WISCONSIN DEPARTMENT OF HEALTH SERVICES
DIVISION OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Community Recovery Services (CRS) Agency Provisional Certification Standards and Policy and Procedure Requirements

December 16, 2009

1. AGENCY IDENTIFICATION AS A PUBLIC ENTITY

The agencies listed below are eligible for certification as providers of Wisconsin Medicaid community recovery services.

- County or tribal department of community programs (51.42 and 51.42/.437 boards).
- County or tribal department of social services.
- County or tribal department of human services.
- County or Tribal public health agency, and multiple tribal health departments (as defined under s. 251.02, Wis. Stats.).

2. CONFLICT OF INTEREST PROVISIONS

CMS requires that States assure 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.

The County/Tribal CRS agency must assure that it has taken all possible measures to reduce the possibility for conflict of interests to occur in the evaluation, assessment and care planning for CRS participants. If there are willing and qualified providers of the service available in the area, the state service plan reviewer will assure that individuals are given the option of the other providers.

Provisional Policy/Procedure: Wisconsin's 1915i application proposes the following to CMS to satisfy the conflict of interest provisions: County/tribal CRS agencies will perform the evaluations, assessments and plans of care. Under Wisconsin statute 51.42 the state has delegated to the county board of supervisors, the primary responsibility for the well-being, treatment and care of the mentally ill. Counties are required to provide comprehensive evaluation and assessment for individuals with mental illness. "County" in Wisconsin is analogous to "state regional office" in many other states; in that it determines eligibility for Medicaid, assesses service needs and contracts to deliver needed services. Therefore, Wisconsin does not believe a conflict of interest exists.

There are additional protections for individuals in need of services. The needs based eligibility criteria are programmed into functional screen logic to provide an automated determination of eligibility or ineligibility. Screeners receive training on completion of the functional screen to assure uniformity. Most individuals who will receive the 1915i services are already receiving services from a county care manager. Counties are responsible for entering into contracts to secure services and if necessary providing the service. The majority of counties do not directly provide the services covered by this application. In the few counties that do provide a service (mostly supported employment) there is no incentive to overuse the service as the county pays the non-federal share. Often the county provides a service because it is not available elsewhere.

3. COMMUNITY RECOVERY SERVICES ELIGIBILITY AND ENROLLMENT PROCESS

In order to qualify for enrollment in the Community Recovery Services (CRS) program, the potential CRS recipient must:

- Be eligible for "State Plan Medicaid;" and
- Have countable income at or below 150% of the Federal Poverty Level (FPL); and
- Reside at home or in the community; and
- Meet CRS functional eligibility requirements; and
- Have a DHS approved service plan.

The agency must have an appropriate process for assuring all the following client enrollment processes are in place and completed for each potential CRS enrollee:

A. **Confirming enrollment in State Plan Medicaid**. CRS care managers will be responsible for confirming that a potential CRS enrollee is enrolled in State Plan Medicaid.

> ***Provisional Policy/Procedures:*** Each person enrolled in State Plan Medicaid has an electronic record on the Department's "interChange" system. Care managers should query the interChange system and view the individual's Medicaid eligibility information. Enrollment in State Plan Medicaid can be confirmed by viewing the individual's Benefit Plan and corresponding medical status code information. Care managers should consult a list of valid Benefit Plan and medical status code combinations associated with State Plan Medicaid subprograms that have income tests at or below 150% FPL. If the potential CRS enrollee's current Benefit Plan and medical status code is on the list, s/he is enrolled in State Plan Medicaid. See the document entitled "Eligibility Verification Guide for the Community Recovery Services Program" and the associated worksheet for more details.

B. **Income Test.** In addition to being enrolled in a State Plan Medicaid program, the potential CRS enrollee must meet a separate CRS income test. The individual's countable income must be no more than 150% of the FPL. In 2009, 150% of the FPL is $1,353.75 monthly.

> ***Provisional Policy/Procedures***. The county or tribal income maintenance agency (or, for an SSI recipient, Social Security Administration) determines what income to count when it determines the individual's eligibility for State Plan Medicaid. Countable income for CRS purposes is the same as it is for State Plan Medicaid. CRS care managers will not be responsible for determining what income to count for potential CRS enrollees. However, the CRS care manager will confirm that the potential CRS enrollee's income does not exceed 150% of the FPL. See the document entitled *Eligibility Verification Guide for the Community Recovery Services Program* and the associated worksheet for more details.

C. **Residence in home or community**. The CRS agency assures that the CRS state plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The agency must assure that each individual receiving State plan HCBS:

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

2. 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.

The type of residential setting needed by the individual would be determined by a person-centered assessment. Allowable settings other than the individuals own home or apartment are Adult Family Homes (AFH), Residential care apartment complex (RCAC), transitional housing facilities 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. Transitional housing is temporary housing, while a more stable living arrangement is developed.

Provisional Policy/Procedures: 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.

Because CBRF's are the most restrictive of the community residential options, only individuals whose health and safety are at risk without 24hr supervision will receive CRS services in a CBRF. It will be the care manager's responsibility to determine that the residence is a community setting appropriate to the individual's need for independence, choice and community integration.

D. **Functional Eligibility.** The CRS Agency must have in place a process to determine the functional eligibility of potential CRS enrollees. The process must meet the following standards:

1. **Qualifications of Individuals Performing Evaluation/Reevaluation**. CMS requires that 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.

   The Community Recovery Services (CRS) agency will demonstrate that it will use Wisconsin's Functional Eligibility Screen for Mental Health and Mental Health & AODA Services (MH/AODA Functional Screen) or the Children's Functional Screen to do the CRS independent evaluation of needs based criteria.

   The CRS agency will assure that the MH/AODA Functional Screen is 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 MH/AODA functional screen must meet the following conditions:

   a. Minimum education and experience criteria**:**
      - 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

   b. Meet all **training requirements** as specified by the Department. Currently that means:
      - Completing the online MH/AODA Functional Screening course, or

- Attending an in-person training by Department staff (or watching video of same), **and**
- Reading and following screen instructions.

2. **Process for Performing Needs-based Eligibility Evaluation/Reevaluation.** The agency has in place a process that assures that the Wisconsin's Mental Health and AODA functional screen or the Children's Functional Screen will be used to identify individual's functional needs-based eligibility. The screen will demonstrate that the needs based criteria are met such that the individuals' needs can not be met with basic outpatient services and they have various combinations of a history of psychiatric treatment, limitations in instrumental skills, inappropriate behaviors and risk factors. When the functional screen automation is complete, the MH/AODA Functional Screen will automatically generate a result as eligible or not eligible for CRS Services. The functional screen must be done annually for each CRS enrollees.

Provisional Policy/Procedures: Until the Functional Screen automation changes are complete (estimated to be about January 15, 2010), counties will use the score of the eligibility result of the CCS level of need as a proxy for CRS service level need as long as the individual has a mental illness diagnosis (not substance abuse alone). The County/tribe will have an identified Screen Lead worker who will be responsible for assuring all screeners meet the required qualifications and receive appropriate training. That individual will also monitor screen quality.

E. **Face-to-Face Assessment and Development of Care Plan of an Individual's Support Needs and Capabilities.** The CRS agency assures that the following will be in place for CRS assessment and service planning:

1. **Staff Qualifications:** Individuals who will complete the face to face assessment and care plan and will meet the following educational/professional qualifications:
   a. Skills and knowledge typically acquired:
      - 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
      - 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
      - Through a minimum of four years experience as a care manager, or
      - 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
      - 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.

   b. The assessors and care managers 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.

   c. Assessors and care managers are subject to the required criminal, caregiver and licensing background checks and hiring prohibitions as prescribed by DHS.

2. **Assessment.** A comprehensive face to face assessment for each individual enrolled in CRS must be completed using a person-centered approach. The

independent assessment must be conducted at least every 12 months and as needed when the individual's support needs or circumstances change significantly. The assessment should be based on:

- An objective face-to-face assessment with a person-centered process by an independent and qualified agent;
- 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;
- 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 determination of need for at least one State plan home and community-based service before an individual is enrolled into CRS.

3. **Individual Service Planning Requirements.** The CRS agency assures that using a person-centered approach, the service plan will be based on the independent assessment and will meet the following CMS requirements:
    - 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 CRS State plan HCBS that the individual is assessed to need;
    - Is guided by best practices and research on effective strategies for improved health and quality of life outcomes;
    - Assures that participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the service plan that agree to rates offered thru CRS program;
    - Is included in the service plan packet that is approved by the Department of Health Services; and
    - Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.

Provisional Policy and Procedures: The Individual Service Planning Process will include the following components:

Person-Centered 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 following elements should be included in the planning process.

- The care manager will ensure that the participant and others they choose are fully involved in the plan development;
- The care manager will document on the service plan those in attendance at the plan development.
- The service plan should reflect both CRS funded services and other funded services necessary to meet the individual's home and community based service needs. This would include Community Support Programs (CSP), Comprehensive Community Services (CCS), and natural supports, etc.
- The service plan should neither duplicate, nor compel, natural supports.
- 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.
- 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.
- The written copy of the Individual Service Plan (ISP) will be given to the individual and legal representative.
- The ISP is to be reviewed in a face-to-face meeting with the individual every six months and upon significant change in the individual's circumstances.

Personal Outcomes - The CRS provider will assure that the CRS participants have individual personal outcomes and demonstrate that:

- The individual outcomes will reflect the person's desired results from the CRS services.
- The program will use the ISP Individuals Outcomes form which will be reviewed in a face-to-face meeting with the individual every six months and upon significant change in the individual's circumstances.
- The ISP Individuals Outcomes form should reflect both CRS funded services and other funded services necessary to meet the individual's home and community based service needs. This would include Community Support Programs (CSP), Comprehensive Community Services (CCS), and natural supports, etc.

Crisis Back-up Plan - A narrative plan for periods of intense supervision and supports identifying the steps to be taken to keep the person in the community and prevent institutionalization. This plan is based on the individual's preferences and safety. This may be the individual's WRAP plan.

Informed Choice of Providers - CRS Agency assures that

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. All willing providers will have the opportunity to register with the DHS.

4. **MONITORING AND SUPPORTING THE PARTICIPANT IN PLAN OF CARE**. The CRS agency assures that supports and information are made available to the participant (and/or the additional parties as appropriate) to direct and be actively engaged in the plan of care development 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. 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.

F. Service Plan Subject to the Approval of DHS – The CRS agency demonstrates that for all individuals to be enrolled in CRS services, the care manager will submit the completed and signed service plan to the DHS or the contracted quality agency for review and approval. State or contracted agency will request additional information as needed and the CRS agency will provide the additional information needed to approve the service plan. The State will send an approval letter to the county/tribe as the final step in enrollment. The CRS agency understands that no individual is enrolled in CRS without DHS final approval.

CRS Service Plan Packet Components for Approval. The CRS Agency will provide a copy of the CRS Service Plan Packet for each proposed CRS recipient for approval prior to billing for Medicaid funded CRS. The CRS Service Plan Packet will include:

1. **Functional Eligibility** - The web based Wisconsin Functional Eligibility Screen for Mental Health and AODA Service must be completed by a certified screener with a CRS eligibility yes result, before the CRS Participant Applicant Packet is submitted. **A hardcopy does not have to be submitted with the Participant Applicant Packet.**
2. **Cover Letter -** Identifies the county/tribe and its contact person's name, phone and fax numbers; the CRS applicant's name and birth date; and the expected date CRS services are to begin.
3. **Assessment** - A copy of the independent assessment (completed, signed and dated by a qualified care manager or certified social worker
4. **Individual Service Plan (ISP)** – Community Recovery Services Form http://dhs.wisconsin.gov/forms/F0/f00202.doc
   Instructions for ISP completion
   http://dhs.wisconsin.gov/forms/F0/f00202i.doc

5. **Individual Service Plan (ISP) – Individual Outcomes** - Community Recovery Services Form http://dhs.wisconsin.gov/forms/F0/f00202a.doc
6. **Crisis Back-up Plan** - A narrative plan for periods of intense supervision and supports identifying the steps to be taken to keep the person in the community and prevent institutionalization. This plan is based on the individual's preferences and safety.

> ***Provisional Policy/Procedure***: For those CRS participants with an established WRAP plan this could be provided to meet this requirement.

7. **Eligibility** – Potential Member Information for Community Recovery Services form. This will provide documented evidence that the individual meets financial and non-financial eligibility for CRS.
8. **Room and Board** - Formula to Determine Amount of Income Available to pay for Room and Board in Substitute Care Form – F-20920 (08/2008) (if applicable). CBRF Model Contract or Form entitled Calculating Expenses for a Substitute Care Facility or similar documentation. **CRS will not pay for room and board or related costs.**

> ***Provisional Policy/Procedure***: In certain circumstances a facility staff person's wages and benefits may be apportioned between room and board costs **and** care and supervision costs. If rehabilitative services include teaching and prompting the individual in areas such as, food preparation and domestic activities, this should be reflected in the ISP and ISP Outcomes. **Note:** DMHSAS has developed a CRS policy similar to the Medicaid Waivers Manual.

Submitting Packet- County/tribe submits the CRS Individual Applicant Packet to:

Wisconsin Department of Health Services
Division of Mental Health & Substance Abuse Services
Bureau of Prevention Treatment and Recovery
1 W. Wilson Street, Room 851
Madison, WI 53707-7851
Attn: CRS Coordinator

> ***Provisional Policy and Procedures***: **DHS Service Plan Packet Review** – The DHS Packet Review for technical compliance and quality will respond to the following:
> - Are all packet components completed correctly?
> - Are the documents signed and dated by the appropriate persons?
> - Is the MH/AODA Functional Screen dated within 90 days prior to the expected CRS effective eligibility date?
> - Does the information in the Assessment coincide with the information entered on the MHAODA Functional Screen?
> - Does the information on the various forms and supporting documents support each other? (No contradictions)
> - Do the CRS services listed on the ISP have an identified and corresponding outcome?
> - Is the role and services to be provided by the CCS or CSP clearly identified in the ISP?
> - Are assessed mental health needs being addressed?

- Are all concerns identified in the Functional Screen addressed in the Assessment?
- Are all concerns raised in the Assessment addressed in the ISP?
- Do there appear to be any unmet safety needs?
- Do the Assessment and ISP appear to give a complete picture of the applicant's needs, wants and interests?
- Does it appear the applicant's preferences have been identified?
- Has the applicant been offered the choice of service providers?
- Have Room & Board costs been calculated and disallowed?

4. **CRS HOME AND COMMUNITY BASED SERVICES REQUIREMENTS**
The CRS Agency is responsible for the establishment of a provider network for CRS services that meet DHS and CMS requirements as follows:

A. Service Specifications

Service Title: Psychosocial Rehabilitation
Sub Service Definitions (Scope)*:*

1. Community Living Supportive Services

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, medication management and monitoring, 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.

Services may be 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), transitional housing facilities and community based residential facilities (CBRF's) of 16 beds or less. The type of residential setting needed would be determined by 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.

2. Supported Employment

This service covers activities necessary to assist individuals to obtain and maintain competitive employment. 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:

- Eligibility 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 intake, 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. Individuals are expected to apply for Wisconsin Division of Vocational Rehabilitation (DVR) services and supported employment providers to coordinate with DVR. If found eligible and not wait listed, this service would cover employment services not covered by VR or follow along supports after VR services have finished.

3. Peer Supports

Individuals trained and certified as Peer Specialists serve as advocates, provide information and peer support for consumers in emergency, outpatient, community or inpatient 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.

B. Provider Qualifications			
Provider Type	License	Certification	Other Standard
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. Any additional training as required by the Department of Health Services.

Community Based Residential Facility (CBRF)	WI Statute Chapter 50 and Administrative Rule DHS 83 for 5 plus beds		Providers are subject to the required caregiver, criminal and licensing background checks. Any additional training as required by the Department of Health Services.
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. Any additional training as required by the Department of Health Services.
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. Any additional training as required by the Department of Health Services.
Household/Chore Services Agency or Individual			Providers are subject to caregiver, criminal and licensing background checks. Any additional training as required by the Department of Health Services.
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). Any additional training as required by the Department of Health Services.
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. Any additional training as required by the Department of Health Services. Peer specialists will be supervised by a mental health professional.

C. Verification of Provider Qualifications		
Provider Type	Entity Responsible for Verification	Frequency of Verification
Adult Family Homes (AFH)	**County/Tribal Agency**	**Annually**
Community Based Residential Facility (CBRF)	**County/Tribal Agency**	**Annually**
Residential Care Apartment Complex (RCAC)	**County/Tribal Agency**	**Annually**
Supportive Home Care Agency or Individual	**County/Tribal Agency**	**Annually**
Household/Chore Services Agency or Individual	**County/Tribal Agency**	**Annually**

Supported Employment Prog. or Individual Employment Specialist	County/Tribal Agency	Annually
Peer Specialist Agency/Individual	County/Tribal Agency	Every other year

D. **Additional CRS provider requirements**. The Centers for Medicare and Medicaid Services (CMS) have a number of requirements pertaining to providers of MA home and community based services. In order to meet these requirements, Community Recovery Services (CRS) will require the following:

E. **Contracted CRS Provider Registration –** All county/tribal contracted CRS service providers may be required to register with the Department of Health Services to be considered as a CRS service provider. All willing providers will have the opportunity to register with the DHS. However, all providers willing and interested must also meet the "qualifications" of CRS providers (see F below) and agree to accept the county/tribal offered rate for services. County/tribal CRS agencies must establish CRS rates using a standardized rate methodology approved by DMHSAS.

Provisional Policy/Procedures:

- The purpose of the registration system is to give Medicaid CRS participants the freedom to choose any willing and qualified service provider.
- The registry will enable county/tribal CRS agencies to provide information to CRS applicants and participants about willing providers. The provider registry will have geographic and service specific lists.
- This requirement may apply to any service provider, who is currently providing services, interested in providing services or selected by a participant to provide services.
- Prospective providers not currently qualified under the standards in the CRS Application are permitted to register as potential providers.
- If a Medicaid CRS participant chooses a new provider, the provider must meet all standards for licensure, certification, experience, training and/or any other qualification outlined in the CRS Application before they may provide services and receive reimbursement with Medicaid Home and Community Based Services (HCBS) funds.
- Provider registration may be accomplished either by the provider or the county waiver agency.
- Providers will be responsible to register only once.
- The specific format for potential CRS service providers to register will be communicated to all CRS county agencies as it becomes available.

F. **Contracted Provider Qualifications** – Registration and placement on the provider registry does not mean that a potential CRS provider is qualified.

- All CRS subcontracted service providers must meet the standards established by the Department and Medicaid HCBS regulations for all covered services.
- All service providers must meet the provider qualifications listed in the CRS Standards**.** Counties/Tribes must have a process to assure that the contracted CRS provider meets those qualifications

- All CRS subcontracted service providers must have an executed State Medicaid Agency (SMA) Provider Agreement and provider registration prior to delivery of services.
- All service providers are required to have background checks completed and on file.

G. **State Medicaid Agency (SMA) Provider Agreements**

- All sub-contracted CRS service providers must execute a SMA Provider Agreement with the Department of Health Services (DHS) facilitated by the County CRS agency.
- Contracted CRS providers who have not completed both registration (above) and signed an agreement will not be approved as a contracted CRS provider and paid by MA HCBS funds.
- The terms of contracted CRS SMA provider agreements may not be supplemented, negotiated, or modified in any way.
- Agreements are required for all CRS service providers, except for providers of incidental services that are provided on an infrequent or one time basis. In these limited circumstances, the county/tribe CRS agency may make such a notation and maintain the unsigned Provider Agreement in their agency files.
- It is the county's/tribe's responsibility to ensure all providers have signed and submitted Provider Agreements to their agency.
- The county/tribe CRS agency representative will sign the form once the provider has signed it.
- Signed Provider Agreement forms are to be maintained by the county/tribe CRS agency.

Provisional Policy/Procedure:
There are two types of agreements which were originally developed for the DMHSAS COR Waiver and will be used for CRS until further notice:

1. **Wisconsin Medicaid Program Provider Agreement And Acknowledgement Of Terms Of Participation For Waiver Service Provider Entities** – This agreement is to be used by entities which are corporations or legal businesses other than individuals that provide CRS services. This form is available at: http://dhs.wisconsin.gov/forms1/F2/f21192.doc .
2. **Wisconsin Medicaid Program Provider Agreement And Acknowledgement Of Terms Of Participation For Individual Or Non-Specified Waiver Service Providers** – This agreement is to be used by providers who are individuals or by a company or organization that provides atypical MA funded services as part of the CRS approved psychosocial rehabilitation services. This form is available at: http://dhs.wisconsin.gov/forms1/F2/f21192a.doc

5. SERVICE PLAN MONITORING

The county/tribal CRS agency will assure that participant service plans are monitored to identify and respond to any changing service needs of CRS recipients. A revised Service Plan will be submitted to DHS for approval for all changes to CRS service plans.

6. NON-COVERED SERVICES

The following are not covered by Wisconsin Medicaid under Community Recovery Services:

- Case management services provided under DHS 107.32, Wis. Admin. Code.
- Services provided to a resident of an intermediate care facility, skilled nursing facility, or an institution for mental diseases, or to a hospital patient.
- Services performed by volunteers, except that out-of-pocket expenses incurred by volunteers in performing services may be covered.
- No room and board costs are payable under Community Recovery Services.
- Community Recovery Services 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.
- Community Recovery Services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that other wise 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.

7. CERTIFICATION OF PUBLIC EXPENDITURES FOR NON FEDERAL SHARE

According to the terms of reimbursement for community recovery service (CRS) providers, Wisconsin Medicaid will reimburse only the federal share for community recovery services. County/Tribal community recovery service providers are responsible for the state non federal share of the Medicaid payment. The state share must be appropriated from nonfederal public funds and must be sufficient to cover the Medicaid payments received.

8. ANNUAL MEDICAID COST REPORT PROCESS

Each county/tribal CRS provider will complete an annual Certified Public Expenditure Medicaid Cost Report in the format required by the Department of Health Services and consistent with federal requirements. The report will cover services delivered in the prior calendar year and be due by May 1 of the following year. The annual Medicaid Cost Report includes a certification of the County/tribal's actual indirect and direct costs related to the provision of CRS services. Payments based on interim rates will be reconciled to the actual costs. All annual cost reports are subject to audit by DHS or its designee.

9. TERMS OF REIMBURSEMENT

The county/tribal CRS agency agrees that it will accept the Wisconsin Medicaid reimbursement policy and conditions. Wisconsin Medicaid reimburses county/tribal agencies only for the federal share of its total costs for CRS services (less the DHS administrative processing fee), if the following conditions are met:

- Only if the county/tribal agency has incurred the non-federal share of the total costs for the CRS services billed, and
- If the appropriate documentation for service delivery is provided, and
- If the appropriate expenditures can be documented for CRS eligible individuals, and
- County/tribal CRS agency files acceptable annual cost reports.

Provisional Policy/Procedure: County and/or tribal CRS agencies will be reimbursed at the federal rate applicable (less administrative processing fee) at the time the claim is paid. The FMAP rate for the last 3 quarters of CY 10 is the enhanced ARRA rate of 70.63%. The state will retain a portion of the claim for CRS administrative costs. The amount retained will be $600,000 in SFY11 and 5% of the total federal claim in subsequent years. This reduction will be proportionate to each county's share of total CRS claiming.