AGREEMENT BETWEEN DIVISION OF HEALTH

-AND-

DIVISION OF VOCATIONAL REHABILITATION

I. Mutual Objectives and Responsibilities

The Rehabilitation Act of 1973, as amended, and implementing Regulations require State vocational rehabilitation agencies to assist eligible handicapped individuals to enter, return to, or remain in gainful employment. Many of the individuals eligible for vocational rehabilitation services are also eligible for Medical Assistance (MA).

Pursuant to s.49.45(1), Wis. Stats., the Division of Health administers the MA program to provide appropriate health care services to qualified persons whose financial resources are inadequate to provide for their health care needs, so that such persons may attain or retain capability for self care or independence.

The two Divisions enter into this cooperative agreement in order to foster good communication, make use of similar benefits and to promote high quality health care and services for recipients who are served by both programs.

II. Services at State Level

Division of Vocational Rehabilitation (DVR): During evaluation or upon completion of a written and approved plan, arrangements are made to initiate and supply necessary services. Services regardless of financial need may consist of: medical and psychological evaluation; comprehensive vocational evaluation; counseling and guidance; tuition, fees, books, supplies as part of an approved Individual Written Rehabilitation Program (IWRP) and job placement assistance.

The following services may be provided as part of an approved IWRP after financial need is considered: room and board while attending training; transportation; occupational licenses, tools, equipment and supplies; training materials; physical and mental restoration; artificial limbs; orthotic braces; wheelchairs; and hearing aids.

Medical Assistance: MA pays for these services: physicians services; dental services; hospital services; nursing home services; drugs; nursing, home health care and personal care services; mental health services; podiatry services; chiropractic services; physical therapy; occupational therapy; speech pathology; audiology; vision care services; family planning services; early and periodic screening, diagnosis and treatment (EPSDT) services; transportation; medical supplies and equipment; diagnostic services; dialysis services; and blood. Details on service limitations are included in the State Plan for MA and HSS 101-108 Administrative Rules.

III. Cooperative and Collaborative Relationships at the State Level

Within the Department of Health and Social Services, the Chief of Policy, Planning and Evaluation Section of the MA Program is the primary liaison to DVR and the Director of the Bureau of Planning Evaluation, and Program Development of DVR is the primary liaison to MA.

IV. Services Provided by Local Agencies

The DVR provides services through 21 offices located around the State that are entirely funded by the State and Federal government. The MA Program has contact with County Departments of Social Services, which handle the eligibility determination process. The MA program also has contact with all local agencies which are certified providers.

V. Early Identification of Individuals Under 21 Years of Age in Need of Medical or Remedial Care and Service

The EPSDT Program (which is part of the MA organization) and the Division of Vocational Rehabilitation will provide each other with copies of program policies, administrative procedures, and brochures. The two programs agree to provide each other with information on the location of offices or contractors through which services are delivered, and a description of services and eligibility requirements. This information will be communicated to the service agencies so that whenever a person is identified who would appropriately be served by the other agency, such a referral will be made.

VI. Reciprocal Referrals

Determination of eligibility for MA is made at the local level by the county Social Services Department.

Determination of VR eligibility is made at the local office level by the DVR counselor.

Through an agreement with the Division of Economic Assistance (DEA) individuals eligible for MA will be referred by the County Social Services Department directly to the DVR field office. Referrals of MA eligible individuals may also come from other sources. It is the responsibility of the VR counselor to obtain information regarding client MA eligibility (showing the counselor the MA card). For the VR recipient who is potentially eligible for MA benefits, it is the responsibility of the VR counselor handling the recipient's case to refer the individual to the appropriate county for MA eligibility determination. Referral procedures are specifically described in the agreement between the DEA and DVR.

VII. Similar Benefits and Reimbursement

Under the Rehabilitation Act of 1973 (Section 101(a)(8)) and implementing regulations (45 CFR 1361.45(b)), the state vocational rehabilitation agency must give full consideration to any "similar benefits" available to a handicapped individual under any other program to meet in whole or in part the cost of certain services.

Where MA can provide physical and mental restoration services to a handicapped individual, this similar benefit provision would apply. MA should be considered as an appropriate source of payment for these services and for diagnostic services.

For those services provided by both MA and VR that appear in an Individualized Written Rehabilitation Plan (IWRP), the first dollar concept will apply to available MA funds under the MA rules at the time. In essence, medical services normally provided by MA will continue to be provided for VR clients if they are MA eligible. If an IWRP includes a medical service not provided by MA, the DVR will have the responsibility of providing that service.

DVR will take the responsibility of ensuring the clients who have an MA card participate in the MA program to receive those medical services included in the IWRP. The IWRP will indicate which medical services will be provided by MA and DVR will be responsible for providing adequate follow-up to ensure that services have been provided.

Problems or questions pertaining to coverage of services will be brought to the attention of DOH and DVR staff designated to monitor the agreement in order to facilitate a timely solution.

VIII. Exchange of Reports

The DVR will provide reports to MA at least annually on the number of its clients who are public assistance and MA recipients, and the eligibility categories of assistance. The DVR and MA agency will cooperate to determine the extent to which MA funds are used where DVR funds could be used.

IX. Periodic Review and Joint Planning

DVR will monitor the agreement on a need basis by randomly selecting cases (IWRP's) and analyzing them to verify that the agreement's mandate is being carried out.

Annual review of the agreement will be performed by the liaison staff. Each review will generate a jointly-signed report to both Division Administrators indicating the extent to which MA is being utilized, and policy changes or issues which have been addressed that affect the agreement. In addition, the review will address anticipated or existing problem areas, and recommend appropriate changes. The agreement may be changed or updated as appropriate, but will be formally reviewed annually one year from the date of signature, and every year thereafter.

X. Continuous Liaison

In addition to the provision in Section III, the DVR will share policy, procedure and operating information with the Division of Health explaining how VR services are provided to clients and how the agency operates. The DOH will also provide policy, procedure, and operating information to the DVR giving information on how medical services are provided through Wisconsin's Medical Assistance Program. DVR and DOH will also make available staff members to provide information at staff conferences and training sessions on their respective programs on a need basis.

Rec'd ☒ Approved ☐ Other ☒ Send ☐ Do not Init. Date

DOH will communicate with DVR during the process of updating the Medicaid Administrative Rule. Incorporation of policy changes to accommodate VR clients will be discussed and resolved at that time.

Division Administrator - DOH

10/20/80
Date

Division Administrator - DVR

10/21/80
Date

TN NO 80-0067 Rec'd 1/19/81
☒ Approved
☐ Other ☒ Send ☐ Do not send
Init. [illegible] Date 3/27/81

Tommy G. Thompson
Governor

Joe Leean
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH

BUREAU OF PUBLIC HEALTH
1414 E. WASHINGTON AVE., ROOM 167
MADISON WI 53703-3044

(608) 266-1251

MEMORANDUM OF UNDERSTANDING
TITLE V, WIC and TITLE XIX

Between the Bureau of Public Health (BPH) --- representing Title V - Maternal and Child Health (MCH) including the Children with Special Health Care Needs (CSHCN) Program and the Supplemental Nutrition Program for Women, Infants and Children (WIC) --- and --- the Bureau of Health Care Financing (BHCF) --- representing Title XIX - the Medicaid Program including the EPSDT (HealthCheck) Program -- within the Wisconsin Division of Health, Department of Health and Family Services. (See also the Memorandum of Understanding between the Department of Health and Family Services and the Department of Workforce Development regarding Medical Assistance Eligibility Functions.)

GOAL

The overall goal of this State MCH (Title V), WIC, and Medicaid (Title XIX) agreement is to improve the health status of low income and special needs children by assuring provision of preventive services and of any necessary treatment and/or follow-up care allowed under the Social Security Act. It is intended that care be provided in the context of an ongoing provider-patient-family relationship and from continuing care providers who can provide quality and comprehensive care.

It is understood that the parties following, as representatives of the programs indicated, are in substantive agreement with the following points:

1. Title V and WIC funded agencies (projects) will be encouraged, and where appropriate required to make available their range of services to the recipients of Medicaid.

2. Recipients of Medicaid will be encouraged to utilize Title V and WIC services when appropriate.

3. Title V - funded agencies (projects) will be instructed to adhere to the precedence of billing principles: for those recipients on Medicaid: Medicare and private third party payers as first recoverable dollar, Medicaid as second dollar, and Title V as third dollar, in payment for services rendered. Medicaid-certified Title V agencies must have an established fee schedule on file and bill Medicaid according to the schedule.

4. Title V program income from Title XIX reimbursed services will be applied as State matching resources, against requirements stated in Federal Title V regulation.

5. The parties are in agreement regarding operation of the federally mandated EPSDT Program, known in Wisconsin as "HealthCheck." (Reference 42 CFR 440.40(b) and Part 441, Subpart B.).

6. The parties agree personally, or by representation, to periodically address issues and resolve problems, and to jointly develop formal procedures that will carry out the spirit and letter of the agreement. An ongoing liaison will be developed between the BPH and the BHCF to review content standards for HealthCheck.

7. This agreement will be reviewed annually by both parties and updated as necessary.

The following procedures and mechanisms have been developed to address the issues outlined above, including, but not limited, to referring eligible clients between participating programs; obtaining reimbursement for services rendered; sharing of data, reports and other relevant information; and developing collaborative and/or complementary service programs.

1. Medicaid Managed Care Expansion

A. Develop an important, system link between Wisconsin's public health system in the Medicaid managed care system consistent with the mission of public health and the core function of public health assessment, assurance and policy development.

B. Encourage state, regional and local health department staff to participate in any MCH Medicaid managed care or W-2 advisory groups.

C. Provide local health departments and WIC projects with essential information on how the Medicaid managed care system works, current information on Medicaid quality of care indicators and their current Medicaid reimbursement.

D. Provide HMOs with information on local health departments and WIC projects and the services they provide.

E. Promote coordination and collaboration between local health departments, WIC projects, HMOs, and other Title XIX managed care programs.

F. Title V and WIC funded agencies will encourage recipients of Medicaid who are eligible for HealthCheck services to receive preventive care through HealthCheck screening. Medicaid children who are enrolled in managed care programs must receive Medicaid services from their assigned managed care providers.

G. Require the HMOs to refer potentially eligible women, infants, and children to the WIC Program. Referrals should include relevant health data (e.g., length/height and weight measurements, hematocrit or hemoglobin, documentation of nutrition-related medical conditions, etc.). In addition, the on-going provision of relevant health data is encouraged in order to prevent duplication of services in subsequent WIC certifications.

2. Wisconsin's Program for CSHCN

The Wisconsin Program for Children with Special Health Care Needs (CSHCN) expects to continue its coordination and cooperation with Title XIX through the following mechanisms: continuation of electronic data access, formalization of provider data exchange, continuation of referral exchanges, increase the frequency of mutually-developed training materials for provider groups, and through established Title V/Title XIX cooperative work groups develop mutually agreeable procedures for CSHCN to provide technical assistance to the BHCF regarding services covered by CSHCN .

Non-duplication of Medicaid payments to SSI recipients under 16

Title V will assure the provision of rehabilitation services for blind and disabled individuals under the age of 16 receiving Supplemental Security Income (SSI) benefits under Title XVI (of the Social Security Act), to the extent such services are not covered under Title XIX (Medicaid).

3. Wisconsin WIC Program

The WIC Program will refer WIC applicants/participants to Medicaid programs (e.g., HealthCheck, Prenatal Care Coordination, Case Management). The WIC Program may disclose individual client information, such as lab results, and manual or computer-generated lists or extract files of women, infants, and children eligible for Medicaid programs to the appropriate Medicaid provider for the purpose of determining eligibility for the program or for further services. Client information disclosed will be limited to the purpose of the referral. The Medicaid provider receiving the information will not redisclose the information to a third party except to the extent the additional disclosure is for the purpose of accomplishing the purpose of the initial referral. Informed written consent of the client or person legally authorized to give consent on behalf of the client shall be obtained prior to disclosure of treatment for mental illness, developmental disabilities, and alcoholism or drug abuse; and for HIV infection as required by Wis. Stat. 252.15.

4. Toll-free Telephone Numbers

MCH Hotline

Title XIX, Title V, and WIC will maintain a toll-free MCH Hotline service for Wisconsin residents including Title XIX recipients, who may call to locate: Title V grantees, HealthCheck, WIC, Alcohol and Other Drug Abuse (AODA), Healthy Start, Presumptive Eligibility, Genetic Services, Prenatal Care Coordination (PNCC), and other health care providers.

In addition, BPH will provide and update a list of Title V services available at the county level to the Medicaid Recipient Hotline for families currently receiving Medicaid benefits.

CSHCN Program

The Wisconsin CSHCN Program also has a toll-free number that is widely disseminated. This toll-free number is intended to provide families with access to CSHCN staff. CSHCN staff rely on these toll-free calls to facilitate rapid response to family needs. The CSHCN program will use the toll-free number as an additional opportunity to refer families to Title XIX services.

BPH and BHCF further agree to collaborate on the development and dissemination of materials used to publicize these toll-free numbers, including both print and electronic media.

5. HealthCheck (EPSDT)

The purpose of HealthCheck is to provide comprehensive preventive services, to identify health problems early and to assure coordinated follow-up services to Medicaid children and youth birth to 21 years of age. Title V state agencies and Title XIX state agencies have a mutual commitment - to improving services to this population. Title V providers serve a predominantly low income population, many of whom are Title XIX eligible. Title V providers are responsible for billing Title XIX for covered services, so as to maximize availability of Title V funding for non-Title XIX clients.

In order to maximize the effective operation of Wisconsin's fee for service Title XIX, Title V and WIC Programs, the following methods for coordination have been established.

A. For identification of individuals under 21 years of age needing health services, HealthCheck Outreach providers must utilize the quarterly and monthly reports to assist their outreach and case management efforts. Managed care enrollees are excluded from this list.

B. Title V agencies certified and providing HealthCheck Outreach services may request listings of Medicaid providers in their service area from BHCF for purposes of referral.

C. HealthCheck outreach agencies will refer all identified Title XIX recipients to the WIC Program, Title V projects, local health departments, community based agencies, Head Start, school health programs, the CSHCN Program, and any other appropriate public or private provider.

D. The Title V and WIC providers must refer all Medicaid HMO enrolled children to their HMO for the comprehensive HealthCheck screening.

E. Title V agencies certified as HealthCheck providers will identify all primary health care and nutritional needs of their Title XIX recipients and will refer patients, as appropriate, to the WIC program, Title V projects, local health departments, community based agencies, Head Start, school health programs, the CSHCN Program, and any other appropriate public or private provider.

F. The Title V and Title XIX agencies will inform providers of Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents, which is listed as a resource for providers conducting HealthCheck comprehensive examinations. HealthCheck providers, however, will be expected to adhere to the HealthCheck periodicity schedule. The Title V and Title XIX agencies will cooperate when providing technical consultation and support sessions for potential HealthCheck providers.

G. Exchange of reports of established services are provided periodically and upon request by either agency including continued collaboration and agreement for the identification of new data needs, reporting formats, and time frames.

H. Payment and reimbursement procedures and policy clarification are provided to all HealthCheck providers and the Title V Program. Additional assistance with billing instructions is provided by the Title XIX fiscal agent. The Title XIX Agency will provide technical training on Medicaid policy and billing for HealthCheck certified providers, including the HealthCheck "other services" component.

I. Jointly evaluate policies that affect both agencies depending on changes in the clinical aspects, provider needs, utilization of the program by recipients, quality assurance reports, and state or federal mandates.

J. Periodically review and jointly plan for changes in this section based on individual agency needs, legislative inquiries, and state or federal mandates.

6. Medicaid Applicant Identification and Assistance (see Memorandum of Understanding between the Title V and the Office of Welfare Reform, Division of Economic Support)

Wisconsin Title V, Title XIX, and WIC Programs agree to collaborate on programs and services to identify pregnant women and children who may be eligible for Medicaid and once identified, to assist them in applying for such assistance, including the following:

A. Healthy Start, and
B. Presumptive Eligibility

Title V, Title XIX, and WIC Programs agree to collaborate on assisting Medicaid recipients with selecting an appropriate managed care delivery system.

7. Cooperative and Collaborative Relationships

Title V, Title XIX, and WIC (state) Programs agree to establish cooperative and collaborative relationships, including work groups and periodic meetings, with respect to the following programs and services, including, but not limited to:

A. HealthCheck (EPSDT)).

B. Immunizations (see Memorandum of Understanding between BPH-BHCF)

C. CSHCN

D. Recipient Access/Provider Participation

E. Medicaid Clinical Review

F. Prenatal Care Coordination

G. Healthy Start (see Memorandum of Understanding between DOH and DES)

H. Birth to Three

I. Children Come First

J. Expansion of Medicaid Managed Care programs statewide

This agreement may be terminated at any time by order of the Administrator of the Division of Health (DOH). Either party may terminate this agreement at any time by providing written notice to the other party. The agreement may be amended in writing at any time by mutual agreement of the parties. This agreement remains in effect until terminated or amended in accordance with this provision.

Kenneth Baldwin, Director
Bureau of Public Health
(Representing the Wisconsin Title V - MCH, CSHCN and WIC Programs)

Date

Peggy Bartels, Director
Bureau of Health Care Financing
(Representing the Wisconsin Title XIX - Wisconsin Medicaid and HealthCheck Programs)

7/14/97
Date

MAMOU2.DOC (Revised3/97)

Tommy G. Thompson
Governor

State of Wisconsin
Department of Health and Social Services

DIVISION OF HEALTH
1 WEST WILSON STREET
P. O. BOX 309
MADISON WI 53701-0309

MEMORANDUM OF UNDERSTANDING, TITLE V AND TITLE XIX EPSDT (HEALTHCHECK)

Between the Bureau of Public Health (BPH)--representing Title V - Maternal and Child Health (MCH), Children with Special Health Care Needs (CSHCN) Programs, and the Supplemental Nutrition Program for Women, Infants and Children (WIC)--and the Bureau of Health Care Financing (BHCF)--representing Title XIX - EPSDT (HealthCheck) Program within the Wisconsin Division of Health (DOH), Department of Health and Social Services (DHSS).

It is understood that the parties following, as representatives of the programs indicated, are in substantive agreement regarding operation of the federally mandated EPSDT Program, known as "HealthCheck." (Reference 42 CFR 440.40(b) and Part 441, Subpart B.).

I. GOALS

The overall goal of this State MCH, WIC, and Medicaid (Title XIX) agreement is to improve the health status of low income and special needs children by assuring provision of preventive services and of any necessary treatment and/or follow-up care allowed under the Social Security Act. It is intended that care be provided in the context of an ongoing provider-patient-family relationship and from continuing care providers who can provide quality and comprehensive care.

A. Improving Services

1. Title V and WIC funded agencies will encourage recipients of Medicaid who are eligible for HealthCheck services to receive preventive care through HealthCheck screenings. Medicaid children who are enrolled in managed care programs must receive Medicaid-covered services from managed care providers.

2. The Title XIX and Title V agencies will review HealthCheck Outreach components to effectively maximize outreach efforts while minimizing duplication.

3. Medicaid-Certified Title V agencies (providers) providing HealthCheck services understand that Medicaid reimbursement for covered services is the lesser of usual and customary charges or maximum allowable fees.

4. An ongoing liaison between the BPH and the BHCF to review measures for containing costs and monitoring the overall quality of services provided by the Title V and Title XIX providers.

5. An ongoing liaison will be developed between the BPH and the BHCF to review content standards for HealthCheck.

B. Focusing Services on the HealthCheck Population

1. Title V agencies certified and providing HealthCheck Outreach services will receive a targeted listing each month of Title XIX recipients in their service area who are in need of preventive services. Managed care enrollees are excluded from this list.

2. Title V agencies certified and providing HealthCheck Outreach services are also provided with a quarterly list of all Title XIX HealthCheck eligibles in their service area. In areas of the state where there are managed care programs, managed care enrollees are excluded.

3. Title V agencies certified and providing HealthCheck Outreach services may request listings of Medicaid providers in their service area for purposes of referral.

4. Title XIX and Title V will maintain a toll-free MCH Hotline service that Title XIX recipients may call to locate Title V grantees, HealthCheck, WIC, Alcohol and Other Drug Abuse (AODA), Healthy Start, Presumptive Eligibility, Genetic Services, Prenatal Care Coordination (PNCC), and other health care providers.

5. The BPH program staff will encourage qualified providers to participate in the HealthCheck program.

6. The BPH will encourage Title V agencies who are HealthCheck certified to provide comprehensive HealthCheck screenings and outreach.

C. Scope of the Programs in Relation to Each Other

1. Title V agencies certified as HealthCheck providers will attempt to identify all primary health care and nutritional needs of Title XIX recipients and will refer patients, as appropriate, to the WIC, Public Health Agencies, Community Based Agencies, Head Start, school health programs, the CSHCN program, and any other appropriate public or private provider.

2. The Title V and Title XIX agencies will inform providers of Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents, which is listed as a resource for providers conducting HealthCheck comprehensive examninations. HealthCheck providers, however, will be expected to adhere to the HealthCheck periodicity schedule. The Title V and Title XIX agencies will cooperate when providing clinical training sessions for all potential HealthCheck providers.

3. The Title XIX (state) Agency will collaborate with the Title V Agency in providing technical consultation and support to Title V and Title XIX programs, as needed.

4. The Title V (state) Agency will collaborate with the Title XIX Agency in providing program level and management staff to participate in Title XIX HealthCheck or Title V workgroups.

5. The Title XIX Agency will provide technical training on Medicaid policy and billing for HealthCheck certified providers, including the HealthCheck "other services" component.

II. OBJECTIVES AND RESPONSIBILITIES

The purpose of HealthCheck is to provide comprehensive preventive services, to identify health problems early and to assure coordinated follow-up services to Medicaid children and youth birth to 21 years of age. Title V state agencies and Title XIX state agencies have a mutual commitment - to improving services to this population. Title V providers serve a predominantly low income population, many of whom are Title XIX eligible. Title V providers are responsible for billing Title XIX for covered services, so as to maximize availability of Title V funding for non-Title XIX clients.

III. OPERATIONAL CONSIDERATIONS

In order to maximize the effective operation of Wisconsin's Title XIX, Title V and WIC Programs, the following methods for coordination have been established.

A. For identification of individuals under 21 years of age needing health services, HealthCheck Outreach providers must utilize the quarterly and monthly reports to assist their outreach and case management efforts.

B. The Title V and WIC providers must refer all Medicaid HMO enrolled children for the comprehensive HealthCheck screening to the appropriate HMO.

C. The Title V and WIC providers must refer all Medicaid enrolled children for comprehensive HealthCheck screening.

D. The WIC Program may provide individual client information, such as lab results, and manual or computer-generated lists or extract files of children eligible for HealthCheck to the appropriate HealthCheck provider for the purpose of determining eligibility for the program or for further services. Client information disclosed will be limited to the purpose of the referral. The provision of additional information requires client written consent. The HealthCheck provider receiving the information will not redisclose the information to a third party.

E. HealthCheck outreach agencies should refer all Medicaid-eligibles to Title V and WIC programs, as appropriate.

F. Payment and reimbursement procedures and policy clarification are provided to all HealthCheck providers and the Title V Program. Additional assistance with billing instructions is provided by the Title XIX fiscal agent.

G. Exchange of reports of services furnished are provided periodically and upon request by either agency. On-going efforts include identification of data needs, reporting formats and time frames.

H. Periodically review and jointly plan for changes in this agreement based on individual agency needs, legislative inquiries, and state or federal mandates.

I. Jointly evaluate policies that affect both agencies depending on changes in the clinical aspects, provider needs, utilization of the program by recipients, quality assurance reports, and state or federal mandates.

This agreement may be terminated at any time by order of the Administrator of the Division of Health (DOH). Either party may terminate this agreement at any time by providing written notice to the other party. The agreement may be amended in writing at any time by mutual agreement of the parties. This agreement remains in effect until terminated or amended in accordance with this provision.

Meg Zaenk for K.B. — 7-24-95

Kenneth Baldwin, Bureau Director
Bureau of Public Health
(Representing the Wisconsin Title V
MCH/CSHCN and WIC Programs)

Date

Kevin B. Piper, Director
Bureau of Health Care Financing
(Representing the Wisconsin Title XIX
Wisconsin Medicaid Program)

Date

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: WISCONSIN

WISCONSIN MEDICAID
MEMORANDUM OF UNDERSTANDING
BETWEEN
DIVISION OF SUPPORTIVE LIVING
AND
DIVISION OF HEALTH CARE FINANCING

The following is the inter-agency agreement between the Division of Supportive Living, Bureau of Quality Assurance (BQA) [the State Survey Agency (SA)], and the Division of Health Care Financing (DHCF), [the State Medicaid agency], as required by Section 431.610 of the *Code of Federal Regulations*, Title 42. This agreement supersedes all previous agreements.

I. General Information

A. The Survey Agency (BQA), shall use qualified staff, federal requirements and approved forms, methods, and procedures designated by the Administrator of the Health Care Financing Administration (HCFA), to determine provider eligibility and certification under the Medicaid Program.

B. BQA surveyors inspecting the premises of a provider will:

1. Complete inspection reports;

2. Note on completed reports whether or not each requirement for which an inspection is made is satisfied;

3. Document deficient practices in reports;

4. Verify correction of deficiencies; and

5. Recommend enforcement actions as necessary.

C. The SA will keep on file all information and reports used in determining whether participating facilities meet Federal requirements.

D. BQA will make the information and reports readily accessible to the United States Department of Health and Human Services (DHHS), DHCF, and the public as necessary:

1. For meeting other requirements under the State Plan;

2. For purposes consistent with DHCF's effective administration of the Medicaid Program; and

3. For compliance with public disclosure requirements.

E. BQA will notify DHCF of certification information regarding providers/suppliers via the Medicare/Medicaid Certification and Transmittal (C & T), HCFA-1539. The scope of this information includes, but is not limited to, certification status, changes in ownership, changes in provider numbers, etc.

F. Hospital providers furnishing specialized treatment for ventilator-dependent patients receive a fixed rate per day. Nursing Home providers furnishing specialized treatment for ventilator-dependent residents may receive a negotiated rate in lieu of the provider's daily rate. To receive the special reimbursement rate for the care of people on ventilators, nursing homes must have their ventilator unit approved by the Department in advance. Approval is based on an assessment developed jointly by DHCF and BQA. BQA is responsible for the initial review and approval of the ventilator unit based on the necessary staffing including nursing; social services; dietary; respiratory and other professional and non-professional services required. BQA must also consider staff expertise; ongoing evaluation of residents requiring ventilator care; physical plant requirements; use of ventilator dependent guidelines mutually approved by BQA and DHCF in the review of the units. BQA will coordinate its approval of the ventilator unit with DHCF by the following activities that may occur in no specific order:

1. BQA will notify and inform DHCF when a provider requests approval of a ventilator unit; or if DHCF receives the request they will notify BQA;

2. BQA will conduct an on-site review of the requesting provider physical plant as well as program components including staff, procedures and policies, training and others as necessary;

3. BQA will notify DHCF of all providers receiving approval for operation of a ventilator unit, its size and effective date of start up;

4. BQA will notify DHCF when serious deficiencies are cited as a result of a resident who is ventilator dependent;

5. DHCF will notify BQA of any care concerns they identify during prior authorization review relating to the care of the ventilator-dependent resident/patient.

G. BQA will refer all information (to include information on waiver programs, provider reimbursement policy and long term care redesign) over which DHCF has jurisdiction to DHCF upon receipt in BQA, in writing with attachments as appropriate. Likewise, DHCF will refer information over which BQA has jurisdiction to BQA upon receipt. BQA and DHCF will share investigative results between them, when referrals are made.

H. BQA will assist DHCF with the annual review and formulation of the State Plan if it affects the operation of BQA.

I. BQA will notify DHCF prior to submitting recommended changes to state statutes and administrative rules. Likewise, DHCF will notify BQA prior to submitting recommended language changes to statutes and administrative rules.

II. Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICF/MR)

A. In certifying NFs and ICF/MRs, BQA will:

1. Review and evaluate the providers medical and independent professional review team reports obtained under part 456 of the Code of Federal Regulations, Title 42, as they relate to health and safety and other part 456 requirements;

2. Take necessary action to achieve compliance or to withdraw certification;

3. Have qualified personnel perform on-site inspections:

a. At least once during each certification period or more frequently if there is a compliance question; and

b. For nursing facilities and intermediate care facilities for the mentally retarded with deficiencies as described in §§442.12, 442.110, and 443.108 of the Code of Federal Regulations, Title 42, BQA staff must conduct follow up visits as needed to ensure compliance with the Code of Federal Regulations.

4. Review the facility's policies for compliance with Civil Rights requirements.

B. Wisconsin Administrative Codes require an application for a change of ownership (CHOW) to submit evidence to establish sufficient resources to permit operation of a facility for a period of six months. When BQA receives the completed CHOW application forms, the financial material will be forwarded to DHCF. DHCF will conduct a review of the financial material for the purpose of satisfying these requirements. DHCF's decision is then rendered to BQA, who will then continue their review process.

C. DHCF will notify BQA of any facility that is in financial distress as determined by DHCF for purposes of determining a remedy or possible adverse effect on quality of care.

D. BQA will notify DHCF when a remedy will be imposed under the federal enforcement/certification regulations. BQA will prepare the formal notice to providers. In the absence of a formal notice from the federal Health Care Financing Administration, BQA and DHCF will jointly issue the formal notice. Additionally, when the

remedy is a civil money penalty, DHCF will review the provider's financial condition and advise BQA of it. BQA will notify DHCF, via the C & T form and other means, of any other remedies to be imposed on a facility not in substantial compliance.

BQA will send the notice to NF only providers when a civil money penalty is to be collected. HCFA will send the notice to SNF providers when a civil money penalty is to be collected. If SNF or NF providers do not negotiate to pay a civil money penalty when it is due then DHCF will authorize the deduction of moneys to the provider. DHCF will authorize the deduction of the civil money penalty from moneys due the provider, should the provider fail to pay the penalty on a timely basis. If civil money penalty funds that have been collected are to be expended both bureaus must sign off on disbursement documents.

BQA and DHCF, working together with their fiscal intermediary, will establish procedures to implement and track enforcement actions.

E. BQA will notify DHCF of any administrative charges (copying charges, telephone charges, etc.) submitted to BQA for payment by a provider. DHCF will take appropriate rate setting action.

F. BQA, in order to comply with appropriate federal regulations, will routinely review NF and ICF-MR procedures for maintaining resident/client fund accounts. DHCF will assist in auditing selected NFs and ICF-MRs in their management of resident fund accounts when requested by BQA as a referral or independently on a random basis. Specifically, DHCF will conduct the following activities either independently or at the request of BQA:

1. Identify whether the facility has a surety bond or equivalent assurance to cover the cost of all patient fund accounts;

2. Identify whether the facility is reconciling resident trust accounts to petty cash and bank accounts;

3. Identify whether resident fund accounts totaling fifty (50) dollars or more are in interest bearing accounts and that the appropriate allocation of interest is applied to resident accounts;

4. Identify when the facility is notifying Medicaid residents when their resident fund account reaches the $2,000 maximum, the balance of the resident fund account on a quarterly basis, and assuring access by the resident to their resident fund account;

5. Identify whether resident fund accounts are being maintained separately and not commingled with facility operations accounts or other facility accounts;

6. Review a sample of items being charged out of the resident fund accounts and check these against the federal list;

7. Assure that all Title 19 residents have either a trust account or other appropriate documentation; and

8. Review facility and resident fund account records to determine whether the NF is only charging residents the difference between a Medicaid-covered item and a specially ordered item with approval from the resident/responsible party for the ordered item.

G. BQA will notify DHCF when state forfeitures assessed upon NFs are paid.

H. BQA will notify DHCF of a NF first submitting a relocation plan under Chapter 50, Wisconsin Statutes. BQA will keep DHCF apprised of progress made with a NF relocation plan. BQA will notify DHCF of all types of relocations described in Chapter 50, Wisconsin Statutes.

I. BQA will prepare the Provider Control Sheet for NFs and send that to DHCF at least monthly based on the survey process and care level determinations. BQA will have responsibility for the authorization segment of the Medicaid recipient subsystem of the Medicaid Management Information System with respect to level of care determinations. BQA will forward to the DHCF's fiscal agent on a weekly basis via electronic transmission all level of care determinations and changes in Medicaid resident status.

J. BQA and the DHCF have entered into a Memorandum of Understanding (MOU) with the Division of Supportive Living, Bureau of Developmental Disabilities Services regarding specialized treatment for persons with head injuries. Refer to Addendum I for specific activities in this area. Addendum I is the traumatic brain injury MOU.

K. BQA will communicate with DHCF, on a monthly basis, regarding nurse aide training and competency evaluation program issues.

L. BQA and DHCF will jointly begin exploring criteria, policies and procedures for the implementation of an incentives program for nursing facilities that provide the highest quality of care.

III. Hospitals

A. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or American Osteopathic Association (AOA) hospitals are " deemed" to meet Medicare certification standards. Hospitals are not " deemed" to meet Medicare certification standards if they have only received JCAHO provisional accreditation or if they hold program accreditation only.

B. BQA surveys non-accredited hospitals and makes a recommendation for certification.

C. BQA will notify DHCF when, through the course of normal survey activity, it determines that a general or psychiatric hospital:

1. Does not meet the conditions of participation and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients;

2. Does not meet the conditions of participation and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients; and/or

3. If a psychiatric hospital has not complied with the conditions for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with the conditions of participation.

IV. Home Health, Personal Care Providers, and Care Maintenance Partnership

A. BQA and DHCF will work together to establish consistency between the home health rules and regulations and the rules governing personal care providers.

B. BQA and DHCF will work together to explore development of survey criteria and protocols for survey and certification of personal care providers under HFS 105.17 Wis. Adm. Code and s. 46.96(1)(a), Wis., Stats.

C. BQA and DHCF will work together to explore development of survey criteria and protocols for quality of care provided through the Partnership program that is a federal demonstration project under Medicare/Medicaid (a federal waiver authorized under 42 USC 1315).

D. BQA and DHCF will create a mechanism for Medicaid reimbursement of BQA staff time spent on activities specified in paragraphs A, B, and C.

V. Program Certification Providers

A. BQA and DHCF will work together to establish consistency between the Program Certification Provider rules and regulations.

B. BQA and DHCF will work together to explore development of survey criteria and protocols for survey and certification of Program Certification providers under the Social Security Act 1929, 42 CFR 441.180 and HFS 105.22, 105.23, 105.24, 105.25 and HFS 105.255 Wis. Adm. Code.

VI. For Medicaid provider quality assurance activities that do not currently receive Medicare or Medicaid funding, DHCF will pursue the feasibility of claiming Medicaid administrative costs for the Medicaid proportionate share of the direct survey activity costs for programs that use state

certification in lieu of federal Medicaid certification. DHCF will explore the feasibility of using program revenue fees to capture federal matching funds under Medicaid administration.

VII. Data Exchange - BQA and DHCF will work jointly to promote efficiencies in information systems.

A. BQA and DHCF will continue to work together during the redesign of BQA's primary data system as it relates to the transfer of information between BQA and DHCF's fiscal agent.

B. BQA and DHCF will develop a process by which information can be processed related to provider cost reports and home health agency patient specific data.

C. BQA and DHCF will continue to jointly develop reports from paid claims data.

D. DHCF will inform BQA when the long term care Pop-IDs are assigned.

E. BQA and DHCF will explore on-line data base access for exchange of data, including but not limited to the Minimum Data Set and Outcome and Assessment Information Set.

1. Other technical assistance needs that arise during the MOU period will be further specified as amendments to this MOU. These agreements will be written and signed by the proper representatives of the Division of Supportive Living and the Division of Health and will identify the nature of the assistance to be provided. These agreements will be attached as amendments or clarification to this MOU.

2. The contact person for the Division of Supportive Living, Bureau of Quality Assurance is Rita Prigioni, Deputy Director. The contact person for the Division of Health Care Financing is Peggy Bartels, Administrator.

3. Effective Date: July 1, 1998. This agreement is effective until terminated by either party with a thirty-day advance written notice. This agreement shall be revised upon the mutual concurrence of both parties.

Signature Page

Division of Health Care Financing

and

Division of Supportive Living

Memorandum of Understanding (MOU)

This signature page applies to the MOU or inter-agency agreement between the Division of Health Care Financing and the Division of Supportive Living's Bureau of Quality Assurance.

Sinikka McCabe, Administrator Date
Division of Supportive Living

Peggy Bartels, Administrator Date
Division of Health Care Financing

Effective Date: July 1, 1998

This agreement is effective until terminated by either party with a thirty-day advance written notice. This agreement shall be revised upon the mutual concurrence of both parties. Other technical assistance or projects that are identified by either party during the MOU period that are over and above those products spelled out in this MOU will be negotiated and further specified as amendments to this MOU. These agreements will be written and signed by the proper representatives of each agency and identify the exact nature of the assistance to be provided. Fiscal specifications if any need to identified. These agreements will be attached as amendments or as clarifications to this MOU.

Addendum 1

Institute for Mental Diseases Inspections and Related Activity

I. Introduction and Purpose

This cooperative agreement is made and entered into to formalize a request from the Bureau of Health Care Financing (BHCF), of the Division of Health, to the Bureau of Quality Assurance (BQA), of the Division of Supportive Living (DSL), regarding a request from the federal Health Care Financing Administration (HCFA-Region V) that the BQA provide physician medical review certification services in Institutions of Mental Diseases to BHCF in support of requirements of the federal government under Title XIX of the Social Security Act and Sections of the Code of Federal Regulations (CFR) including 42 CFR 456.601-Institution for Mental Disease (IMD) Inspection of Care.

II. Roles and Responsibilities

The BQA employee responsible for the administration of this agreement will be Judy Fryback, Director, Bureau of Quality Assurance. The BHCF employee responsible for the administration of this agreement will be Peggy L. Bartels, Director, Bureau of Health Care Financing.

WHEREAS, the BHCF has obtained federal and state funding for meeting the federal requirements for Institutions of Mental Diseases certification; and

WHEREAS, the BQA has qualified personnel to administer the federal requirements and recommend certification;

NOW, THEREFORE, the Bureaus understand and agree to the following cooperative responsibilities in the administration of the IMD certification program:

1. The BHCF shall notify the BQA in a timely manner of the providers to be surveyed and the time frame in which the activity must be completed.

2. The BHCF shall apprise the BQA of any HCFA State Agency Quality Improvement Program (SAQIP) previous fiscal year findings and expected criteria/standards to be reviewed for the current federal fiscal year.

3. The BQA shall assign qualified personnel to complete the required surveys, complaint investigations and follow-up visits within the time frames identified, ensuring that all appropriate survey criteria identified in accordance with all applicable federal and state statutes, SAQIP criteria/standards, rules and regulations and federal state operations manual policies are met. BHCF shall deliver to BQA copies of appropriate statutes and regulations for both program

compliance and cost reimbursement, along with current and future amendments or changes to the statutes and regulations.

4. The BQA will forward all necessary documentation in the proper format to the BHCF within required time frames.

5. The BHCF will reimburse the BQA for all costs incurred by BQA employees in the performance of duties required under this agreement. These expenses shall be costs allowable under applicable federal regulations, and will include salary and fringe benefits, travel expenses, and supplies and contractual services.

   Total funding is strictly contingent upon receipt and level of federal grant awards. BHCF will notify BQA as soon as it becomes evident that funding will be withdrawn or reduced, this notice to be given prior to work being performed by BQA staff.

   Funding will be as follows:

Appropriation 112:	
Medical Assistance State Administration (25%)	$12,500.00
Appropriation 154: Medical Assistance State Administration (75%)	$37,500.00
Total State Fiscal Year 1998 Budget	$50,000.00

6. The BQA shall make expenditures only for purposes requested by the BHCF.

This cooperative agreement shall be for the period July 1, 1997, to June 30, 1998, and shall automatically be renewed unless terminated by either party with a thirty day advance notice. This agreement is contingent upon authorization and appropriation of funds and any material amendment or repeal of the same affecting relevant funding or authority and may be renegotiated in such circumstances as:

1. Increased or decreased volume or services;

2. Change required by federal law or regulation, state law or regulation changes to SAQIP requirements or court action; or

3. Funding available affecting the substance of this contract.

Any audit exception resulting from any federal audit of this program shall be charged to the party responsible for such audit exception(s).

Addendum 2

MEMO OF UNDERSTANDING (MOU)
TRAUMATIC BRAIN INJURY (TBI) PROGRAM

DIVISION OF HEALTH (DOH)
BUREAU OF HEALTH CARE FINANCING (BHCF)

DIVISION OF SUPPORTIVE LIVING (DSL)
BUREAU OF QUALITY ASSURANCE (BQA)
BUREAU OF DEVELOPMENTAL DISABILITIES SERVICES (BDDS)

A. Institutional Program

The Traumatic Brain Injury (TBI) program provides specialized rehabilitative treatment in units approved by the Department. The TBI program is designed to facilitate, to the extent possible, the individual's ability to return to community based living. Approval for utilization of the TBI program is done by the designated Nurse Consultant (NC) in the Bureau of Quality Assurance (BQA), Division of Supportive Living (DSL).

Bureau of Health Care Financing (BHCF) Responsibilities

- BHCF NC informs BQA and Bureau of Developmental Disabilities Services (BDDS) when a nursing home requests approval to operate a brain injury unit. BHCF/NC informs BQA and DSL of the facility, name, location, number of beds, requested date of start-up, effective date of approval and notification of approval.

- BHCF/Nursing Home Section with input from the BHCF NC negotiates the daily head injury all inclusive rate for nursing facilities that have an approved brain injury facility.

- Hospital brain injury rates are established by the Medicaid Hospital State Plan.

- BHCF NC will process the BHCF prior authorization request form (PA/RF) received from the BQA NC; processing will follow the current procedures for handling prior authorization requests.

- BHCF NC maintains a registry of all institutionalized traumatic brain injury (TBI) program recipients.

Bureau of Quality Assurance (BQA) Responsibilities

- BQA NC evaluates the necessary staffing pattern, staff expertise, and the physical environment and approves/disapproves the unit.

- BQA NC informs BQA and BDDS of approved brain injury facilities.

- BQA NC establishes the care level determination for all institutional brain injury admissions after confirmation of receipt of the DSL 822 form and communicates the care level determination to BDDS.

- BQA NC authorizes all admissions to a BHCF approved brain injury unit.

- BQA NC transmits the PA/RF form to BHCF NC for processing. The PA/RF will contain the following:

  1. Approved admission with from and to dates of stay; or

  2. Denied admission with statement regarding reason for denial of admission; and

  3. Date and signature of the BQA NC.

- BQA NC responds to appeals by recipients regarding denial of admission to the brain injury unit to the Division of Hearings and Appeals (DHA).

- BQA NC submits the care level determination to the Medicaid fiscal intermediary for system processing.

- BQA NC provides BDDS with the following information on all requests for brain injury institutional admission on a routine basis:

  1. Recipient name and MA number;

  2. Responsible county;

  3. Facility (facilities) where recipient may potentially be admitted;

  4. Current recipient status; and

  5. Estimated duration of stay and potential care level determination for the TBI Waiver program.

- BQA NC provides a copy of the DOH 2256 form to the appropriate BQA Regional Office for entry into the Nursing Home Resident Registry.

Bureau of Developmental Disabilities Services (BDDS) Responsibilities

- At BQA NC's request, BDDS reviews the appropriateness of referrals for admission to brain injury facilities. For individuals who BQA and BDDS evaluate to be more appropriately served through the TBI Waiver Program, BDDS will communicate that decision to the appropriate county agency and offer support to the agency in developing a waiver plan.

- For individuals in brain injury facilities, BDDS works with the counties to develop a TBI Waiver plan and shares progress in such planning with the BQA NC.

- BDDS assists the counties with placement, at an appropriate care level determination, of recipients from out-of-state traumatic brain injury facilities.

Brain Injury Facility Responsibilities

- The facility requests and obtains approval for admission from the responsible county agency (DSL 822 form). The DSL 822 form must be completed and submitted to the BQA Regional Office before a care level determination will be assigned by the BQA NC.

- The facility submits to the BQA NC the following documentation prior to admission to the brain injury unit:

  1. Request for Title XIX Care Level Determination (DOH 2256- Revised 9/92);

  2. Minimum Data Set (MDS) - Version 2.0, Full Assessment Form, completed in collaboration with familiar care givers;

  3. Current medications;

  4. Copy of the current Functional Independence Measurement (FIM); and

  5. Brain injury facility's proposed interdisciplinary plan of care for the recipient, including the discharge plan.

- The facility submits the BHCF prior authorization request form (PA/RF) to the Medicaid fiscal intermediary for system processing.

- The facility submits to the BQA NC the following documentation when requesting continued stay by the recipient in the brain injury facility:

  1. Newly completed Minimum Data Set (MDS) - Version 2.0, Full Assessment Form;

2. Minimum Data Set (MDS) - Version 2.0, Full Assessment Form completed at the time of admission to the brain injury facility;

3. Current medications;

4. Copy of the current FIM;

5. Current interdisciplinary plan of care for the recipient, including the current discharge plan; and

6. Documentation of recipient progress toward stated goals.

- The facility submits the BHCF PA/RF requesting continued stay in the brain injury facility to the Medicaid fiscal intermediary.

- The facility coordinates the discharge plan with the individual (family/guardian, county case worker) responsible for transition to another living environment.

County Agency Responsibilities

- The County Department (Department of Human Services/Developmental Disabilities Services/Community Programs) with responsibility for the program in which the person is seeking admission, reviews the request for admission and submits the DSL 822 form to the facility prior to admission.

- For individuals in brain injury facilities, the responsible county agency works with the individual and the brain injury facility in developing discharge plans, including a TBI Waiver individualized service plan (ISP) when appropriate.

B. Traumatic Brain Injury Waiver Program

The Traumatic Brain Injury Waiver Program provides home and community-based services to persons with traumatic brain injuries who would otherwise require care in a nursing facility or hospital.

Bureau of Quality Assurance (BQA) Responsibilities

- BQA NC makes the care level determination for all community based services brain injury waiver participants and provides that information to BDDS.

- BQA NC performs the care level determination and annual reevaluations for brain injury waiver program participants and provides that information to BDDS.

- BQA NC responds to all appeals by recipients concerning the care level determination which result in denial of participation in the TBI Waiver.

Bureau of Developmental Disabilities Services (BDDS) Responsibilities

- BDDS approves all ISPs which authorize participation in the home and community based services waiver for person with brain injuries and funding for the county agency and provides that information to the BQA NC.

- BDDS provides, on a monthly basis, the BQA NC with a listing of approved brain injury relocations and diversions; the listing includes the following information:

  1. Recipient name and MA number;

  2. Date of placement; and

  3. Responsible county.

- BDDS assures that relevant information is transmitted to the BQA NC for the purpose of making a care level determination.

- BDDS provides ongoing monitoring of the execution of ISPs by county agencies under the TBI Waiver.

- BDDS maintains, and makes available to the BQA NC, a case file of all waiver participants.

- BDDS assists the counties in developing/expanding alternative community resources for ensuring the recipient's successful community placement.

County Responsibilities

- The responsible county agency submits the requested TBI Waiver care level determination form to the BQA NC and the Individual Services Plan to BDDS for approval.

- Upon approval of the TBI care level determination and waiver plan, the responsible county agency assures implementation of the approved plan, and provides periodic updates and reevaluations as required.

- The responsible county agency submits all information required by BQA specified in DSL numbered memorandum or the manual governing the TBI Waiver to BQA NC for the annual evaluation and re-determination of the care level determination by the BQA NC. This information includes completed copies of the DOH-2256 form and the DOH-2256a, Parts A and B form.

- The responsible county agency submits the TBI Waiver Medicaid eligibility status to the Medicaid fiscal intermediary for system processing.

Signature Page

Division of Health and Division of Supportive Living

Memorandum of Agreement (MOU)

This signature page applies to the MOU or intra-agency agreement between the Division of Health's Bureau of Health Care Financing and the Division of Supportive Living's Bureau of Quality Assurance including any addendum to this MOU.

Gerald A. Born, Administrator
Division of Supportive Living

9-24-97
Date Signed

John Chapin, Interim Administrator
Division of Health

9-24-97
Date Signed

Effective Date: July 1, 1997

This agreement is effective until terminated by either party with a thirty day advance written notice. This agreement shall be revised upon the mutual concurrence of both parties.

INTER-AGENCY AGREEMENT
BETWEEN
THE DIVISION OF HEALTH, THE DIVISION OF COMMUNITY SERVICES AND THE DIVISION OF CARE AND TREATMENT FACILITIES

I. PURPOSE

This agreement is entered into between the State Medicaid Administration Agency, the State Mental Health Agency, and the Agency which operates the State Mental Health Facilities, for the purpose of implementing section 1902(a)(20)(A) of the ~~State Organization and General Administration~~ Act for states offering Medicaid services in institutions for mental diseases to Medicaid recipients aged 65 or older.

This cooperative agreement provides a working arrangement between the Division of Health (DOH), the Division of Community Services (DCS), and the Division of Care & Treatment Facilities (DCTF), and establishes individual responsibilities for: joint planning; development of alternative methods of care; readmission to an institution by a recipient who is in alternative care; access to the institution, recipient and the recipient's records; recording, exchanging and reporting medical information about recipients and other procedures needed to carry out the agreement.

II. RESPONSIBILITIES OF THE PARTIES TO THIS AGREEMENT

A. Division Of Health (DOH)

1. Community Options Program (COP) And Administrative Order 1.67

The DOH, Bureau of Quality Compliance, will conduct at least annual level of care reviews for all Medicaid recipients residing in nursing homes, centers for the developmentally disabled, institutions for mental diseases and Title XIX certified community based residental facilities. If the Bureau of Quality Compliance finds a recipient no longer requires institutional placement, a referral will be sent to the designated local service coordinator, via Administrative Order 1.67 for assessment and planning of an alternate placement.

In addition, the Bureau of Quality Compliance will notify the Bureau of Health Care Financing of an inappropriate placement and Title XIX will cease for institutional coverage within the times specified in Administrative Order 1.67 unless an appeal is filed, or an extension is requested and approved by the DOH.

TN 83-0116 Rec'd 5/9/83
☑ Approved
☐ Do not send
t. EMR Date 5-13-83

The DOH, Bureau of Health Care Financing, will verify eligibility and retroactive eligibility for those recipients designated by DCS to be appropriate to participate in COP and will fund pre-admission assessments at an agreed-upon reimbursement rate.

Reimbursement by the DOH to the DCS for COP assessments will be based upon the provision of timely and accurate information by DCS to DOH regarding recipient identification, and eligibility.

2. Mental Health

The DOH, Bureau of Health Care Financing, will establish for mental health service providers:

a. Medicaid provider certification criteria;
b. reimbursement mechanisms;
c. payment levels;
d. third party collection procedures;
e. service limitations; and
f. non-covered services.

In addition, DOH, the Bureau of Health Care Financing, via the Medicaid fiscal agent will provide cost utilization reports to county 51.42 boards.

The DOH will share information with DCS and DCTF subject to statutory limitations including client confidentiality and access to medical records. Such information includes, but is not limited to, recipient medical information, records, reports, certified provider lists (which include verification of licensure), as well as lists of decertified providers and those against which criminal charges have been filed.

The DOH, Bureau of Health Care Financing will maintain written agreements in the form of individual provider contracts with institutions for mental diseases which are not under the jurisdiction of state authorities but provide mental health services to recipients aged 65 or older who are covered by Title XIX.

83-0116 Rec'd 5/9/83
☑ Approved
☐ Send ☐ Do not s
Date 5-13-83

The DOH, Bureau of Health Care Financing, will provide reimbursement for the provision of mental health services to Medicaid recipients aged 65 or older residing in institutions for mental diseases. The DOH, Bureau of Health Care Financing, will provide reimbursement for case assessments offered to recipients who are at risk of institutionalization due to age and frail health, developmental or physical disability, or a combination of these characteristics who may be appropriate for placement in alternative, non-institutional care settings. Such reimbursement shall be subject to federal/state Medicaid requirements (including eligibility and coverage stipulations), limitations and any applicable waivers.

The DOH and its Bureaus will enter into other memoranda of understanding, agreements and joint memoranda with the parties of this Memorandum Of Understanding whenever greater specificity about policies, procedures, reimbursement rates, etc. is required.

Appropriate DOH staff will be provided to the parties of this agreement to insure joint planning and overall coordination regarding mental health issues are achieved.

B. Division Of Community Services

1. Community Options Program (COP)

The DCS, Office of Program Inititatives, will develop, coordinate and implement the Community Options Program (COP), and will provide preadmission assessments of Medicaid recipients of all ages.

The DCS will collect data from the counties on potential Medicaid eligible persons and will review for adequacy of information, including Medicaid certification. In addition, the DCS will send incomplete reports to the DOH, Bureau of Health Care Financing, management records and reports that include the following information on all assessed recipients for whom Medicaid payment is requested.

a. name, age, sex, county of residence;
b. Medicaid I.D. number;
c. preliminary assessment outcome (feasibility of community service alternatives); and
d. type of usual residence of the person.

Reports will be provided every 6 months.

...1 PO 83-0116 Rec'd 5/9/83
... ☒ Approved
... ☐ Send ☐ Do not s...
...it EMR Date 5-13-83

Medicaid reimbursement to the DCS by the BHCF for COP assessments will be dependent upon accurate and timely delivery to the DOH of the above-named information. The DCS will name a staff person responsible for the collection and delivery of such information to the DOH and will coordinate between the DOH and the DCTF so that admission or readmission to an institution will occur should it be needed by a Medicaid recipient who is placed in alternative care.

Appropriate DCS staff will be provided to the parties of this agreement to insure joint planning and overall coordination regarding COP issues are achieved.

Access to client records will be provided by DCS to DOH and DCTF so that each Division may discharge respective responsibilities under this memorandum. These records will be available within the limitations of patient confidentiality.

2. Mental Health

The DCS will establish guidelines for the provision of mental health services by community mental health agencies (51.42 Boards) and other local agencies throughout the State. Guidelines include criteria for scope, delivery, efficiency and quality of non-institutional mental health services.

The DCS., Office of Mental Health, will provide consultants and technical assistance to its regional offices and to the 51.42 Board to insure compliance with program objectives and Title XIX regulations.

The DCS, Office of Mental Health, will designate a lead consultant to work with other DCS staff and with DOH and DCTF regarding mental health issues.

The DCS will review, certify and decertify day treatment programs and mental health facilities according to criteria established in HSS 61.91 and 61.50-61.68.

The DCS will provide to the DOH accurate up-to-date lists of mental health programs and facilities which meet DCS certification requirements and those which do not meet such requirements and are in danger of decertification.

The DCS will review the uniform fee application of county 51.42 Boards and will approve psychotherapy reimbursement rates based upon established criteria.

The DCS will maintain key policy, advocacy and program administration functions for the provision of mental health services to Wisconsin citizens, and will focus on specific needy populations.

C. Division Of Care And Treatment Facilities - (DCTF)

The DCTF is responsible for insuring that all Wisconsin citizens residing in State owned and operated facilities receive appropriate care and treatment.

The DCTF, which includes the Mendota Mental Health Institutes the Winnebago Mental Health INstiutue, the Wisconsin Resource Center, the Southern Wisconsin Center For The Developmentally Disabled, the Central Wisconsin Center for the Developmentally Disabled, and the Northern Wisconsin Center for the Developmentally Disabled will insure development and implementation of the following:

a. effective programming;
b. cost effective personnel and fiscal planning;
c. development of mental health programs;
d. development of developmentally disabled and AODA programs; and
e. development of forensic and child care standards.

In addition, the DCTF will maintain a client rights/advocacy office to which any institutionalized person in the state has access.

The DCTF will maintain close and explicit communication with DCS staff to insure a continuum of mental health care is available to Wisconsin citizens including Medicaid recipients.

Appropriate DCTF staff will be provided to COP to provide assistance should readmission to an institution be needed by a Medicaid recipient placed in an alternative care setting. Such readmission need not be to a facility operated by DCTF.

83-0116 Rec'd 5/9/83
Approved
☑ Send ☐ Do not send
Date 5-13-83

Access to client records will be provided by DCTF to DOH and DCS so that their respective responsibilities can be carried out. These records will be available within the limitations of patient confidentiality.

III. TERMS

The terms of this agreement are extended indefinitely, subject to a 90-day termination of agreement notice by any party. Any modifications to this agreement must be approved by all parties and will become effective upon approval.

Kenneth Rentmeester, Administrator
Division of Health — Date 4.6.83

Gerald Berge, Administrator
Division of Community Services — Date 4.15-83

Burton Wagner, Administrator
Division of Care & Treatment Facilities — Date 4/18/83

83-0116 Rec'd 5/9/83
☒ Approved
☐ Send ☐ Do not send
Ink Date 5-13-83

TITLE XIX - TITLE V INTERAGENCY AGREEMENT
BUREAU OF HEALTH CARE FINANCING AND BUREAU FOR CHILDREN WITH PHYSICAL NEEDS

I. Mutual Objectives and Responsibilities

The Title XIX Program (Bureau of Health Care Financing-BHCF) enters into a cooperative arrangement with the Title V Grantee - The Bureau for Children with Physical Needs (BCPN) of the Department of Public Instruction. The BHCF includes the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT). The requirements of this agreement are specified in Title 42 CFR 431.615 for the provision of services to recipients of Medical Assistance.

The mutual objectives and responsibilities of the Title XIX program and the Title V program are to encourage and support the provision of comprehensive quality care to eligible children in the state and to insure that the services are accessible to all those who are eligible.

The Title XIX plan will recognize BCPN as eligible to furnish care and services under the XIX program if it meets the provider certification standards specified in HSS 105 of the Medicaid Administrative Code, or can comply with the provision of 42 CFR 431.615.

As part of the cooperative arrangement and when requested by a Medicaid certified Title V grantee, the Title XIX program will provide reimbursement as determined by the Title XIX program for the allowable cost of care and services furnished to eligible recipients under the State Plan for Medical Assistance. The Title XIX Program fiscal agent will reimburse the BCPN directly for services provided by certified Medicaid providers.

The intent of this MOU is to improve cooperations and communication between these agencies. In addition to the specifics included below, the general objectives are to:

A. Determine the extent to which the programs are providing services to the same clients or through the same providers, or both.

B. Determine the extent to which referrals are made between these agencies.

C. Gather information to determine if these programs can more effectively serve each other's objectives.

II. Services

The BCPN provides these services; clinic services; multi-discipline consultant services; diagnostic services; treatment services and financial assistance for treatment costs. Details on these services and the circumstances under which they are offered are included in the state plan for Title V.

The BHCF pays for these services: physician services; dental services; hospital services; nursing home services; drugs; nursing; home health care and personal care services; mental health services; podiatry services; chiropractic services; physical therapy, occupational therapy; speech pathology; audiology; vision care services; family planning services;

OPC-11 NO 82-0091 Rec'd 4/6/82
☒ Plan ☒ Approved
☐ Other ☒ Send ☐ Do not send
Init. [illegible] Date 4/7/82

early, periodic screening, diagnosis and treatment (EPSDT) services; transportation; medical supplies and equipment; diagnostic services; dialysis services; blood; and rural health clinic services. Details on coverage and limitations are included in the state plan for Title XIX and HSS 101-108 of the Medicaid Administrative Rule.

III. Cooperative Relationships at the State Level

The administrative coordinator of the BCPN is the primary liaison to the Title XIX program. The chief of the Policy, Planning and Evaluation Section, BHCF, is the primary liaison to the BCPN.

IV. Local Services

The Title V program deals with the following local agencies: (a) local health departments; (b) local social service departments; (c)visiting nursing associations; (d) developmental disability agencies; (e) schools; (f) neighborhood health centers and (g) Head Start agencies. The BCPN informs these local agencies of its programs and solicits referrals of people who might benefit from its program. The BCPN also works closely with private providers in the care and treatment of children with handicaps.

The Title XIX program has contact with the local Departments of Social Services, and other local certification agencies, which handle all aspects of the Title XIX eligibility determination process. The Title XIX program also has contact with all local agencies and individuals who are certified providers.

V. Early Identification of Individuals Under 21

The early identification of individuals under 21 in need of medical or remedial services will be accomplished through the outreach and screening efforts of the EPSDT program and the Title V program. These efforts will be coordinated in the following manner:

A. The BCPN will:

1. Develop the capacity and begin as soon as possible to provide to EPSDT (each quarter) information on any health examinations that contain any elements of EPSDT activities, with adequate detail so that EPSDT can report to the federal government the number of "equivalencies": (examinations equivalent to EPSDT screening).

B. The BHCF (EPSDT) program will:

1. Include the following provision in each contract for EPSDT outreach and referral: "Notification of criteria for eligibility for crippled children services under Title V of the Social Security Act".

   a. The Department shall notify contractor* of the location or agencies funded under Title V of the Social Security Act to provide services within the geographical area

* Contractor refers to each EPSDT outreach agency

OPC-11 NO 82-0091 Rec'd 4/[illegible]
☑ Plan ☑ Approved
☐ Other ☑ Send ☐ Do not send
Init. JO Date 4/[illegible]

contractor serves. Said notification shall also specify the services offered by those agencies and the criteria individuals must meet to establish eligibility for these services.

b. Contractor shall develop a working knowledge of the information provided under subparagraph above such that it can determine which individuals identified on the EPSDT eligibility lists would be appropriate to refer to BCPN for possible service.

c. Contractor shall inform individuals qualified for both EPSDT and Title V of the services available to them through the Title V funded agencies and shall refer individuals desiring such services to the BCPN.

2. Provide to Title V (BCPN) current information on EPSDT activities and projects including eligibility criteria, the groups and individuals actually being served, services being provided and the geographical area served by EPSDT agencies.

3. Monitor outreach/screening agencies to assure compliance with the above and evaluate the degree of compliance.

VI. Reciprocal Referrals

Reciprocal referrals will occur as specified in Section V above. Referrals will also occur between the county departments of social services and the Title V program. Title XIX rules and pamphlets outlining availability of services and eligibility will be provided to all Title V projects and Title V rules and pamphlets outlining availability of services and eligibility will be provided to the county departments, to encourage and facilitate referral.

VII. Reimbursement

The BCPN will apply to the BHCF for certification as a "billing provider." BHCF will certify the BCPN, establishing a special provider type and specialty and notify BCPN of a billing number and effective date. Reimbursement will follow the BHCF billing requirements as detailed in the Administrative Rules and Provider Handbooks, including the following:

A. Prior Authorization

To foster the use of the BCPN case management capabilities and improve coordination of services, the following procedure will be used. The BCPN will instruct its providers who are Title XIX-certified to submit the prior authorization requests for Title XIX services first to BCPN. The BCPN will first review appropriateness and medical necessity for case management purposes, then send the prior approval request to EDSF for the regular Title XIX review and processing. Title XIX reimbursable services that do not require prior authorization will be billed directly to the Medicaid fiscal agent by BCPN.

OPC-11 NO 82-0091 Rec'd 4/6/82
☒ Plan ☒ Approved
☐ Other ☒ Send ☐ Do not send
Init. [signature] Date 4/7/82

The Bureau will conduct prior authorizations for a period of six months from the effective date of this agreement. The need for continued prior authorization will be evaluated and possibly waived if data indicates that prior authorization by BHCF is not warranted.

B. Billing

The BCPN will submit claims for Medicaid billable services directly to the fiscal agent, EDS-Federal, on appropriate claim forms utilizing all required data (e.g., CPT-4, ICD-9-CM, performing provider number) and other information. The BHCF and BCPN will negotiate a fixed per capita fee for periodic field clinics coordinated by the BCPN. All other services will be billed using the performing provider's usual and customary charges.

VIII. Exchange of Reports

Data and statistical information of a general nature will be exchanged between the Title XIX program and the Title V grantee upon request. These requests will be shared between the primary program liaisons and could relate to budgetary, planning, evaluation and/or research.

Specific case management information will be shared only if the confidentiality of records is maintained according to Wisconsin Statutes 905.04 and Wisconsin Administrative Code HSS 108. The BHCF will provide access to microfiche of the eligibility file, and use of the on-line computer terminal for administrative purposes.

To further improve coordination, the BCPN may submit to BHCF on a quarterly basis the names and MA identification numbers of persons also served by Title V. The BHCF will provide Recipient History Reports on an agreed upon sample size of these persons so that BCPN can know what services are being provided by Title XIX. The BCPN will reimburse Title XIX at cost for these reports.

IX. An annual meeting between the Title XIX and Title V Program at the state level is planned to review the agreements and discuss any necessary changes.

X. Continuous liaison and staff responsibility between the Title XIX and Title V program was outlined in Section IV.

XI. Annual joint evaluation sessions between the Title XIX and Title V program at the state level are planned.

D. E. P.

Donald E. Percy, Secretary
Department of Health and Social Services

Date 9-21-81

Herbert J. Grover, State Superintendent
Department of Public Instruction

Date 8/19/81

OPC-11 NO 82-0091 Rec'd 4/6/82
☒ Plan ☒ Approved
☐ Other ☒ Send ☐ Do not send
Init. ____ Date 4/12

MEMO OF UNDERSTANDING (MOU)
TRAUMATIC BRAIN INJURY (TBI) PROGRAMS

DIVISION OF HEALTH (DOH)
BUREAU OF HEALTH CARE FINANCING (BHCF) AND
BUREAU OF QUALITY COMPLIANCE (BQC)

DIVISION OF COMMUNITY SERVICES (DCS)
BUREAU OF DEVELOPMENTAL DISABILITIES (BDD)

Amend Section IV. A. 6. Relating to Approval of Nursing Facility Programs For Traumatic Brain Injury Recipients:

A. Institutional Program

The traumatic brain injury (TBI) program provides specialized rehabilitative treatment in units approved by the department. The TBI program is designed to facilitate, to the extent possible, the individual's ability to return to community based living. Approval for utilization of the TBI program is done by the designated Nurse Consultant (NC) in the Bureau of Quality Compliance (BQC), Division of Health (DOH).

Bureau of Health Care Financing (BHCF) Responsibilities

- BHCF NC informs BQC and DCS when a nursing home requests approval to operate a brain injury unit. BHCF/Med Con informs BQC and DCS of the facility, name, location, number of beds, requested date of start-up, effective date of approval and notification of approval.
- BHCF NC evaluates the necessary staffing pattern, staff expertise, and the physical environment and approves/disapproves the unit.
- BHCF/Nursing Home Section with input from the BHCF NC negotiates the daily head injury all inclusive rate for nursing facilities that have an approved brain injury facility.
- Hospital brain injury rates are established by the State Plan.
- BHCF NC informs BQC and DCS of approved brain injury facilities.
- BHCF NC will process the BHCF prior authorization request form (PA/RF) received from the BQC NC; processing will follow the current procedures for handling prior authorization requests.
- BHCF NC maintains a registry of all institutionalized traumatic brain injury (TBI) program recipients.

Bureau of Quality Compliance (BQC) Responsibility

- BQC NC establishes the care level determination for all institutional brain injury admissions after confirmation of receipt of the DCS 822 form and communicates the care level determination to DCS.

- BQC NC authorizes all admissions to a BHCF approved brain injury unit.

- BQC NC transmits the PA/RF form to BHCF NC for processing. The PA/RF will contain the following:
  1. Approved admission with from and to dates of stay; or
  2. Denied admission with statement regarding reason for denial of admission; and
  3. Date and signature of the BQC NC.

- BQC NC responds to appeals by recipients regarding denial of admission to the brain injury unit to the Office of Administrative Hearings.

- BQC NC submits the care level determination to the Medicaid fiscal intermediary for system processing.

- BQC NC provides DCS with the following information on all requests for brain injury institutional admission on a routine basis:
  1. recipient name and MA number;
  2. responsible county;
  3. facility (facilities) where recipient may potentially be admitted;
  4. current recipient status; and
  5. potential care level determination and the estimated duration of stay.

- BQC NC provides a copy of the DOH 2256 form to the appropriate BQC Regional Office for entry into the Nursing Home Resident Registry.

Division of Community Services (DCS) Responsibilities

- At BQC NC's request, DCS reviews the appropriateness of referrals for admission to brain injury facilities. For individuals who BQC and DCS evaluate to be more appropriately served through the TBI Waiver Program, DCS will communicate that decision to the appropriate county agency and offer support to the agency in developing a waiver plan.

- For individuals in brain injury facilities, DCS works with the counties to develop a TBI waiver plan and shares progress in such planning with the BQC NC.

- DCS assists the counties with placement, at an appropriate care level determination, of recipients from out-of-state traumatic brain injury facilities.

Brain Injury Facility Responsibilities

- The facility requests and obtains approval for admission from the responsible county agency (DCS 822 form). The DCS 822 form must be completed and submitted to the BQC Regional Office before a care level determination will be assigned by the BQC NC.

- The facility submits to the BQC NC the following documentation prior to admission to the brain injury unit:
  1. Request for Title XIX Care Level Determination (DOH 2256- Revised 9/92);
  2. Minimum Data Set (MDS) - Version 2.0, Full Assessment Form, completed in collaboration with familiar care givers;
  3. current medications;
  4. copy of the current Functional Independence Measurement (FIM); and
  5. Brain Injury Facility's proposed interdisciplinary plan of care for the recipient, including the discharge plan.

- The facility submits the BHCF prior authorization request form (PA/RF) to the Medicaid fiscal intermediary for system processing.

- The facility submits to the BQC NC the following documentation when requesting continued stay by the recipient in the brain injury facility:
  1. newly completed Minimum Data Set (MDS) - Version 2.0, Full Assessment Form;
  2. Minimum Data Set (MDS) - Version 2.0, Full Assessment Form completed at the time of admission to the Brain Injury Facility;
  3. current medications;
  4. Copy of the current FIM;
  5. current interdisciplinary plan of care for the recipient, including the current discharge plan; and
  6. documentation of recipient progress toward stated goals.

- The facility submits the BHCF PA/RF requesting continued stay in the brain injury facility to the Medicaid fiscal intermediary.

- The facility coordinates the discharge plan with the individual (family/guardian, county case worker) responsible for transition to another living environment.

County Agency Responsibilities

- The County Department (Department of Human Services/Developmental Disabilities Services/Community Programs) with responsibility for the program in which the person is seeking admission, reviews the request for admission and submits the DCS 822 form to the facility prior to admission.

- For individuals in brain injury facilities, the responsible county agency works with the individual and the brain injury facility in developing discharge plans, including a TBI waiver individualized service plan (ISP) when appropriate.

B. Waiver Program

The traumatic brain injury waiver program provides home and community-based services to persons with traumatic brain injuries who would otherwise require care in a nursing facility or hospital.

Bureau of Quality Compliance (BQC) Responsibilities

- BQC NC makes the care level determination for all community based services brain injury waiver participants and provides that information to DCS.
- BQC NC performs the care level determination and annual reevaluations for brain injury waiver program participants and provides that information to DCS.
- BQC NC responds to all appeals by recipients concerning the care level determination which result in denial of participation in the TBI waiver.

Division of Community Services (DCS) Responsibilities

- DCS approves all ISPs which authorize participation in the home and community based services waiver for person with brain injuries and funding for the county agency and provides that information to the BQC NC.
- DCS provides, on a monthly basis, the BQC NC with a listing of approved brain injury relocations and diversions; the listing includes the following information:
  1. recipient name and MA number;
  2. date of placement; and
  3. responsible county.
- DCS assures that relevant information is transmitted to the BQC NC for the purpose of making a care level determination.
- DCS provides ongoing monitoring of the execution of ISPs by county agencies under the TBI Waiver.
- DCS maintains, and makes available to the BQC NC a case file of all waiver participants.
- DCS assists the counties in developing/expanding alternative community resources for ensuring the recipient's successful community placement.

County Responsibilities

- The responsible county agency submits the requested TBI Waiver care level determination form to the BQC NC and the Individual Services Plan to DCS for approval.

- Upon approval of the TBI care level determination and waiver plan, the responsible county agency assures implementation of the approved plan, and provides periodic updates and reevaluations as required.

- The responsible county agency submits all information required by BQC specified in DCS numbered memorandum or the manual governing the TBI waiver to BQC NC for the annual evaluation and re-determination of the care level determination by the BQC NC. This information includes completed copies of the DOH-2256 form and the DOH-2256a, Parts A and B form.

- The responsible county agency submits the TBI waiver Medicaid eligibility status to the Medicaid fiscal intermediary for system processing.

K. B. Piper, Administrator
Division of Health (DOH)

3/19/96
(Date)

Gerald A. Born, Administrator
Division of Community Services (DCS)

3-12-96
(Date)