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

TARGETED CASE MANAGEMENT SERVICES
Target Group P

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

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

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

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

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

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

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

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

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

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

❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
- activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

❖ Monitoring and follow-up activities:
- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
  - services are being furnished in accordance with the individual's care plan;
  - services in the care plan are adequate; and
  - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional limitations

Case management is not available to any recipient:

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