of service have been provided in a calendar year.

Services must be supervised by an RN who reviews the plan of care, the performance of the personal care worker and evaluates the recipient's condition at least every 60 days. Reimbursement for RN supervisory visits is limited to one visit per month.

Eff. 1-1-89 Personal care workers can perform home health aide tasks when delegation, training and supervision criteria are met. Housekeeping tasks performed by the personal care worker are limited to 1/3 of the time spent in the recipient's home.

Eff. 1-1-98

HealthCheck (EPSDT) Other Services

In addition to services provided elsewhere in this Plan, HealthCheck (EPSDT) recipients may receive, if medically necessary and prior authorized, the following services:

1. Mental Health
   a. In-home psychotherapy
   b. Mental health day treatment
   c. Specialized psychological evaluation for conditions, such as children with sexually deviant behavior, where a limited number of providers are qualified. The evaluation includes components not included under outpatient psychotherapy services.
2. Dental
   a. Oral examinations exceeding the limitations for adults
   b. Single unit crowns
3. Otherwise Non-Covered Over-the-Counter Medications

   Certain commonly required medications such as multivitamins require only a prescription and not prior authorization.

State: Wisconsin

HealthCheck (EPSDT) Other Services, continues

4. Comprehensive Treatment

See “Comprehensive Treatment” under Behavioral Treatment Services in Section 6.d., Other Practitioners.

1915(i) State plan Home and Community-Based Services

Administration and Operation

The State implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

1. **Services.** *(Specify service title(s) for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

HCBS Psychosocial Rehabilitation

2. **Statewideness.** *(Select one)*:

○	The State implements the 1915(i) State plan HCBS benefit statewide, per §1902(a)(1) of the Act.
●	The State implements this benefit without regard to the statewideness requirements in §1902(a)(1) of the Act. State plan HCBS will only be available to individuals who reside in the following geographic areas or political subdivisions of the State. *(Specify the areas to which this option applies)*:
	Services will be available in the following Wisconsin counties: Adams, Barron, Buffalo, Chippewa, Clark, Dane, Dodge, Dunn, Eau Claire, Forest, Green, Green Lake, Jackson, Jefferson, Kenosha, LaCrosse, Langlade, Lincoln, Marathon, Milwaukee, Monroe, Oneida, Ozaukee, Pepin, Pierce, Portage, Richland, Rock, Sheboygan, St. Croix, Trempealeau, Vernon, Vilas, Washington, Waukesha, Wood

3 **State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit.** *(Select one)*:

●	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:	
	○ The Medical Assistance Unit *(name of unit)*:	
	● Another division/unit within the SMA that is separate from the Medical Assistance Unit	
	(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	Department of Health Services Division of Mental Health and Substance Abuse Services, Bureau of Prevention, Treatment and Recovery
○	The State plan HCBS benefit is operated by *(name of agency)*	
	A separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.	

4. Distribution of State plan HCBS Operational and Administrative Functions.

X *(By checking this box the State assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐	☐	☑
2 State plan HCBS enrollment managed against approved limits, if any	☑	☐	☐	☑
3 Eligibility evaluation	☑	☐	☐	☑
4 Review of participant service plans	☑	☐		☐
5 Prior authorization of State plan HCBS	☑	☐	☐	☐
6 Utilization management	☑	☐		☑
7 Qualified provider enrollment	☑	☐	☐	☑
8 Execution of Medicaid provider agreement	☑	☐	☐	☑
9 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☑	☐
10 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☐	☐
11 Quality assurance and quality improvement activities	☑	☐		☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Numbers 1, 2, 3, 6, 7 and 8 are performed by County Human Services Departments or in a few counties a Department of Community Programs that has a specific focus on persons with mental illness and/or developmental disabilities in addition to the SMA. Number 9 has been completed under contract with The Public Consulting Group.

(By checking the following boxes the State assures that):

5. X **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

   - related by blood or marriage to the individual, or any paid caregiver of the individual
   - financially responsible for the individual
   - empowered to make financial or health-related decisions on behalf of the individual
   - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

6. X **Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. X **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. X **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	1/16/10	9/30/10	1077
Year 2			
Year 3			
Year 4			
Year 5			

2. **X Annual Reporting.** *(By checking this box the State agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

3. **Optional Annual Limit on Number Served.** *(Select one):*

O	The State does not limit the number of individuals served during the year or at any one time. **Skip to next section.**
●	The State chooses to limit the number of *(check each that applies):*

☐ Unduplicated individuals served during the year. *(Specify in column **A** below):*

X Individuals served at any one time ("slots"). *(Specify in column **B** below):*

Annual Period	From	To	A Maximum Number served annually *(Specify):*	B Maximum Number served at any one time *(Specify):*
Year 1	1/16/10	9/30/10		938
Year 2				
Year 3				
Year 4				
Year 5				

☐ The State chooses to further schedule limits within the above annual period(s). *(Specify):*

4. **Waiting List.** *(Select one only if the State has chosen to implement an optional annual limit on the number served):*

O	The State will not maintain a waiting list.
●	The State will maintain a single list for entrance to the State plan HCBS benefit. State-established selection policies: are based on objective criteria; meet requirements of the Americans with Disabilities Act and all Medicaid regulations; and ensure that only individuals enrolled in the State plan HCBS benefit receive State plan HCBS once they leave/are taken off of the waiting list.

Financial Eligibility

1. X **Income Limits.** *(By checking this box the State assures that):* Individuals receiving State plan HCBS are in an eligibility group covered under the State's Medicaid State plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL). Individuals with incomes up to 150% of the FPL who are only eligible for Medicaid because they are receiving 1915(c) waiver services may be eligible to receive services under 1915(i) provided they meet all other requirements of the 1915(i) State plan option. The State has a process in place that identifies individuals who have income that does not exceed 150% of the FPL.

2. **Medically Needy.** *(Select one):*

○	The State does not provide State plan HCBS to the medically needy.
●	The State provides State plan HCBS to the medically needy *(select one):*
○	The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
●	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III).

Needs-Based Evaluation/Reevaluation

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual according to the requirements of 42 CFR §441.556(a)(1) through (5). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*select one*):

●	Directly by the Medicaid agency
○	By Other (*specify State agency or entity with contract with the State Medicaid agency*):

2. Qualifications of Individuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified as defined in 42 CFR §441.568. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

The1915(i) program will use Wisconsin's Functional Eligibility Screen for Mental Health and Mental Health & AODA (Co-Occurring) Services in doing the independent evaluation of needs based criteria. This will be conducted by a trained certified screen administrator. Certified screeners are knowledgeable about mental health issues, interviewing skills needed to gather information, conducting a holistic dialogue, recovery-based best practices, including learning what the person needs help with within a larger, recovery-focused dialogue that includes the person's strengths, values, goals and perspectives. All persons administering the functional screen must meet the following conditions:

1. Meet the following **minimum criteria for education and experience**:
– Nursing license or a BA or BS, preferably in a health or human services related field, and at least one year of experience working with people with chronic needs, or
– Prior approval from the Department based on a combination of post-secondary education and experience or on a written plan for formal and on-the-job training to develop the required expertise; and
2. Meet all **training requirements** as specified by the Department. Currently that means:
– Completing the online course, or
– Attending an in-person training by Department staff (or watching video of same), **and**
– Reading and following screen instructions.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

Wisconsin's Mental Health and AODA functional screen has been in use since 2005 to identify individual's functional needs. The screen has three sections: Community living skills inventory, crisis and situational factors (factors such as a history of inpatient stays, emergency detentions, suicide attempts etc.) and risk factors (substance use, housing instability etc.). The functional screen is web based and can be completed only by certified screeners. The needs based eligibility criteria are incorporated into the screen logic to provide an automated determination of eligibility or ineligibility. The functional screen will be completed annually. Screen reports are available showing when annual screens are due or are late.

4. X **Needs-based HCBS Eligibility Criteria.** *(By checking this box the State assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

Wisconsin's 1915(i) needs based criteria requires an individual to have a variety of combinations of risk factors and functional need for assistance with community living skills such that those needs cannot be met by an outpatient clinic service. ("Assistance" is defined as including any kind of support from another person (monitoring, supervising, reminders, verbal cueing, or hands-on assistance) needed because of a physical, cognitive, or mental health condition disorder)
The following is the minimum possible combinations of factors that demonstrate 1915i eligibility:

The criteria for eligibility group seven (the lowest level of eligibility) are that the individual's needs can not be met by an outpatient clinic service plus they meet the following:

- Applicant meets at least one Eligibility Group Two criteria

OR

- Applicant meets at least one Eligibility Group Three criteria

-AND-

At least 3 of the following are true for the applicant

- Needs assistance to work or to find work less than monthly OR needs assistance with schooling less than monthly
- Needs help with home hazards 1 to 4 times a month
- Needs help to use effective social/interpersonal skills
- Needs help with money management 1 to 4 times a month
- Needs help with maintaining basic nutrition 1 to 4 times a month
- Needs help with transportation because person cannot drive due to physical, psychiatric or cognitive impairment.

Group Two eligibility criteria normally require two of the following but any one of these criteria meets the first part of the group seven requirement.

- Needs help in maintaining basic safety
- Needs assistance to manage psychiatric symptoms more than once a week
- Needs assistance with taking medications 2 to 6 days per week OR needs monitoring medication effects 2 to 6 days per week
- Has required use of emergency rooms, crisis intervention or detox units 4 or more time in the past year OR has had 1 to 3 psychiatric inpatient stays within the past year OR has had 1 to 3 emergency detentions within the past year
- Has had 4 or more psychiatric inpatient stays within the past 13 months to 3 years OR has made 4 or more suicide attempts within the past 13 months to 3 years
- Has had incidents of physical aggression 4 or more times within the past year OR has had involvement with the corrections system 4 or more times within the past year

Group 3 eligibility requires three of the following but for Group seven only one of the following is sufficient to meet the first part of the eligibility.

- Needs assistance to work more than 1 time per week
- Needs help with home hazards more than once a week
- Needs help with money management more than once a week
- Needs help with basic nutrition more than once a week
- Needs help performing general health maintenance at least 1 to 4 times a month
- Needs help managing psychiatric symptoms 1 to 4 times a month

- Needs assistance with taking medications 1 to 4 days a month or needs monitoring medication effects 1 to 4 days a month
- Has required use of emergency rooms, crisis intervention, or detox units at least 1 time in the past year; or has had 1 to 3 psychiatric inpatient stays within the past year
- Has required use of emergency rooms, crisis intervention, or detox units 4 or more times within the past 13 months to 3 years; OR has had at least 1 psychiatric inpatient stay within the past 13 months to 3 years OR has made at least one suicide attempt within the past 13 months to 3 years.
- Has had at least 1 emergency detention within the past 13 months to 3 years
- Has had at least 1 incident of physical aggression in the past year; OR has had involvement with the correctional system 4 or more times within the past 13 months to 3 years
- Currently homeless (on the street or no permanent address) OR has been evicted 2 or more times in the past year; OR homeless more than half of the time in the past year; OR currently homeless, not in transitional housing OR in Transitional Housing – Mental Health, Substance Abuse or Corrections System
- Has demonstrated self-injurious behaviors within the past year; OR has demonstrated self-injurious behaviors 13 months to 3 years ago
- Has at least one Substance-Related diagnosis except nicotine dependence or other related disorder; OR in the past 12 months, person has experienced negative consequences in legal (including OWI), financial, family, relational, or health domains that are linked to substance use

5. **X Needs-based Institutional and Waiver Criteria.** *(By checking this box the State assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the State has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
The needs based eligibility criteria are described in #4.	Wisconsin Law allows reimbursement to nursing homes for eligible persons who require skilled, intermediate, or limited levels of nursing care. Wis. Stat. § 49.45(6m)(i). Those levels are defined in Wis. Adm. Code § DHS 132.13. Wisconsin's BC waiver criteria for nursing home level of care are as follows: A person is functionally eligible at the nursing home level if the person requires ongoing care, assistance or supervision from another person, as is evidenced by any of the following findings from application of the functional screening: 1. The person cannot safely or appropriately perform 3 or more activities of daily living. 2. The person cannot safely or appropriately perform 2 or more ADLs and one or more instrumental activities of daily living. 3. The person cannot safely or appropriately perform 5 or more IADLs.	ICF_MR referred to in Wisconsin as FDD (Facility serving people with developmental disabilities) Wis. Adm. Code § DHS 134.13 contains the following definitions: **(13)** "FDD" or "facility serving people with developmental disabilities" means a residential facility with a capacity of 4 or more individuals who need and receive active treatment and health services as needed. **(2)** "Active treatment" means an ongoing, aggressive and consistently applied program of training and treatment services to allow the client to function as independently as possible and maintain his or her maximum functional	For inpatient hospital psychiatric emergency detention or involuntary commitment, state statutes require that: 1) The individual is mentally ill, drug dependent, or developmentally disabled; 2) The individual presents an immediate danger of harm to self or others based on a recent act or omission; and 3) Inpatient hospitalization is the least restrictive placement consistent with the requirements of the individual (i.e., the individual's needs can only be met on an inpatient basis). IMD hospital admissions nearly always occur on an emergency detention or involuntary commitment basis. For a voluntary admission (to a psychiatric unit of a general hospital), the inpatient services must: 1) Directed by a

		abilities. **(9)** "Developmental disability" means mental retardation or a related condition such as cerebral palsy, epilepsy or autism, but excluding mental illness and infirmities of aging, which is: (a) Manifested before the individual reaches age 22; (b) Likely to continue indefinitely; and (c) Results in substantial functional limitations in 3 or more of the following areas of major life activity: 1. Self–care; 2. Understanding and use of language; 3. Learning; 4. Mobility; 5. Self–direction; and 6. Capacity for independent living.	physician or dentist; and 2) Be medically necessary as certified by a physician or dentist. Among the criteria in the state definition of "medical necessity" is the requirement that the service (e.g., inpatient hospitalization) is the most appropriate level of service that can safely and effectively be provided to the recipient/individual.

*Long Term Care/Chronic Care Hospital

(By checking the following boxes the State assures that):

6. **X Reevaluation Schedule**. Needs-based eligibility reevaluations are conducted at least every twelve months.

7. **X Adjustment Authority**. The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

8. **X** **Residence in home or community**. The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving State plan HCBS:

(i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or

(ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State. *(If applicable, specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):*

Wisconsin's 1915i services will expect recovery, outcome based services that are individualized based on the needs identified through the comprehensive assessment and person-centered planning process. This includes identifying the type of community setting most able to meet the individuals assessed support needs and individual choice. There is not an automatic placement into a service. An individual choice may require that professionals assess the housing choice and assist with recommendations for modifications that promote both independence and safety. A care manager is required to use a person centered planning process. The consumer and the care manager decide together on the appropriateness of the community setting.

The choice of the home and the decoration of personal space by the individual as well as the neighborhood are basic rights promoted through the use of person centered planning. Opportunity to exercise personal freedom in all domains will be promoted through training of qualified staff. Participation in community events, activities and resources will be supported and limits exercised only where required to assure safety. As an example, if a person is at risk around sharp knives they would not be excluded from activities in their kitchen. Instead the knives would be stored safely. Community integration has many features and are dependent on the person's preferences and availability. Establishing choices for each person is a process of asking, learning in a trusting relationship, and providing the means to access services, supports and naturally occurring activities offered to anyone in the community at large. Many of the services offered to gain such participation will be skill building and self management strategies. Peer Specialists are often the best teachers and models supporting this type of service. They are part of the state work force to bring about system and person specific transformation.

The type of residential setting needed would be determined by the person-centered assessment. Allowable settings other than the individuals own home or apartment are Adult Family Homes (AFH), Residential care apartment complex (RCAC), and community based residential facilities (CBRF).

RCACs are by definition independent apartments with a lockable entrance and exit, a kitchen including a stove and individual bathroom, sleeping and living areas. RCAC settings are apartment complexes that offer additional services and supports to its residents. These settings are the individual's home apartment. As in any apartment setting, the owner/manager of the building may have rules or limitations to manage the building and the day to day management of the environment and services. The state has administrative rules and quality oversight that assure individuals' rights and safety in such settings.

Care Managers would be responsible for determining that AFH's offer individuals opportunity to participate in community activities. AFH's would need to offer private personal quarters or the choice of whom to share their room with and access to food and food preparation areas.

CBRF's are the most restrictive of the community residential options which is a facility that provides from 5 to 16 beds (inclusive). For this reason, only individuals whose health and safety are at risk without 24hr supervision will receive 1915(i) services in a CBRF. The care manager together with the person receiving 1915(i) services will determine that the residence is a community setting and offers opportunities for independence, choice and community integration. Wisconsin has developed standards to ensure that these facilities are community based.

Person-Centered Planning & Service Delivery

(By checking the following boxes the State assures that):

1. X There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:

- An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified as defined in 42 CFR §441.568;
- Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;
- An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the plan of care as required in 42 CFR §441.565;
- An examination of the individual's physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the plan of care, a caregiver assessment;
- If the State offers individuals the option to self-direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
- A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.

2. X Based on the independent assessment, the individualized plan of care:

- Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
- Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;
- Prevents the provision of unnecessary or inappropriate care;
- Identifies the State plan HCBS that the individual is assessed to need;
- Includes those services, the purchase or control of which the individual elects to self-direct, meeting the requirements of 42 CFR §441.574(b) through (d);
- Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
- Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.

3. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. *(Specify qualifications):*

The assessment will be completed by a care manager.

1. A care manager shall have the skills and knowledge typically acquired:

a. Through a course of study and practice experience that meets requirements for state certification/licensure as a social worker and also one year experience working with persons living with mental illness, or

b. Through a course of study leading to a BA/BS degree in a health or human services related field and one year of experience working with persons living with mental illness, or

c. Through a minimum of four years experience as a care manager, or

d. Through an equivalent combination of training and experience that equals four years of long term support and/or mental health practice in care management, or

e. The completion of a course of study leading to a degree as a registered nurse and one year employment working with persons living with mental illness.

2. The care manager shall be knowledgeable of person centered planning, the service delivery system, the needs of persons living with mental illness, and the availability of mental health recovery focused services and resources or the need for such services and resources to be developed.

3. Providers of care management are subject to the required criminal, caregiver and licensing background checks and hiring prohibitions as prescribed by the SMA.

4. **Responsibility for Plan of Care Development**. There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. *(Specify qualifications):*

The service plan will be developed by the care manager with the participant and other appropriate parties determined appropriate by the participant.

1. A care manager shall have the skills and knowledge typically acquired:

a. Through a course of study and practice experience that meets requirements for state certification/licensure as a social worker and also one year experience working with persons living with mental illness, or

b. Through a course of study leading to a BA/BS degree in a health or human services related field and one year of experience working with persons living with mental illness, or

c. Through a minimum of four years experience as a care manager, or

d. Through an equivalent combination of training and experience that equals four years of long term support and/or mental health practice in care management, or

e. The completion of a course of study leading to a degree as a registered nurse and one year employment working with persons living with mental illness.

2. The care manager shall be knowledgeable of person centered planning, the service delivery system, the needs of persons living with mental illness, and the availability of mental health recovery focused services and resources or the need for such services and resources to be developed.

3. Providers of care management are subject to the required criminal, caregiver and licensing background checks and hiring prohibitions as prescribed by the SMA.

5. **Supporting the Participant in Plan of Care Development**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the plan of care development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

The care manager will provide information both verbally and in writing to the participant about the person-centered planning process, their opportunity to include others to participate in the planning, the services available through the program and that they will be able to select qualified service providers of their choice. The care manager will ensure that the participant and others they choose are fully involved in the plan development. Service plan meetings are conducted at times and places that are convenient for the participant. The care manager will document on the service plan those in attendance at the plan development. The care manager will ensure that the participant and legal representative sign and date the service plan and that they receive a copy of the completed plan.

6. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the plan of care):*

The care manager will provide information and answer questions before and during the service plan development about the qualified service providers available to meet the assessed needs of the participant. The care manager will assist the participant in contacting and /or visiting the service provider to determine if they are a good match. On an ongoing basis thereafter, the care manager will assist the participant in interactions with service providers, including but not limited to selecting different providers who may prove to be a better match for them. All willing providers will have the opportunity to register with the DHS. The care manager will assist the person on an ongoing basis to assure that the service plan continues to meet their needs.

7. **Process for Making Plan of Care Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

The care manager will submit the completed and signed service plan to the DHS. Services are not authorized until DHS has approved the service plan.

8. **Maintenance of Plan of Care Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

X	Medicaid agency		Operating agency	X	Case manager
☐	Other *(specify):*				

Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Psychosocial Rehabilitation
Service Definition (Scope):	

Community Living Supportive Services (CLSS)

This service covers activities necessary to allow individuals to live with maximum independence in community integrated housing. Activities are intended to assure successful community living through utilization of skills training, cuing and/or supervision as identified by the person-centered assessment. Community Living supportive services consist of meal planning/preparation, household cleaning, personal hygiene, reminders for medications and monitoring symptoms and side effects, teaching parenting skills, community resource access and utilization, emotional regulation skills, crisis coping skills, shopping, transportation, recovery management skills and education, financial management, social and recreational activities, and developing and enhancing interpersonal skills. CLSS tasks, such as meal planning, cleaning, etc. are not done for the individual, but rather they are delivered through training, cueing, and supervision to help the participant become more independent in doing these tasks.

Wisconsin would make these services available in a variety of community locations that encompass residential, business, social and recreational settings. Residential settings are limited to an individual's own apartment or house, supported apartment programs, adult family homes (AFH), residential care apartment complexes (RCAC), and community based residential facilities (CBRF's) of from 5 to 16 beds (inclusive). The type of residential setting needed would be as agreed upon in the person-centered assessment. Individuals needing services in a CBRF setting would be those whose health and safety are at risk without 24hr supervision. Payment is not made for room and board including the cost of building maintenance.

The services provided under 1915(i) will not be duplicative of other State Plan services, including but not limited to personal care and transportation.

Supported employment

This service covers activities necessary to assist individuals to obtain and maintain competitive employment. This service may be provided by a supported employment program agency or individual employment specialist. The service will follow the Individual Placement and Support (IPS) model recognized by SAMHSA to be an evidence-based practice. This model has been shown to be effective in helping individuals obtain and maintain competitive employment. This promotes recovery through a community integrated socially valued role and increased financial independence. The core principles of this supported employment approach are:

- Participation is based on consumer choice. No one is excluded because of prior work history, hospitalization history, substance use, symptoms, or other characteristics. No one is excluded who wants to participate.
- Supported employment is closely integrated with mental health treatment. Employment specialists meet frequently with the mental health treatment team to coordinate plans.
- Competitive employment is the goal. The focus is community jobs anyone can apply for that pay at least minimum wage, including part-time and full-time jobs.
- Job search starts soon after a consumer expresses an interest in working. There are no requirements for completing extensive pre-employment assessment and training, or intermediate work experiences (like pre-vocational work units, transitional employment, or sheltered workshops).
- Follow-along Supports are Continuous. Individualized supports to maintain employment continue as long as the consumer wants assistance.
- Consumer preferences are important. Choices and decisions about work and support are individualized based on the person's preferences, strengths, and experiences.

The service covers supported employment intake, assessment (not general 1915(i) intake and assessment), job development, job placement, work related symptom management, employment crisis support, and follow-along supports by an employment specialist. It also covers employment specialist time spent with the individual's mental health treatment team and Vocational Rehabilitation (VR) counselor. The Wisconsin 1915(i) HCB services will not duplicate other State Plan services. The Supported employment service does not include services available as defined in S4 (a) (4) of the 1975 Amendments to the Education of the Handicapped Act (20 U.S.C. 1401(16), (17)) which otherwise are available to the individual through a State or local educational agency and vocational rehabilitation services which are otherwise available to the individual through a program funded under S110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

Peer Supports
Individuals trained and certified as Peer Specialists serve as advocates, provide information and peer support for consumers in outpatient and other community settings. All consumers receiving 1915(i) peer support services will reside in home and community settings. Certified Peer Specialists perform a wide range of tasks to assist consumers in regaining control over their own lives and over their own recovery process. Peer Specialists function as role models demonstrating techniques in recovery and in ongoing coping skills through: (a) offering effective recovery-based services; (b) assisting consumers in finding self-help groups; (c) assisting consumers in obtaining services that suit that individual's recovery needs; (d) teaching problem solving techniques; (e) teaching consumers how to identify and combat negative self-talk and how to identify and overcome fears; (f)assisting consumers in building social skills in the community that will enhance integration opportunities; (g) lending their unique insight into mental illness and what makes recovery possible; (h) attending treatment team and crisis plan development meetings to promote consumer's use of self-directed recovery tools; (i) informing consumers about community and natural supports and how to utilize these in the recovery process; and (j)assisting consumers in developing empowerment skills through self-advocacy and stigma-busting activities. 1915(i) HCBS will not duplicate other State Plan services.
Additional needs-based criteria for receiving the service, if applicable *(specify):*
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*
☐ Categorically needy *(specify limits):*
☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Community Living Supportive Services:			
➢ **Adult Family Homes (AFH)**	WI Statute Chapter 50 and Administrative Rule DHS 88 for 3-4 bed Adult Homes		Providers are subject to the required caregiver, criminal and licensing background checks. 15 hrs of training related to fire safety, first aid, health, safety and welfare of residents, resident rights, and treatment.
➢ **Community Based Residential Facility (CBRF)**	WI Statute Chapter 50 and Administrative Rule DHS 83 for 5 to 16 beds		Providers are subject to the required caregiver, criminal and licensing background checks. Orientation and ongoing training required that includes: training on job responsibilities, prevention and reporting of resident abuse, neglect, assessing needs and individual services, emergency and disaster plans and evacuation procedures, recognizing and responding to resident changes of condition, fire safety, first aid and choking, medication safety, standard precautions, resident rights, recognizing, preventing and responding to challenging behaviors.
➢ **Residential Care Apartment Complex (RCAC)**	WI Statute Chapter 50 and Administrative Rule DHS 89		Providers are subject to the required caregiver, criminal and licensing background checks. Training required in the services the staff are assigned; safety procedures, including fire safety, first aid, universal precautions and the facilities emergency plan, tenant rights and privacy, autonomy and independence, physical, functional and psychological characteristics of the tenant population.
➢ **Supportive Home Care Agency , Home Health Agency or Individual**	WI Statute Chapter 50. Administrative Rule DHS 133.	Administrative Code DHS 105.17.	Providers are subject to the required caregiver, criminal and licensing background checks. Orientation to job duties, policies of agency, information on other community agencies, ethics, confidentiality of patient information and patients' rights, prevention of infections. Continuing education required as appropriate to job.
➢ **Household/Chore Services Agency or Individual**			Providers are subject to caregiver, criminal and licensing background checks. Orientation for job duties, polices of agency, information about other community agencies, ethics, confidentiality of patient information, patients' rights, infection control and continuing education as required by duties.

Supported Employment:			
➢ **Supported Employment Program or Individual Employment Specialist**			One year experience working with persons living with mental illness and IPS Supported Employment Specialists Competencies developed by Dartmouth (09/09).
Peer Supports:			
➢ **Peer Specialist Agency or Individual**		Certification that the Peer Specialist has successfully completed an approved training course and that they have passed the competency based exam.	Providers are subject to caregiver, criminal and licensing background checks. Curricula of Wisconsin approved Certified Peer Specialist training include cultural competence, consumer rights, ethics and boundaries, crisis planning, trauma-informed care, and specifics to the peer specialist's role. Peer specialists will be supervised by a mental health professional.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Adult Family Homes (AFH)	**County/Tribal Agency – Human Service Department or Department of Community Programs**	**Annually**
Community Based Residential Facility (CBRF)	**County/Tribal Agency – Human Service Department or Department of Community Programs**	**Annually**
Residential Care Apartment Complex (RCAC)	**County/Tribal Agency – Human Service Department or Department of Community Programs**	**Annually**
Supportive Home Care Agency or Individual	**County/Tribal Agency – Human Service Department or Department of Community Programs**	**Annually**
Household/Chore Services Agency or Individual	**County/Tribal Agency – Human Service Department or Department of Community Programs**	**Annually**
Supported Employment Prog. or Individual Employment Specialist	**County/Tribal Agency – Human Service Department or Department of Community Programs**	**Annually**
Peer Specialist Agency/Individual	**County/Tribal Agency – Human Service Department or Department of Community Programs,** **Human Service Department Care Manager**	**Every other year** **Ongoing oversight & monitoring**

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	X	Provider managed

2. X **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the State assures that):* There are policies pertaining to payment the State makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the State makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) how the State ensures that the provision of services by such persons is in the best interest of the individual; (c) the State's strategies for ongoing monitoring of services provided by such persons; (d) the controls to ensure that payments are made only for services rendered; and (e) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Wisconsin's 1915(i) program will be consistent with the DHS HCBS 1915 c waiver programs in regards to payment for State plan HCBS furnished by relatives, legally responsible individuals and legal guardians. Thus the following limitations will be followed. Legal guardians, spouses of 1915(i) participants or the parents of minor children who are 1915 (i) participants will not be paid for providing any service. However, county/tribal agencies may choose to reimburse those persons for services provided to 1915(i) participants using other funding sources. Relatives not falling under the above exceptions may provide HCBS services in the quantity and to the extent determined by the needs of the consumer as specified in the individual assessment and care plan.

Oversight of this policy will be part of the on-going quality review of the person centered plan of care and provider qualifications conducted on an ongoing basis by the DHS. Further provider qualifications review will occur at the annual review process.

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. **Election of Participant-Direction.** (*Select one):*

X	The State does not offer opportunity for participant-direction of State plan HCBS.
O	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
O	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the State. *(Specify criteria):*

2. **Description of Participant-Direction.** *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

3. **Limited Implementation of Participant-Direction.** (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

O	Participant direction is available in all geographic areas in which State plan HCBS are available.
O	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals who reside in these areas may elect self-directed service delivery options offered by the State, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the State affected by this option):*

4. **Participant-Directed Services.** *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

5. **Financial Management.** *(Select one):*

O	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
O	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Plan of Care.** *(By checking this box the State assures that):* Based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

7. **Voluntary and Involuntary Termination of Participant-Direction.** *(Describe how the State facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff). *(Select one):*

○	The State does not offer opportunity for participant-employer authority.
○	Participants may elect participant-employer Authority *(Check each that applies):*
☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide 1915 (i) services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide 1915 (i) services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget). *(Select one):*

○	The State does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the plan of care):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards):*

Quality Improvement Strategy

(Describe the State's quality improvement strategy in the tables below):

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** ***(Source of Data & sample size)***	**Monitoring Responsibilities** *(agency or entity)*	**Frequency**	**Remediation Responsibil-ities** *(Who does this)*	**Frequency** *of Analysis and Aggregation*
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	1. Service plans will reflect the use of the person-centered planning approach.	1. All (100%) initial and updated service plans will be reviewed when submitted by the provider.	1. DHS (SMA)	1. Ongoing	1. DHS (SMA)	1. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.
	2. Participants choice of providers will be documented in the service plan by the case manager.	2. All (100%) service plans will be reviewed for documentation of participant choice of providers	2. DHS (SMA)	2. Annually	2. DHS (SMA)	2. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.
	3. Interviews of participant satisfaction will be conducted.	3. Representative sampling of interview results will be reviewed and put into a summary report. The State's sampling methodology will ensure a 95 percent confidence	3. DHS (SMA)	3. Annually or at disenrollment	3. DHS (SMA)	3. If a corrective action plan is needed it must be provided within 15 days

		level with a 5 percent margin of error (confidence interval). The sample will be drawn from the universal population, which is defined as the total number of approved 1915i participants. The sample size will be determined by applying the methodology to the universal population.				and the state will respond in 15 days for a total of 30 days.
	4. Participant needs assessment conducted by the case manager.	4. Representative sampling of case files will be reviewed. The State's sampling methodology will ensure a 95 percent confidence level with a 5 percent margin of error (confidence interval). The sample will be drawn from the universal population, which is defined as the total number of approved 1915i participants. The sample size will be determined by applying the methodology to the universal population.	4. DHS (SMA)	4. Annually	4. DHS (SMA)	4. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.
	5. All willing providers have the opportunity to register with the DHS.	5. Representative sampling of service plans will be reviewed. . The State's sampling methodology will ensure a 95 percent confidence level with a 5 percent margin of error (confidence interval). The sample will be drawn from the universal population, which is defined as the total number of approved 1915i participants. The sample size will be determined by applying the methodology to the universal population.	5. DHS (SMA)	5. Annually	5. DHS (SMA)	5. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.

	6. Services are delivered in accordance with the service plan.	_6. Representative sampling of services delivered will be reviewed. . The State's sampling methodology will ensure a 95 percent confidence level with a 5 percent margin of error (confidence interval). The sample will be drawn from the universal population, which is defined as the total number of approved 1915i participants. The sample size will be determined by applying the methodology to the universal population.	6. DHS (SMA)	6. Annually	6. DHS (SMA)	6. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.
Providers meet required qualifications.	1. All providers meet requirements established by DHS and documented by the case manager.	1. Representative sampling of case files will be reviewed. The State's sampling methodology will ensure a 95 percent confidence level with a 5 percent margin of error (confidence interval). The sample will be drawn from the universal population, which is defined as the total number of approved 1915i participants. The sample size will be determined by applying the methodology to the universal population.	1. DHS (SMA)	1. Annually	1. DHS (SMA)	1. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.
	2. All providers have a current agreement with the SMA.	2. Presence of MA agreement in sampling of case records. The State's sampling methodology will ensure a 95 percent confidence level with a 5 percent margin of error (confidence interval). The sample will be drawn from the universal population, which is defined as the total number of	2. DHS (SMA)	2. Annually	2. DHS (SMA)	2. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.

		approved 1915i participants. The sample size will be determined by applying the methodology to the universal population.				

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** ***(Source of Data & sample size)***	**Monitoring Responsibilities** *(agency or entity)*	**Frequency**	**Remediation Responsibil-ities** *(Who does this)*	**Frequency** *of Analysis and Aggregation*
The SMA retains authority and responsibility for program operations and oversight.	1. Case files will reflect that local non-state entities and providers adhere to federal and state program requirements, policies and regulations for 1915i program.	1. Representative sampling record reviews of case files, mental health functional screen, service provider records, monitoring reports and on-site interviews. The State's sampling methodology will ensure a 95 percent confidence level with a 5 percent margin of error (confidence interval). The sample will be drawn from the universal population, which is defined as the total number of approved 1915i participants. The sample size will be determined by applying the methodology to the universal population.	1. DHS (SMA)	1. Annually	1. DHS (SMA)	1. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.
	2. Presence of the county entities entering accurate information into the automated functional screen.	2. All (100%) initial and updated automated functional screens will be reviewed when service plan packets are submitted by the county entity.	2. DHS (SMA	2. Ongoing	2. DHS (SMA	2. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15

						days for a total of 30 days.
The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.	1. DHS oversight through the MMIS system to assure claims are coded and paid in accordance with the state plan.	1. MMIS Reports	1. DHS (SMA)	1. Ongoing	1. DHS (SMA)	1. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days
	2. Representative sample of claims, case files and service plans.	2. Program review of MMIS Reports, documentation of sample selection process.	2. DHS (SMA)	2. Annually	2. DHS (SMA)	2. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days
	3. Claims are authorized and furnished appropriately.	3. Program testing in annual single audit of county agency.	3. DHS (SMA)	3. Annually	3. DHS (SMA)	3. If a corrective action plan is needed it must be provided within 45 days and the state will respond in 45 days for a total of 90 days
The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	1. Service plans address health and welfare needs of the participant.	1. Representative sampling record reviews of case files, service plans and outcomes, mental health functional screen, service provider records, monitoring reports and on-site interviews. The State's sampling methodology will ensure	1. DHS (SMA)	1. Annually	1. DHS (SMA)	1. Immediate safety issues identified must have a corrective action plan within 3 days. If a corrective

		a 95 percent confidence level with a 5 percent margin of error (confidence interval). The sample will be drawn from the universal population, which is defined as the total number of approved 1915i participants. The sample size will be determined by applying the methodology to the universal population.				action plan is needed that is not urgent, it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.
	2. Providers will complete and submit incident reports as required by DHS policy.	2. All (100%) of incident reports will be reviewed to ensure appropriate actions have been taken. Adverse incidents are reported to the county case manager (CM). The CM reviews the situation and takes steps to protect safety of participant. The CM immediately notifies, as appropriate, the DHS Division of Quality Assurance. The CM also notifies the state 1915(i) coordinator. All critical incidents tracked by the state 1915(i) coordinator who will follow-up as needed. Coordinator will review incidents for any patterns that would suggest the need for further investigation or technical assistance.	2. DHS (SMA)	2. Ongoing	2. County Agency and DHS (SMA)	2. Reported to care manager within 24 hrs. Reported to state within 3 days with corrective action plan. State reviews plan and responds within 10 days. Formal report submitted by county to state on outcome of corrective action in 30 days.
	3. CLSS providers supply medication reminders to participants and monitor their signs and symptoms and side-effects.	3. Representative sampling record reviews of case files, service provider records, monitoring reports and on-site interviews. The State's sampling methodology will ensure a 95 percent confidence	3. DHS (SMA)	3. Annually	3. DHS (SMA)	3. Immediate safety issues identified must have a corrective action plan within 3 days.

		level with a 5 percent margin of error (confidence interval). The sample will be drawn from the population of 1915(i) CLSS recipients, and not the universal 1915(i) population				If a corrective action plan is needed that is not urgent, it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.

System Improvement: *(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)*			
Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
1. The automated functional screen provides a great deal of information regarding individuals' functioning. Wisconsin intends to compare the initial screen to subsequent annual screens. We expect to see decreases in a variety of indicators such as ER use, inpatient stays, emergency detentions, physical aggression, and housing instability. Previous analysis of this data with other MH programs has demonstrated a high degree of statistical significance.	This analysis will be done by the DHS (SMA)	Annually	1. Counties with a high rate on one of these indicators that does not show comparable decreases over time will be asked to develop a Quality Improvement project around that indicator. Counties will be expected to maintain data to track improvements from the changes they make and to continue to make adjustments until they see an improvement in the specific indicator.
2. Adverse incident reports will also be tracked	DHS (SMA)	Annually	2. Counties with a pattern of incident reports may be asked to obtain training and/or implement a quality improvement project as appropriate. If patterns of adverse incident reports are noted across counties, the state will provide training to address those issues.

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates)*:

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☐	HCBS Habilitation
☐	HCBS Respite Care

For Individuals with Chronic Mental Illness, the following services:

☐	HCBS Day Treatment or Other Partial Hospitalization Services
X	HCBS Psychosocial Rehabilitation

COMMUNITY LIVING SUPPORTIVE SERVICES

OVERVIEW

Providers will be reimbursed on an interim basis for Medicaid-covered Community Living Supportive Services provided to Medicaid-eligible clients for covered services delivered on or after the implementation date of these services. Providers submit CMS-approved annual cost reports of certified public expenditures, identifying total allowable Medicaid costs, including both federal and nonfederal expenditures for Medicaid-covered services provided by Medicaid qualified providers. The annual cost report will utilize federal principles of cost apportionment and federally required reporting methods. The report will include all expenditures related to the calculation of the Medicaid-allowable cost per unit of service. The Wisconsin Department of Health Services (DHS) will reconcile the Medicaid-allowable cost per unit of service to the provider's interim rate and cost settle the difference on all units of service delivered to Medicaid-eligible clients during the reporting period.

INTERIM RATES

On an interim basis, providers will be reimbursed the lower of billed charges or the interim rate. The interim rate is provisional payment pending the completion of the cost reconciliation and cost settlement processes for the cost report year. Public providers provide the nonfederal share through the certification of public expenditures process and, as a result, will only be reimbursed the federal share on an interim basis and upon final settlement.

Interim rates for Community Living Supportive Services are established by the State. There will be two rates; one for services in the individual's own home or apartment and another for residential settings such as CBRF's and AFH's. There is a high degree of variability of the costs of residential settings currently serving individuals with mental illness. This variability is a result of the level of need of the individuals in a particular setting. Some AFHs serve individuals with greater needs than some CBRF's and vice versa. The residential interim rate was set at a level to meet the costs of a majority of residential settings, but not so high as to result in frequent overpayments.

Initial interim rates are based on a review of rate setting methods for similar services of selected states and a review of rates for similar services currently provided in Wisconsin.

The review of selected states determined reimbursement practices used in other states for similar services. Information reviewed included the scope of the programs under which the services are provided, the eligibility criteria for the programs and the methodology each state uses to calculate and set interim rates. Considerations for

selecting states included geography, demographics, history of individual states' waiver programs, and examples of states cited as national models.

The review analyzed programs within Wisconsin that provide services to persons with mental illness that are similar in scope. Survey data was collected regarding those costs. Additional in depth analysis was completed at two counties currently providing these services.

The combination of the results of the other state review and review of similar state services determined best practices that the state followed in developing its interim rates.

After the completion and desk review of the first full year cost report, DHS will reevaluate its interim rates and revise them to reflect actual 1915(i) cost data reported by the counties.

ANNUAL COST REPORT PROCESS

Each governmental provider will complete an annual cost report in the format required by DHS and approved by CMS. Such cost report shall utilize and be incorporated into the state's proven Wisconsin Medicaid Cost Report (WIMCR) system, but with refinements to capture greater unit cost detail related to 1915(i).The report will cover services delivered in the prior calendar year and be due by May 1 of the following year. The following steps will be used to determine Medicaid-allowable cost per unit of service:

A. The provider will identify direct costs to provide the covered services. Direct costs include residential facility costs exclusive of room and board, including residential staff costs, and operating costs such as client transportation, staff training, and staff certification

B. The provider will identify nondirect and overhead costs to provide the covered services. Allocation of these costs to the covered services can be based on the salaries method, cost-to-cost method, or pro rata method. Nondirect and overhead costs include costs for nondirect service staff (e.g., administrators, supervisors, clerical, and other) and allowable overhead costs as dictated by the DHS Allowable Cost Policy Manual and OMB Circular A-87.

C. The results from Paragraph A will be combined with the results from Paragraph B, to result in total allowable costs for the covered service for all payers.

D. The results from Paragraph C will be divided by the total number of units of service irrespective of payer for the reporting period to result in the cost per unit of service.

E. The results from Paragraph D will be multiplied by the number of Medicaid allowable units of service.

COST RECONCILIATION AND COST SETTLEMENT

DHS will review the annual cost reports submitted by providers, making adjustments as necessary in accordance with cost report instructions and the scope of costs approved by CMS.

The adjusted Medicaid-allowable cost per unit of service will be compared/reconciled to the provider's interim rate per service. The difference will be applied to the provider's total Medicaid allowable units of service in the cost settlement process.

Providers will be notified of all adjustments to their cost reports and the resulting cost settlement amounts, indicating the amount due to or from the provider, no later than 24 months after the close of the applicable cost-reporting period.

The State cannot adjust its interim rates prospectively to account for overpayment. Instead, if the provider's interim payments exceed the actual, certified costs of the provider, the federal share of the overpayment will be recouped either from offsetting all future claims payments from the provider until the amount of the federal share of the overpayment is recovered or the provider will return an amount equal to the overpayment in a lump sum payment.

If the provider's Medicaid-allowable costs exceed its interim payments, the federal share of the difference will be paid to the provider in accordance with the final certification agreement and claims will be submitted to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

SUPPORTED EMPLOYMENT

OVERVIEW

Providers will be reimbursed on an interim basis for Medicaid-covered Supported Employment services provided to Medicaid-eligible clients delivered on or after the implementation date of these services. Providers submit CMS-approved annual cost reports of certified public expenditures, identifying total allowable Medicaid costs, including both federal and nonfederal expenditures for Medicaid-covered services provided by Medicaid qualified providers. The annual cost report will utilize federal principles of cost apportionment and federally required reporting methods. The report will include all expenditures related to the calculation of the Medicaid-allowable cost per unit of service. The Wisconsin Department of Health Services (DHS) will reconcile the Medicaid-allowable cost per unit of service to the provider's interim rate and cost

settle the difference on all units of service delivered to Medicaid-eligible clients during the reporting period.

INTERIM RATES

On an interim basis, providers will be reimbursed the lower of billed charges or the interim rate. The interim rate is provisional payment pending the completion of the cost reconciliation and cost settlement processes for the cost report year. Public providers provide the nonfederal share through the certification of public expenditures process and, as a result, will only be reimbursed the federal share on an interim basis and upon final settlement.

Interim rates for Supported Employment services are established by the State and there is a single statewide interim rate for the service.

Initial interim rates are based on a review of rate setting methods for similar services of selected states and a review of rates for similar services currently provided in Wisconsin.

The review of selected states determined reimbursement practices used in other states for similar services. Information reviewed included the scope of the programs under which the services are provided, the eligibility criteria for the programs and the methodology each state uses to calculate and set interim rates. Considerations for selecting states included geography, demographics, history of individual states' waiver programs, and examples of states cited as national models.

The review analyzed programs within Wisconsin that provide services to persons with mental illness that are similar in scope. Survey data was collected regarding those costs. Additional in depth analysis was completed at two counties currently providing these services.

The combination of the results of the other state review and review of similar state services determined best practices that the state followed in developing its interim rates.

After the completion and desk review of the first full year cost report, DHS will reevaluate its interim rates, and revise them to reflect actual Community Recovery Services (1915(i)) cost data reported by the counties.

ANNUAL COST REPORT PROCESS

Each governmental provider will complete an annual cost report in the format required by DHS and approved by CMS. Such cost report shall utilize and be incorporated into the state's proven Wisconsin Medicaid Cost Report (WIMCR) system, but with refinements to capture greater unit cost detail related to 1915(i). The report will cover services delivered in the prior calendar year and be due by May 1 of the following year. The following steps will be used to determine Medicaid-allowable cost per unit of service:

F. The provider will identify direct costs to provide the covered services. Direct costs include staff costs (e.g., salaries, payroll taxes, employee benefits, and contacted compensation) of service providers and costs directly related to the approved services providers for the delivery of covered services, such as purchased services, staff travel/training, licensure/certification renewal and/or continuing education costs, and materials and supplies.

G. The provider will identify nondirect and overhead costs to provide the covered services. Allocation of these costs to the covered services can be based on the salaries method, cost-to-cost method, or pro rata method. Nondirect and overhead costs include costs for nondirect service staff (e.g., administrators, supervisors, clerical, and other) and allowable overhead costs as dictated by the DHS Allowable Cost Policy Manual and OMB Circular A-87.

H. The results from Paragraph F will be combined with the results from Paragraph G, to result in total allowable costs for the covered service for all payers.

I. The results from Paragraph H will be divided by the total number of units of service irrespective of payer for the reporting period to result in the cost per unit of service.

J. The results from Paragraph I will be multiplied by the number of Medicaid allowable units of service.

COST RECONCILIATION AND COST SETTLEMENT

DHS will review the annual cost reports submitted by providers, making adjustments as necessary in accordance with cost report instructions and the scope of costs approved by CMS.

The adjusted Medicaid-allowable cost per unit of service will be compared/reconciled to the provider's interim rate per service. The difference will be applied to the provider's total Medicaid allowable units of service in the cost settlement process.

Providers will be notified of all adjustments to their cost reports and the resulting cost settlement amounts, indicating the amount due to or from the provider, no later than 24 months after the close of the applicable cost-reporting period.

The State cannot adjust its interim rates prospectively to account for overpayment. Instead, if the provider's interim payments exceed the actual, certified costs of the provider, the federal share of the overpayment will be recouped either from offsetting all future claims payments from the provider until the amount of the federal share of the overpayment is recovered or the provider will return an amount equal to the overpayment in a lump sum payment.

If the provider's Medicaid-allowable costs exceed its interim payments, the

federal share of the difference will be paid to the provider in accordance with the final certification agreement and claims will be submitted to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

PEER SUPPORTS

OVERVIEW

Providers will be reimbursed on an interim basis for Medicaid-covered Peer Supports services provided to Medicaid-eligible clients delivered on or after the implementation date of these services. Providers submit CMS-approved annual cost reports of certified public expenditures, identifying total allowable Medicaid costs, including both federal and nonfederal expenditures for Medicaid-covered services provided by Medicaid qualified providers. The annual cost report will utilize federal principles of cost apportionment and federally required reporting methods. The report will include all expenditures related to the calculation of the Medicaid-allowable cost per unit of service. The Wisconsin Department of Health Services (DHS) will reconcile the Medicaid-allowable cost per unit of service to the provider's interim rate and cost settle the difference on all units of service delivered to Medicaid-eligible clients during the reporting period.

INTERIM RATES

On an interim basis, providers will be reimbursed the lower of billed charges or the interim rate. The interim rate is provisional payment pending the completion of the cost reconciliation and cost settlement processes for the cost report year. Public providers provide the nonfederal share through the certification of public expenditures process and, as a result, will only be reimbursed the federal share on an interim basis and upon final settlement.

Interim rates for Peer Supports services are established by the State and there is a single statewide interim rate for the service.

Initial interim rates are based on a review of rate setting methods for similar services of selected states and a review of rates for similar services currently provided in Wisconsin.

The review of selected states determined reimbursement practices used in other states for similar services. Information reviewed included the scope of the programs under which the services are provided, the eligibility criteria for the programs and the methodology each state uses to calculate and set interim rates. Considerations for selecting states included geography, demographics, history of individual states' waiver programs, and examples of states cited as national models.

The review analyzed programs within Wisconsin that provide services to persons with mental illness that are similar in scope. Survey data was collected regarding those costs. Additional in depth analysis was completed at two counties currently providing these

services.

The combination of the results of the other state review and review of similar state services determined best practices that the state followed in developing its interim rates.

After the completion and desk review of the first full year cost report, DHS will reevaluate its interim rates, and revise them to reflect actual 1915(i) cost data reported by counties.

ANNUAL COST REPORT PROCESS

Each governmental provider will complete an annual cost report in the format required by DHS and approved by CMS. Such cost report shall utilize and be incorporated into the state's proven Wisconsin Medicaid Cost Report (WIMCR) system, but with refinements to capture greater unit cost detail related to 1915(i).The report will cover services delivered in the prior calendar year and be due by May 1 of the following year. The following steps will be used to determine Medicaid-allowable cost per unit of service:

K. The provider will identify direct costs to provide the covered services. Direct costs include staff costs (e.g., salaries, payroll taxes, employee benefits, and contacted compensation) of service providers and costs directly related to the approved services providers for the delivery of covered services, such as purchased services, staff travel/training, licensure/certification renewal and/or continuing education costs, and materials and supplies.

L. The provider will identify nondirect and overhead costs to provide the covered services. Allocation of these costs to the covered services can be based on the salaries method, cost-to-cost method, or pro rata method. Nondirect and overhead costs include costs for nondirect service staff (e.g., administrators, supervisors, clerical, and other) and allowable overhead costs as dictated by the DHS Allowable Cost Policy Manual and OMB Circular A-87.

M. The results from Paragraph K will be combined with the results from Paragraph L, to result in total allowable costs for the covered service for all payers.

N. The results from Paragraph M will be divided by the total number of units of service irrespective of payer for the reporting period to result in the cost per unit of service.

O. The results from Paragraph N will be multiplied by the number of Medicaid allowable units of service.

		COST RECONCILIATION AND COST SETTLEMENT DHS will review the annual cost reports submitted by providers, making adjustments as necessary in accordance with cost report instructions and the scope of costs approved by CMS. The adjusted Medicaid-allowable cost per unit of service will be compared/reconciled to the provider's interim rate per service. The difference will be applied to the provider's total Medicaid allowable units of service in the cost settlement process. Providers will be notified of all adjustments to their cost reports and the resulting cost settlement amounts, indicating the amount due to or from the provider, no later than 24 months after the close of the applicable cost-reporting period. The State cannot adjust its interim rates prospectively to account for overpayment. Instead, if the provider's interim payments exceed the actual, certified costs of the provider, the federal share of the overpayment will be recouped either from offsetting all future claims payments from the provider until the amount of the federal share of the overpayment is recovered or the provider will return an amount equal to the overpayment in a lump sum payment. If the provider's Medicaid-allowable costs exceed its interim payments, the federal share of the difference will be paid to the provider in accordance with the final certification agreement and claims will be submitted to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)

State: Wisconsin

HealthCheck (EPSDT) Other Services, continued

4. Comprehensive Treatment

See "Comprehensive Treatment" under Behavioral Treatment Services in Section 6.d., Other Practitioners.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

A. Target Group A:

Recipients participating in Community Care Organizations (CCO's).

B. Areas of State in which services will be provided:

☐ Entire State.

☒ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

LaCrosse County, Milwaukee County, and Barron County.

Services will be available if the provider elects to participate in case management services.

C. Comparability of Services:

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Includes assessment of recipients, development of case plans and ongoing monitoring and follow-up services. To assure that recipients receive appropriate services in an effective manner, the provider is responsible for locating, coordinating and monitoring one or more medical, educational and social service.

E. Qualification of Providers:

See the narrative that follows and narrative E. in the following section for Target Group C.

E. QUALIFICATION OF PROVIDERS

Providers of case management services to recipients who are participating in Community Care Organizations (CCO's) must be knowledgeable concerning the local service delivery system, the needs and dysfunctions of this recipient group, and the need for integrated services and the resources available.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

A. Target Group B:

Recipients of early periodic screening, diagnosis and testing services (HealthCheck).

B. Areas of State in which services will be provided:

Eff. 4-1-93

[X] Entire State.

See narrative B. in the following section for Target Group C, page 1-C-1.

Currently, this benefit is available statewide, but provider participation is voluntary.

[ ] Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide).

C. Comparability of Services:

[X] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[ ] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Case Management Services are defined as including the following activities for targeted recipients: pro-active outreach to get non-users into a screening, a comprehensive health and social service assessment, referral to resources beyond the EPSDT screening process, health and MA utilization education, removal of barriers to accessing service resources (both EPSDT related, and non-covered), follow-up and linkage of the recipient to a primary care physician and dentist (as appropriate) for future care.

E. Qualification of Providers:

Medicaid-certified providers of EPSDT health assessment and evaluation services shall be eligible to receive reimbursement for EPSDT case management in accordance with the limitations contained in the case management agreement between the provider and the department.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

A. Target Group C:

Recipients who are age 65 or older. See attached.

B. Areas of State in which services will be provided:

☐ Entire State.

☒ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

The benefit is available statewide, but provider participation will be voluntary. It is assumed that initial participation of providers will see a majority of counties covered, and most target populations selected. The State will require the county board of supervisors in any county in which the benefit is provided, to elect to have this benefit offered. This will ensure coordination and enhance case management.

Eff. 4-1-93 All but the following counties have indicated that they provide case management services for persons in this target group: Adams, Douglas, Florence, Jefferson, Vernon and Washington.

C. Comparability of Services

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached.

E. Qualification of Providers:

See attached.

F. The State assures that the provision of case management services will not restrict an individual's freedom of choice with regard to providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of other health care providers under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

A. TARGET GROUP:

Targeted Group: This target group consists of persons who are:

1. At least 65 years old or older and who are:

   a. Medically eligible for Medical Assistance (MA);

   b. Recipients with a long-term chronic or irreversible illness or disability resulting in significant functional impairment;

   c. Documented as having multiple, complex, and diverse service needs and an inability or lack of a support system to meet those needs without the availability of case management;

   d. Residing in their own homes, the home of another or in a community home.

D. DEFINITION OF MEDICAID - COVERED CASE MANAGEMENT SERVICES

Case management services are those services and activities which help MA recipients, and when appropriate, their families, to identify their needs, and manage and gain access to necessary medical, social, rehabilitation, vocational, educational, and other services.

Basic Assumptions

There are some basic assumptions upon which MA coverage of case management (CM) is based.

First, CM is viewed as an instrument used by CM providers to effectively manage multiple resources for and to gain access and have linkages with needed services for the benefit of MA-eligible persons who belong to the targeted group(s).

Effective management is concerned with the adequacy, quality and continuity of CM services. Gaining access to and having linkages with needed services is concerned with the availability of services, the identification of appropriate service providers, and the determination that case management providers and other service providers can and will serve recipients. In order to further ensure the effectiveness of case management, ongoing monitoring and service coordination will be done by one case manager. This furthers consistency with regard to the delivery of CM services and affords a single contact point for the recipient.

Targeted groups consist of functionally and/or developmentally limited persons with multiple needs and/or high vulnerability who require intensive and/or ongoing intervention by health, social, and other human services providers.

Second, recipients will voluntarily participate in CM services by maintaining contact with and receiving services from case management provider(s). MA recipients will be free to choose CM services when they become aware of those services and those case management providers available to them. The State of Wisconsin is prepared to assure a recipient's knowledge and freedom of choice of provider by informing recipients through a Recipient Handbook and through MA Recipient written and telephone services. Furthermore, freedom of choice is guaranteed through service monitoring and the establishment of a complaint and investigating capacity in the Department of Health and Social Services' (DHSS) Bureau of Long Term Support. This will be in addition to the normal appeal rights to which any recipient is entitled. Recipients and their families shall participate, to the fullest extent of their ability, in all decisions regarding appropriate services and case management providers.

Even though MA is funding CM services as an enhancement of Medicaid funding and as an extension of traditional Medicaid services, the State will focus on appropriate CM practices as they relate to human services needs as well as the more specialized Medicaid requirements.

Core Elements of Case Management

MA reimbursement will be available only to CM providers with qualified staff, the capability of delivering all of the following elements of CM, and who are certified by the DHSS. It should be noted that not all recipients assessed will actually need case management. As a result of the assessment, it may be determined that further CM service components are not appropriate or necessary for a recipient. However, each case management provider must make all of the following elements available for all assessed persons who are determined to need CM services.

1. Assessment - A CM provider must have the capacity and ability to perform a written comprehensive assessment of a person's abilities, deficits, and needs. Persons from relevant disciplines should be used to document service gaps and unmet needs. All services appropriate to the recipient's needs should be part of this activity. The following areas must be documented and addressed when relevant:

a. Identifying information (referral source, emergency contacts, source of assessment information, etc.);

b. Physical and/or dental health assessments and consideration of potential for rehabilitation (health problems/concerns, current diagnoses, medications, treatments, physical and/or sensory impairments, etc.);

c. Review of the recipient's performance in carrying out activities of daily living (such as mobility levels, personal care, household chores, personal business, and the amount of assistance required);

d. Social interactive skills and activities (behavior problems or concerns, alcohol/drug abuse, etc.);

e. Record of psychiatric symptomology and mental and emotional status (intellectual functioning, mental impairments, alcohol/drug abuse, etc.);

f. Identification of social relationships and support (informal care givers, i.e., family, friends, volunteers, formal service providers, significant issues in relationships, social environment);

g. Description of the recipient's physical environment (safety and mobility in home and accessibility);

h. In-depth financial resource analysis and planning, (including identification of and coordination with insurance and veteran's benefits, and other sources of financial assistance);

i. Recipient's need for housing, residential support, adaptive equipment (and assistance with decision-making in these areas);

j. Vocational and educational status and daily structure (prognosis for employment, educational/vocational needs, appropriateness/availability of educational programs);

k. Legal status, if appropriate (guardian relationships, involvement with the legal system);

l. Accessibility to community resources needed or wanted by the recipient.

m. For a recipient identified as severely emotionally disturbed under age 21, a record of the multidisciplinary team evaluation required under state law.

n. Assessment of drug and/or alcohol use and misuse for recipients identified as alcoholic or drug dependent.

Assessments must be done by a person or persons from a discipline that matches the needs and/or dysfunctions identified in the specific target population in which the recipient is included. Persons from other disciplines will be included when results of the assessment are interpreted. Using the assessment to document service gaps and unmet needs enables the CM provider to act as an advocate for the recipient and to assist other human service providers in planning and program development on the recipient's behalf.

Should the assessment reveal that the recipient does not need CM services, appropriate referrals should be made to meet other client needs.

2. Case Plan Development - Following the assessment and determination of the need for case management, the case management provider develops a written plan of care, called the case plan, as a vehicle to address the needs of the recipient, enabling him/her to live in the community. To the maximum extent possible, the development of a case plan is a collaborative process involving the recipient, the family or other support systems and the case management provider. It is a negotiated agreement on the short- and long-term goals of care and includes at a minimum:

a. Problems identified during the assessment;

b. Goals to be achieved;

c. Identification of all formal services to be arranged for the recipient, including costs and the names of the service providers;

d. Development of a support system, including a description of the recipient's informal support system;

e. Identification of individuals who participated in development of the plan of care;

f. Schedules of initiation and frequency of the various services to be made available to the recipient, and

g. Documentation of unmet needs and gaps in service(s).

Services for every case management recipient must be guided by a written case plan.

3. Ongoing Monitoring and Service Coordination - The CM provider ascertains, on an ongoing basis, what services have been or are being delivered to a recipient, and whether they are adequate for the recipient's needs. A single case manager will be assigned to the recipient to provide supportive contact to ensure that the person is able to access services, is actually receiving services, or is engaging in activities specified in the recipient's case plan. Client and family satisfaction and participation is also monitored. The case manager will identify any changes in the client's condition that would require an adjustment in the case plan or arrangements for other services. This monitoring function does not preclude independent monitoring for purposes of evaluation of MA quality assurance.

Ongoing monitoring and service coordination includes:

a. Face-to-face and telephone contacts with recipients (who are not hospital inpatient or nursing home residents) for the purpose of assessing or reassessing needs, or planning or monitoring services;

b. Face-to-face and telephone contact with collaterals for the purposes of mobilizing services and support, advocating on behalf of a recipient, educating collaterals, and to evaluate and coordinate services specified in the plan;

c. Case management staff time spent on case-specific staffings and formal case consultation with the unit supervisor/other professionals regarding the needs of the recipient;

d. Recordkeeping necessary for case planning, coordination and service monitoring.

4. Discharge Planning

If the recipient enters an inpatient hospital, nursing facility, or ICF-MR, the case management provider may bill for discharge-related case management services up to 30 days prior to discharge from the institutional setting. WMAP discharge-related case management services may not duplicate discharge planning services that the institution normally is expected to provide as part of inpatient services.

E. QUALIFICATION OF CASE MANAGEMENT PROVIDERS

Providers - CM providers must be certified by the Department as meeting the following criteria:

1. Demonstrated capacity to provide all core elements of case management services, including:

   a. Comprehensive recipient assessment;

   b. Comprehensive case plan development;

   c. Comprehensive ongoing monitoring and services coordination.

2. Demonstrated CM experience in coordinating and linking such community resources as required by the target population(s);

3. Demonstrated experience with the needs and dysfunctions of the target population(s);

4. A sufficient staff to meet the CM service needs of the target population(s);

5. An administrative capacity to insure quality of services in accordance with State and Federal requirements;

6. A financial management capacity and system that provides documentation of services and costs;

7. Capacity to document and maintain individual case records in accordance with State and Federal requirements.

Qualifications of Personnel: Qualifications for individuals performing case management are divided into two levels: One skill level and proficiency is for individuals performing assessments and case plans, and another is for individuals performing ongoing monitoring and service coordination. It should be noted that many knowledges and skills overlap between the two groups.

Qualifications for individuals performing assessments and case planning are:

1. Knowledge concerning the local service delivery system;

2. Knowledge of the needs and dysfunctions of the target group(s);

3. Knowledge of the need for integrated services and of the resources available;

4. A degree in a related human services field and one year of experience, or two years of experience working with the persons in the targeted population(s) for which they are employed, or an equivalent combination of training and experience.

Case managers providing ongoing monitoring and service coordination must be knowledgeable about:

1. The local service(s) delivery system(s);

2. The needs and dysfunctions of the recipient group(s);

3. The need for integrated services;

4. The resources available or needing to be developed.

The knowledge with regard to the provision of ongoing monitoring and service coordination is typically gained through at least one year of supervised experience working with the persons in the program's target group(s).

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MARCH 1987

OMB No.: 0939-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

A. Target Group D:

Recipients with Alzheimer's disease or related dementia.

B. Areas of State in which services will be provided:

☐ Entire State.

☒ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

See narrative B. in the preceding section for Target Group C, page 1-C-1.

Eff. 4-1-93 All but the following counties have indicated that they provide case management services for persons in this target group: Ashland, Shawano, and Washington.

C. Comparability of Services

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See narrative D. in the preceding section for Target Group C.

E. Qualification of Providers:

See narrative E. in the preceding section for Target Group C and the narrative that follows.

A. TARGET GROUP

Target Group D: This target group consists of persons with a physician's diagnosis of Alzheimer's disease or related dementia, i.e., a degenerative disease of the central nervous system characterized especially by premature senile mental deterioration. This also includes any other irreversible deterioration of intellectual faculties with concomitant emotional disturbance resulting from this organic brain disorder.

E. QUALIFICATION OF PROVIDERS

Providers of case management services to recipients with Alzheimer's disease or related dementia must be knowledgeable concerning the local service delivery system, the needs and dysfunctions of this recipient group, and the need for integrated services and the resources available.

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MARCH 1987

OMB No.: 0939-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

A. Target Group E:

Recipients who are physically or sensory disabled.

B. Areas of State in which services will be provided:

☐ Entire State.

☒ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

See narrative B. in the preceding section for Target Group C, page 1-C-1.

Eff. 4-1-93 All but the following counties have indicated that they provide case management services for persons in this target group: Shawano and Washington.

C. Comparability of Services

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See narrative D. in the preceding section for Target Group C.

E. Qualification of Providers:

See narrative E. in the preceding section for Target Group C and the narrative that follows.

A. TARGET GROUP:

Target Group E: This target group consists of persons with one or more conditions affecting physical or sensory functioning, limiting mobility or the ability to see or hear, resulting from injury, disease or congenital deficiency which significantly interferes with or limits one or more major life activities, and the performance of major personal or social roles.

E. QUALIFICATION OF PROVIDERS

Providers of case management services to recipients with a physical or sensory disability must be knowledgeable concerning the local service delivery system, the needs and dysfunctions of this recipient group, and the need for integrated services and the resources available.

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0939-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

A. Target Group F:

Recipients who are developmentally disabled.

B. Areas of State in which services will be provided:

[X] Entire State.

See narrative B. in the preceding section for Target Group C, page 1-C-1.

Eff. 4-1-93 Currently, this benefit is available statewide, but provider participation is voluntary.

[ ] Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

[ ] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See narrative in D. in the preceding section for Target Group C.

E. Qualification of Providers:

See narrative E. in the preceding section for Target Group C and the narrative that follows.

A. TARGET GROUP

Target Group F: This target group consists of persons with one or more disabilities attributable to brain injury, cerebral palsy, epilepsy, autism, mental retardation, or other neurological condition(s) closely related to mental retardation or requiring treatment similar to that required for mental retardation, which was manifested before the individual reaches age 22, has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the affected recipient. Developmental disability does not include mental illness or senility which is primarily caused by the process or infirmities of aging.

E. QUALIFICATION OF PROVIDERS

Providers of case management services to recipients who are developmentally disabled must be knowledgeable concerning the local service delivery system, the needs and dysfunctions of this recipient group, and the need for integrated services and the resources available.

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Page 1-G-1
OMB No.: 0939-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

A. Target Group G:

Recipients who are chronically mentally ill, and age 21 or older.

B. Areas of State in which services will be provided:

☐ Entire State.

☒ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

See narrative B. in the preceding section for Target Group C, page 1-C-1.

Eff. 4-1-93 All but the following counties have indicated that they provide case management services for persons in this target group: Iowa County.

C. Comparability of Services

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See narrative D. in the preceding section for Target Group C.

E. Qualification of Providers:

See narrative E. in the preceding section for Target Group C and the narrative that follows.

A. TARGET GROUP

Target Group G: This target group consists of persons aged 21 or over with mental illness which is severe in degree and persistent in duration causing a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life. These conditions may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support, which may be of lifelong duration. The chronically mentally ill group includes persons with schizophrenia as well as a wide spectrum of psychotic and other severely disabling psychiatric diagnostic categories. This target group does not include persons with the infirmities of aging, or a primary diagnosis of mental retardation or of alcohol and/or drug dependence.

E. QUALIFICATION OF PROVIDERS

Providers of case management services to recipients who are chronically mentally ill must be knowledgeable concerning the local service delivery system, the needs and dysfunctions of this recipient group, and the need for integrated services and the resources available.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

A. Target Group H:

Recipients who are alcohol and/or other drug dependent.

B. Areas of State in which services will be provided.

☐ Entire State.

☒ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

See narrative B. in the preceding section for Target Group C, page 1-C-1.

Eff. 4-1-93 All but the following counties have indicated that they provide case management services for persons in this target group: Columbia, Douglas, Iowa, Ozaukee and Washington.

C. Comparability of Services

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See narrative D. in the preceding section for Target Group C.

E. Qualification of Providers:

See narrative E. in the preceding section for Target Group C and the narrative that follows.

A. TARGET GROUP:

Target Group H: This target group consists of persons who are dependent on drugs and/or alcohol to the extent that the person's health is substantially impaired or endangered, or economic functioning is substantially disrupted.

E. QUALIFICATION OF PROVIDERS

Providers of case management services to recipients who are alcohol or drug dependent must be knowledgeable concerning the local service delivery system, the needs and dysfunctions of this recipient group, and the need for integrated services and the resources available.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

A. Target Group I:

Recipients who are severely emotionally disturbed and under age 21.

B. Areas of State in which services will be provided:

☐ Entire State.

☒ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

See narrative B. in the preceding section for Target Group C, page 1-C-1.

Eff. 4-1-93 All but the following counties have indicated that they provide case management services for persons in this target group: Adams, Clark, Columbia, Crawford, Marinette, Pepin and Washington.

C. Comparability of Services

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See narrative D. in the preceding section for Target Group C.

E. Qualification of Providers:

See narrative E. in the preceding section for Target Group C and the narrative that follows.

A. TARGET GROUP:

Target Group I: This target group consists of persons who are under age 21 with emotional and behavioral problems which are all of the following:

a. Severe in degree, with the presence of a mental or emotional disturbance diagnosable under DSM-III-R;

b. Expected to persist for at least one year;

c. Substantially interfering with the person's functioning in the family, schools, or community and with the person's ability to cope with the ordinary demands of life;

d. Causing the person to need services from two or more of the following systems: mental health, juvenile justice, social services, child welfare, special education or health organizations.

E. QUALIFICATION OF PROVIDERS

Providers of case management services to recipients who are severely emotionally disturbed must be knowledgeable concerning the local service delivery system, the needs and dysfunctions of this recipient group, and the need for integrated services and the resources available.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

A. Target Group J:

High risk pregnant and postpartum women - See attached.

B. Areas of State in which services will be provided:

[X] Entire State.

[ ] Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

See definition in B. 1-C, above.

Case Management services for persons in this target group are not provided in the following counties:_____

C. Comparability of Services:

[ ] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Covered services include risk assessment, care planning, ongoing care coordination and monitoring. See attached.

E. Qualifications of Providers:

See attached 1-J-4.

A. TARGET GROUP:

Targeted Group: This target group consists of all Medical Assistance recipients throughout the entire state who meet the following criteria:

1. Pregnant and postpartum women (up to 60 days after delivery);

2. Expected to have difficulty receiving proper medical care; and

3. Determined by administering the Department-sanctioned risk assessment to be at high risk for adverse pregnancy outcomes such as a preterm births or low birth weight babies due to medical and nonmedical factors.

D. DEFINITION OF SERVICES

1. General Description: Prenatal care coordination services assist recipients at high risk for adverse pregnancy outcomes, and when appropriate, assist individuals related to the recipient. This assistance is to: gain access to; coordinate with; assess and follow-up on necessary medical, social, educational, and other services related to the recipient's pregnancy. Prenatal care coordination services usually include: risk assessment, care planning, ongoing care coordination and monitoring.

(Nutrition counseling and health education services, components of prenatal care coordination, are under the extended services to pregnant women section of this plan. Outreach, a component of prenatal care coordination, is an administrative service.)

2. Definitions:

a. High risk for adverse pregnancy outcome means a situation where a pregnant woman has a high probability of having a preterm birth, a low birth weight baby or other negative birth outcome because of medical and/or nonmedical factors including psychosocial, behavioral, environmental, educational and nutritional factors. These risk factors are identified by administering the Department-sanctioned risk assessment. To decrease the identified risks, additional prenatal care services and follow-up services are provided through this benefit.

b. Risk assessment. A risk assessment is a written appraisal of a recipient's pregnancy-related needs to determine if a recipient is at high risk of an adverse pregnancy outcome and to determine the type and level of the recipient's needs. When conducting the risk assessment the certified provider utilizes a Department-sanctioned instrument. The assessment must be performed by a person either employed by or contracted with the certified prenatal care coordination agency and must be reviewed by a qualified professional.

c. Care planning. Following completion of the risk assessment and determination of the need for prenatal care coordination, the prenatal care coordination provider will do care planning. Care planning is development of an individualized written plan of care which will identify needs, problems and possible services to reduce the recipient's identified risk factors and therefore reduce the probability of the recipient having a preterm birth, low birth weight baby or other negative birth outcomes. Care planning provides the means to ensure that through all care coordination services the recipient has accessible, coordinated, adequate, quality, and continuous services to address her identified needs. Care planning must be performed by a person employed by or contracted with the MA-certified prenatal care coordination agency. To the maximum extent possible, the development of a care plan is done in collaboration with the recipient, the family or other supportive persons.

d. Plan of Care. The plan of care is a written document that may include, but is not limited to:

(1) Identification and prioritization of risks found during the assessment;

(2) Identification and prioritization of all services and service providers to be arranged for the recipient;

(3) Description of the recipient's informal support system and activities to strengthen it;

(4) Identification of individuals who participated in the development of the plan of care;

(5) Arrangements made for and frequency of the various services to be made available to the recipient and the expected outcome for each service component;

(6) Documentation of unmet needs and gaps in service; and

(7) Responsibilities of the recipient in the participation of the plan.

e. Ongoing care coordination and monitoring. After the development of the plan of care, ongoing care coordination and monitoring is the supervision of the provision of the services to ensure that quality service is being provided and to evaluate whether a particular service is effectively meeting the recipient's needs and reaching the goals and objectives of the care plan. Ongoing care coordination and monitoring is performed by a person who is employed by or under contract with the prenatal care coordination agency and is supervised by or is a qualified professional.

Ongoing care coordination and monitoring services may include, but are not limited to:

(1) Face-to-face and telephone contacts with recipients and related individuals for the purpose of following up on arranged services;

(2) Documentation to record care plan management activities.

E. QUALIFICATION OF PROVIDERS

Prenatal Care Coordination Provider Certification

Any provider that meets the criteria outlined below is eligible to become certified as a prenatal care coordination provider.

1. Clinics and agencies that have experience in serving low income people as well as pregnant women and their families. These clinics and agencies include but are not limited to: community-based agencies or organizations; county, city or combined local public health agencies; departments of human or social services; family planning agencies; federally qualified health centers (FQHCs); health maintenance organizations (HMOs); independent physician associations (IPAs); hospital facilities; physician offices and clinics; registered nurses or nurse practitioners; rural health clinics; tribal agencies and health centers; private case management agencies; and Women, Infant, Children (WIC) programs.

2. Agencies, organizations and providers eligible to become certified as prenatal care coordination providers will meet the following staffing standards:

   a. A prenatal care coordination agency employs at least one qualified professional with experience in coordinating services for at-risk and low-income women.

   b. Qualified professionals are employed by or under contract with a certified prenatal care coordination agency that bills for the services and may include: licensed and registered nurses, certified midwives, physicians, physician assistants, registered dieticians, bachelor's degree social workers and health educators.

3. Prenatal care coordination providers are required to meet the Medicaid Program's documentation, recordkeeping and reimbursement requirements.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

A. Target Group K:

Persons diagnosed as having HIV infection.

B. Areas of State in which services will be provided:

☒ Entire State.

Currently this benefit is available statewide, but provider participation is optional.

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

See narrative B. in the preceding section for Target Group C, page 1-C-1.

C. Comparability of Services:

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See narrative D. in the preceding section for Target Group C.

E. Qualification of Providers:

See narrative E. in the preceding section for Target Group C and the narrative that follows.

A. TARGET GROUP:

Targeted Group K: This target group consists of persons diagnosed as having any strain of human immunodeficiency virus which causes acquired immunodeficiency syndrome.

E. QUALIFICATION OF PROVIDERS

Providers of case management services to recipients who are diagnosed as having HIV infection must be knowledgeable concerning the local service delivery system, the needs and dysfunctions of this recipient group, and the need for integrated services and the resources available.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

A. Target Group L:

Recipients who are infected with tuberculosis.

B. Areas of State in which services will be provided:

☐ Entire State.

☒ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

The benefit is available statewide, but provider participation will be voluntary. It is assumed that initial participation of providers will see a majority of counties covered, and most target populations selected. The State will require the county board of supervisors in any county in which the benefit is provided, to elect to have this benefit offered. This will ensure coordination and enhance case management.

C. Comparability of Services

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See narrative D. in the section for Target Group C.

E. Qualification of Providers:

See narrative E. in the section for Target Group C and the narrative that follows:

Qualifications of Providers

Providers of case management services to recipients infected with tuberculosis must be knowledgeable concerning local service delivery systems, the needs of this recipient group, and the need for integrated services and the resources available.

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State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

A. Target Group M:

Recipients up to age 21 who are diagnosed as having asthma. See attached.

B. Areas of State in which services will be provided:

☐ Entire State.

☒ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

The benefit is available statewide, but provider participation will be voluntary. It is assumed that initial participation of providers will see a majority of counties covered, and most target populations selected. The State will require the county board of supervisors in any county in which the benefit is provided, to elect to have this benefit offered. This will ensure coordination and enhance case management.

C. Comparability of Services

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See narrative D. in the section for Target Group C.

E. Qualification of Providers:

See narrative E. in the section for Target Group C and the narrative that follows.

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State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

A. TARGET GROUP

Target Group M: This target group consists of recipients under the age of 21 who are diagnosed as having asthma and require case management services to ensure that they receive appropriate intervention and to prevent a deterioration of their condition.

E. QUALIFICATIONS OF PROVIDERS

Providers of case management services to recipients under age 21 with asthma must be knowledgeable concerning the local service delivery system, the needs and dysfunctions of this recipient group, and the need for integrated services and the resources available.

In addition to the qualifications noted under section E. for target group C., registered nurses who are knowledgeable about the local service delivery system, the needs and dysfunctions of this recipient group and the need for integrated services and the resources available or needing to be developed may provide any of the components of case management.

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State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

A. Target Group N:

Families with children up to the age of 21 who are at risk of physical, mental or emotional dysfunction.

B. Areas of State in which services will be provided:

☐ Entire State.

☒ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

The benefit is available statewide, but provider participation will be voluntary, or as established by the State Legislature. It is assumed that initial participation of providers will see a majority of counties covered, and most target populations selected. The State will require the county board of supervisors in any county in which the benefit is provided, to elect to have this benefit offered, except that in a county of 500,000 population or greater, the Department may choose to make this benefit available. This will ensure coordination and enhance case management.

C. Comparability of Services:

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See narrative D. in the section for Target Group C and the narrative that follows, or as established by the State Legislature.

E. Qualification of Providers:

See narrative E. in the section for Target Group C and the narrative that follows, or as established by the State Legislature.

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State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

A. TARGET GROUP

Target Group N: This target group consists of families of recipients under the age of 21 who are at risk of physical, mental or emotional dysfunction. A child is at risk if any of the following apply:

- The child exhibits biological or environmental characteristics associated with a heightened probability of developing a chronic physical, developmental, behavioral or emotional condition and requires health or health related services of a type or amount beyond that required by children generally.
- There is a finding that the child has been maltreated or a finding that there is a significant probability of maltreatment.
- The child has been placed in substitute care.
- The child is involved with the juvenile justice system.
- The primary caregiver has a mental illness, developmental disability or substance abuse disorder.
- The child's mother required care coordination services during her pregnancy with the child because of the risk of an adverse birth outcome, and coordination activities continue to be required to ensure the best possible health outcome for the child.

D. DEFINITION OF SERVICES

The basic components of targeted case management (assessment, case planning, on-going monitoring and service coordination, and institutional discharge planning), as described in section D for target group C, all apply to this target group. However, the focus of this target group on the family of the child at risk requires that some additional issues be addressed within these components to ensure that all the factors which place the child at risk are addressed in the most efficient manner.

Assessment: In addition to completing the comprehensive assessment for the identified child at risk, the case manager will also:

- Assess the needs of any primary caregiver, where that person's condition (e.g., mental illness, substance abuse disorder, maltreatment) is the primary reason for the child being at risk and the caregiver is not already served by a case manager under MA. The assessment shall include those components of the comprehensive assessment which are applicable to the caregiver's situation.

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CASE MANAGEMENT SERVICES

SPA Case Management: Family Case Management

- Assess the needs of other child(ren) in the family when the conditions placing the identified child at risk might also place the other child(ren) at risk (e.g., maltreatment) and the other child(ren) are not already served by a case manager under MA. The assessment shall include only those components of the comprehensive assessment which are applicable to the other child(ren). Where components of the assessment apply equally to the identified at risk child and other child(ren) in the family, these components should not be duplicated in the assessment of the other child(ren) in the family (e.g., needs of the primary care giver).

- Assess the family's ability to provide for the needs of the identified at risk child and other children in the family deemed to be at risk after further assessment. This should include an assessment of the family's ability to utilize the system of health and health-related services in addition to other community-based social and other services which may be needed to address the needs of the identified at-risk child.

- Assess the involvement of other case managers who may be working with members of the family.

Case Plan: The case plan should address the case plan elements a.-g. under section D for target group C as they apply to the assessment of the needs of the identified at risk child, or the needs of Medicaid eligible caregivers and other children in the family. In addition, where multiple members of the family have case managers, whether related to the specific conditions placing the identified child at risk or not, the case plan will identify how the activities of the various case managers will be coordinated so that duplication of effort will not occur.

E. QUALIFICATIONS OF PROVIDERS

Providers of case management services to families of children at risk of physical, mental and emotional dysfunction must be knowledgeable concerning the local service delivery system, the needs and dysfunctions of this recipient group, and the need for integrated services and the resources available.

In addition to the qualifications noted under section E. for target group C., registered nurses who are knowledgeable about the local service delivery system, the needs and dysfunctions of this recipient group and the need for integrated services and the resources available or needing to be developed may provide any of the components of case management.

Substitute page

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

A. Target Group O:

Persons enrolled in the Birth to Three Program. See attached.

B. Areas of State in which services will be provided:

☐ Entire State.

☒ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

The benefit is available statewide, but provider participation will be voluntary. It is assumed that initial participation of providers will see a majority of counties covered, and most target populations selected. The State will require the county board of supervisors in any county in which the benefit is provided, to elect to have this benefit offered. This will ensure coordination and enhance case management.

C. Comparability of Services

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See narrative D. in the section for Target Group C.

E. Qualification of Providers:

See narrative E. in the section for Target Group C and the narrative that follows.

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State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

A. TARGET GROUP

Target Group O: This target group consists of recipients who are receiving services from a program certified under Ch. HSS 90 WI Adm. Code. These recipients are aged birth to three and significantly delayed developmentally insofar as their cognitive development, physical development, including vision and hearing, communication development, social and emotional development or development of adaptive behavior and self-help skills is concerned, or are diagnosed as having a physical or mental condition which is likely to result in significantly delayed development.

E. QUALIFICATIONS OF PROVIDERS

Providers of case management services to recipients in the birth to three program must be knowledgeable concerning the local service delivery system, the needs and dysfunctions of this recipient group, and the need for integrated services and the resources available.

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TARGETED CASE MANAGEMENT SERVICES
Target Group P

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):
Target group includes Milwaukee County and City of Racine postpartum women and their infants who are at risk of child abuse and neglect as determined by the department. This includes post-partum women and infants with medical needs. In Milwaukee County, these recipients remain in the target group until the child is 7 years old. In the City of Racine, these recipients remain in the target group until the child is 2 years old.

X Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to **30** consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
___ Entire State
X Only in the following geographic areas: **Milwaukee County and City of Racine**

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
X Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- 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;

  A comprehensive assessment is covered at least once every 365 days. Comprehensive reassessments are covered if there is a significant change in the recipient's circumstances. Periodic reassessments are covered as an ongoing activity.

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that

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TARGETED CASE MANAGEMENT SERVICES
Target Group P

- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- identifies a course of action to respond to the assessed needs of the eligible individual;

At a minimum, care plans must be reviewed and updated every 60 days during the first year of the child's life. The care plan should be reviewed at least every 180 days thereafter.

❖ Referral and related 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 annual monitoring, to determine whether the following conditions are met:
  - services are being furnished in accordance with the individual's care plan;
  - services in the care plan are adequate; and
  - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Covered activities also include periodic reassessments and time spent on recordkeeping. Recordkeeping includes: updating the care plan, documenting recipient and collateral contacts, preparing and responding to correspondence to and for the recipient or collateral contact, documenting the recipient's activities in relation to the care plan.

Monitoring contacts may be face-to-face, by telephone, or in writing. Frequency of contacts are jointly determined by the recipient and the case manager, however the minimum requirements are:

- **A face-to-face or telephone contact every 30 days, if the child is aged 6 months or less;**
- **A face-to-face contact with recipient every 60 days, if the child is aged 12 months or less;**

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TARGETED CASE MANAGEMENT SERVICES
Target Group P

- **A face-to-face or telephone contact with the recipient every 90 days after the first year of the child's life**

The case manager must document the reason for less frequent contacts.

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Agencies must have at least one qualified professional with at least 2 years experience in coordinating services for at-risk and low-income pregnant women. The experience should be in a health care or family services setting. Qualified professionals include registered nurses, certified nurse midwives, registered dieticians, social workers, health educators, physicians and physician assistants. Trained paraprofessionals may provide services under the general supervision of a qualified professional. The qualified professional must review and signoff on assessments and care plans developed by paraprofessionals.

Providers must demonstrate that they are knowledgeable about the local health and social services delivery system. They must indicate that they have referral and / or working relationships with key health care and other service providers (e.g., WIC, transportation, child care)

Freedom of choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

State Plan under Title XIX of the Social Security Act
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TARGETED CASE MANAGEMENT SERVICES
Target Group P

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services: **[Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]**

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows:
(i)The name of the individual;
(ii) The dates of the case management services;
(iii)The name of the provider agency (if relevant) and the person providing the case management service;
(iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
(v) Whether the individual has declined services in the care plan;
(vi) The need for, and occurrences of, coordination with other case managers;
(vii) A timeline for obtaining needed services;
(viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

State Plan under Title XIX of the Social Security Act
State/Territory: Wisconsin

TARGETED CASE MANAGEMENT SERVICES
Target Group P

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

Additional limitations

Case management is not available to any recipient:

a. **Participating in a home and community-based [1915(c)] waiver program**
b. **Residing in an MA-funded institution (e.g., hospital or nursing home), except for discharge-related case management services prior to discharge from an institutional setting.**
c. **In excess of one comprehensive assessment or case plan per 365 days**
d. **In excess of one claim for ongoing monitoring per month**
e. **Enrolled in an MA-certified community support program**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

A. Target Group Q:

Women aged 45 to 64 who are not covered under other case management categories. These women are middle aged and not yet defined as elderly. For example, they may be grandmothers or middle aged mothers raising children on Medicaid.

B. Areas of State in which services will be provided:

☐ Entire State.

☒ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

The benefit is available statewide, but provider participation will be voluntary, or as established by the State Legislature. It is assumed that initial participation of providers will see a majority of counties covered, and most target populations selected. The State will require the county board of supervisors in any county in which the benefit is provided, to elect to have this benefit offered. This will ensure coordination and enhance case management.

C. Comparability of Services:

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See narrative D. in the section for Target Group C, or as established by the State Legislature. This case management benefit will focus on facilitating early and ongoing screenings for breast cancer, cervical cancer, osteoporosis, diabetes and high blood pressure.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

E. Qualification of Providers:

See narrative E. in the section for Target Group C and the narrative that follows:

Providers of case management services to women aged 45 to 64 must be knowledgeable concerning the local service delivery system, the needs and dysfunctions of this recipient group, and the need for integrated services and the resources available, or as established by the State Legislature.

Substitute Page

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

A. TARGET GROUP

Targeted Group: This target group consists of women aged 45 to 64 who are not residing in nursing homes and are not otherwise receiving case management services. The benefit will focus on women who are unaware of the importance of preventive services and the resources to receive those services.

D. DEFINITION OF SERVICES

See narrative D. in the section for Target Group P. This case management benefit will focus on early and ongoing screenings for breast cancer, cervical cancer, osteoporosis, diabetes and high blood pressure.

E. QUALIFICATIONS OF PROVIDERS

Providers of case management services to women aged 45 to 64 must be knowledgeable concerning the local service delivery system, the needs and dysfunctions of this recipient group, and the need for integrated services and the resources available.

Substitute page

State Plan under Title XIX of the Social Security Act
State/Territory: Wisconsin

TARGETED CASE MANAGEMENT SERVICES
Target Group R

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):
Children with medical complexity (CMC). Target group includes children enrolled in the Medicaid program who meet enrollment criteria as established by the Department as having medical complexity and high resource utilization. Individuals up to age 26 who continue to meet enrollment criteria remain in the target group. Children with medical complexity enrolled in this program are defined as having chronic medical conditions with three or more organ systems AND require three or more medical or surgical specialists AND have one or more hospital admissions totaling five or more days OR ten or more clinic visits measured during the preceding year from the date of the referral to the program. Children who are recent NICU/PICU graduates have the same eligibility criteria as above, except that their tertiary center use is anticipated by clinicians to continue to be high as they may not be old enough to have met the requisite 10 clinic visits.

X Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
X Entire State
___ Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
X Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

State Plan under Title XIX of the Social Security Act
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TARGETED CASE MANAGEMENT SERVICES
Target Group R

- 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;

  Comprehensive assessments are covered no more than once every three (3) years from the date of the individual's enrollment in the program unless approved by the Department. Periodic reassessments are covered as ongoing monitoring and follow-up activities.

- 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, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

  At a minimum, care plans must be reviewed and updated every 6 months or as the individual's needs change.

- Referral and related 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

State Plan under Title XIX of the Social Security Act
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TARGETED CASE MANAGEMENT SERVICES
Target Group R

- 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 annual monitoring, to determine whether the following conditions are met:
    - services are being furnished in accordance with the individual's care plan;
    - services in the care plan are adequate; and
    - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Referral, monitoring and follow-up activities are covered as frequently as necessary to ensure that services in the individual's care plan are adequate and goals identified in the care plan are met. Such activities may be face-to-face, by telephone, or in writing.

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

The qualified staff providing case management services on behalf of the program include: nurse practitioners, registered nurses, para professionals, social workers, and physicians. Staff must be knowledgeable about the care and needs of children with high-resource utilization and medical complexity, and local health care and social services delivery systems.

Providers must be certified as a children's hospital with pediatric medical and surgical specialty areas able to support full integration of psychosocial and clinical care. Providers must possess sufficient documentation that demonstrates that staff has adequate knowledge and experience to provide comprehensive and specialized case management services to children with complex medical and psychosocial needs. Providers must have referral and / or effective working relationships with key health care and other service providers that are essential to the individual's care (e.g., primary care team, private duty nurses, sub-specialists, and community and social organizations).

State Plan under Title XIX of the Social Security Act
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TARGETED CASE MANAGEMENT SERVICES
Target Group R

Freedom of choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services: [**Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.**]

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

State Plan under Title XIX of the Social Security Act
State/Territory: Wisconsin

TARGETED CASE MANAGEMENT SERVICES
Target Group R

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows:
(i)The name of the individual;
(ii) The dates of the case management services;
(iii)The name of the provider agency (if relevant) and the person providing the case management service;
(iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
(v) Whether the individual has declined services in the care plan;
(vi) The need for, and occurrences of, coordination with other case managers;
(vii) A timeline for obtaining needed services;
(viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))