

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.

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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.

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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. Entire State.

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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:

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.

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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.

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- 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.

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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.

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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:

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- 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.

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- 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;

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- 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.

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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);

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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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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.

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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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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.

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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.

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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:

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.

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.

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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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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.

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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:

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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:

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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:

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.

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 dietitians, 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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MARCH 1987

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Page 1-K-1
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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.

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Supersedes
TN #93-015

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7/12/93

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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.

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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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

A. Target Group M:

Recipients up to age 21 who are diagnosed as having ~~mental illness~~ 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 PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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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Substitute page

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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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Page 1-N-3
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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.

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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 Q: 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.

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
 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.
 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 dietitians, 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.

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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
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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**

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

CASE MANAGEMENT SERVICES

A. Target Group P:

Milwaukee County postpartum women and their infants - 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: Milwaukee 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:

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

E. Qualification of Providers:

See the narrative that follows.

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A. TARGET GROUP:

Targeted Group: Milwaukee County postpartum women and their infants who are at risk for child abuse and neglect as determined by the department. These recipients remain in the target group until the child is 7 years old.

D. DEFINITION OF SERVICES

General Description. The basic components of targeted case management (assessment, case planning, on-going monitoring and service coordination), 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 of poor health outcomes or child abuse and neglect 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.

Risk assessment. A risk assessment is a written appraisal of a recipient's needs to determine if a recipient is at risk of a poor health outcome or child abuse and neglect 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 care coordination agency and must be reviewed by a qualified professional.

Care Planning. Following completion of the risk assessment and determination of the need for care coordination, the 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. 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 the identified needs. Care planning must be performed by a person employed by or contracted with the MA-certified 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.

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;

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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.

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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.

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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.

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