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State/Territory Name: WI

State Plan Amendment (SPA) #: 17-0007

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

December 5, 2017

Michael Heifetz, Medicaid Director
Division of Medicaid Services
Department of Health Services
1 West Wilson Street, Room 350
Madison, WI 53702

ATTN: Al Matano, SPA Coordinator

RE: Transmittal Number (TN) 17-0007

Dear Mr. Heifetz:

Enclosed for your records is an approved copy of the following State Plan Amendment (SPA):

Targeted Case Management Services for High-Cost Children with Medical Complexity

Effective Date: September 1, 2017

Approval date: December 5, 2017

If you have any questions, please have a member of your staff contact Mai Le-Yuen at (312) 353-2853 or by email at mai.le-yuen@cms.hhs.gov.

Sincerely,

/s/

Ruth A. Hughes
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 17-0007

2. STATE: Wisconsin

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
09/01/2017

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 441.18(8)(i) and 441.18(9)

7. FEDERAL BUDGET IMPACT:
a. FFY 2017 ..... $239K
b. FFY 2018 ..... $2.4M

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A, Supplement 1, Pages 1-R-1, 1-R-2, 1-R-3, 1-R-4, and 1-R-5. .....
Attachment 4.19-B Page 7b. .....

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
New. .....
New. .....

10. SUBJECT OF AMENDMENT:
Targeted Case Management Services for High-Cost Children with Medical Complexity.

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:
[redacted]

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Michael G. Heifetz

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
September 29, 2017

16. RETURN TO:
Michael G. Heifetz
State Medicaid Director
Department of Health Services
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 5, 2017

18. DATE APPROVED:
December 5, 2017

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
September 1, 2017

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME:
Ruth A. Hughes

22. TITLE:
Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

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

TARGETED CASE MANAGEMENT SERVICES
Target Group R

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

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

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

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

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

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

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

  Comprehensive assessments are covered no more than once every three (3) years from the date of the individual's enrollment in the program unless approved by the Department. Periodic reassessments are covered as ongoing monitoring and follow-up activities.

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

  At a minimum, care plans must be reviewed and updated every 6 months or as the individual's needs change.

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

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Target Group R

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

Referral, monitoring and follow-up activities are covered as frequently as necessary to ensure that services in the individual's care plan are adequate and goals identified in the care plan are met. Such activities may be face-to-face, by telephone, or in writing.

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

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

The qualified staff providing case management services on behalf of the program include: nurse practitioners, registered nurses, para professionals, social workers, and physicians. Staff must be knowledgeable about the care and needs of children with high-resource utilization and medical complexity, and local health care and social services delivery systems.

Providers must be certified as a children's hospital with pediatric medical and surgical specialty areas able to support full integration of psychosocial and clinical care. Providers must possess sufficient documentation that demonstrates that staff has adequate knowledge and experience to provide comprehensive and specialized case management services to children with complex medical and psychosocial needs. Providers must have referral and / or effective working relationships with key health care and other service providers that are essential to the individual's care (e.g., primary care team, private duty nurses, sub-specialists, and community and social organizations).

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

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

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

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

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

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

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TARGETED CASE MANAGEMENT SERVICES
Target Group R

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

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

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

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

9.c. Case Management Services

Children with Medical Complexity (CMC) Target Group R

For children with medical complexity (CMC) the Department established maximum allowable fees for targeted case management services. Reimbursement will be made to certified children's hospitals as determined by the department. For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum fee established by the Department.

Providers will be reimbursed at a uniform rate for the completion of a comprehensive patient assessment and the development of an individualized care plan; and ongoing care management and care coordination activities. The actuarially developed rate is based on a three-month time study of care management and care coordination activities completed by the Medicaid-enrolled children's hospitals for Medicaid members in the target group.

The Department will limit reimbursement to one claim per eligible individual per calendar month. A unit of service will be one (1) month. Providers must provide a minimum of one (1) contact that can include face-to-face, telephone, or written contact with, or on behalf of, the eligible individual.

The agency's fee schedule rates were set as of September 1, 2017 and are effective for services provided on or after that date. All current and adjusted rates are published on the Wisconsin ForwardHealth website:

https://www.forwardhealth.wi.gov/WIPortal/Max%20Fee%20Home/tabid/77/Default.aspx