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

JUN - 3 2010

Jason A. Helgerson, Administrator
Division of Health Care Access and Accountability
Wisconsin Department of Health Services
1 West Wilson Street
P. O. Box 309
Madison, Wisconsin 53701-0309

Dear Mr. Helgerson:

I am pleased to inform you that the Centers for Medicare and Medicaid Services (CMS) has approved State Plan Amendment (SPA) Transmittal #09-017. This SPA authorizes Wisconsin to implement an optional 1915 (i) State plan home and community-based service, specifically psychosocial rehabilitation services. The effective date of the amendment is January 15, 2010.

Please be advised that Wisconsin will need to submit a SPA to CMS to comply with changes to 1915(i) under Sections 2402(b) through 2402(f) of the Affordable Care Act no later than December 31, 2010 that will take effect October 1, 2010. Additionally, upon publication of the final regulations concerning Section 1915 (i), Wisconsin will need to come into compliance with any requirements imposed by those regulations.

If you have any additional questions, please have a member of your staff contact Cynthia Garraway at (312) 353-8583 or Cynthia.Garraway@cms.hhs.gov.

Sincerely,

Verlon Johnson
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Cc: Al Matano, Wisconsin Department of Health Services

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: 09-017

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: 10/01/2009

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:
Section 1915 (i) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2010 ..... $7,489K
b. FFY 2011 ..... $9,739K

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-G, pages 1 to 27. .....

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: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

10. SUBJECT OF AMENDMENT:
Home and Community-Based Psychosocial Rehabilitation

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:

12. SIGNATURE OF STATE AGENCY OFFICIAL: for JAH

13. TYPED NAME: Jason A. Helgerson

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: November 10, 2009

16. RETURN TO:
Jason A. Helgerson
State Medicaid Director
Division of Health Care Access and Accountability
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: November10, 2009

18. DATE APPROVED: June 3, 2010

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 01 2009

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Verlon Johnson

22. TITLE: Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

1915(i) State plan Home and Community-Based Services

Administration and Operation

The State implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

1. **Services.** *(Specify service title(s) for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

HCBS Psychosocial Rehabilitation

2. **Statewideness.** *(Select one)*:

○	The State implements the 1915(i) State plan HCBS benefit statewide, per §1902(a)(1) of the Act.
●	The State implements this benefit without regard to the statewideness requirements in §1902(a)(1) of the Act. State plan HCBS will only be available to individuals who reside in the following geographic areas or political subdivisions of the State. *(Specify the areas to which this option applies)*:
	Services will be available in the following Wisconsin counties: Adams, Barron, Buffalo, Chippewa, Clark, Dane, Dodge, Dunn, Eau Claire, Forest, Green, Green Lake, Jackson, Jefferson, Kenosha, LaCrosse, Langlade, Lincoln, Marathon, Milwaukee, Monroe, Oneida, Ozaukee, Pepin, Pierce, Portage, Richland, Rock, Sheboygan, St. Croix, Trempealeau, Vernon, Vilas, Washington, Waukesha, Wood

3 **State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit.** *(Select one)*:

●	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:	
	○ The Medical Assistance Unit *(name of unit)*:	
	● Another division/unit within the SMA that is separate from the Medical Assistance Unit	
	(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	Department of Health Services Division of Mental Health and Substance Abuse Services, Bureau of Prevention, Treatment and Recovery
○	The State plan HCBS benefit is operated by *(name of agency)*	
	A separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.	

4. Distribution of State plan HCBS Operational and Administrative Functions.

X *(By checking this box the State assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐	☐	☑
2 State plan HCBS enrollment managed against approved limits, if any	☑	☐	☐	☑
3 Eligibility evaluation	☑	☐	☐	☑
4 Review of participant service plans	☑	☐		☐
5 Prior authorization of State plan HCBS	☑	☐	☐	☐
6 Utilization management	☑	☐		☑
7 Qualified provider enrollment	☑	☐	☐	☑
8 Execution of Medicaid provider agreement	☑	☐	☐	☑
9 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☑	☐
10 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☐	☐
11 Quality assurance and quality improvement activities	☑	☐		☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Numbers 1, 2, 3, 6, 7 and 8 are performed by County Human Services Departments or in a few counties a Department of Community Programs that has a specific focus on persons with mental illness and/or developmental disabilities in addition to the SMA. Number 9 has been completed under contract with The Public Consulting Group.

(By checking the following boxes the State assures that):

5. X **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

6. X **Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. X **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. X **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	1/16/10	9/30/10	1077
Year 2			
Year 3			
Year 4			
Year 5			

2. [X] **Annual Reporting.** *(By checking this box the State agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

3. **Optional Annual Limit on Number Served.** *(Select one):*

[O] The State does not limit the number of individuals served during the year or at any one time. **Skip to next section.**

[●] The State chooses to limit the number of *(check each that applies):*

[☐] Unduplicated individuals served during the year. *(Specify in column A below):*

[X] Individuals served at any one time ("slots"). *(Specify in column B below):*

Annual Period	From	To	A Maximum Number served annually *(Specify):*	B Maximum Number served at any one time *(Specify):*
Year 1	1/16/10	9/30/10		938
Year 2				
Year 3				
Year 4				
Year 5				

[☐] The State chooses to further schedule limits within the above annual period(s). *(Specify):*

4. **Waiting List.** *(Select one only if the State has chosen to implement an optional annual limit on the number served):*

[O] The State will not maintain a waiting list.

[●] The State will maintain a single list for entrance to the State plan HCBS benefit. State-established selection policies: are based on objective criteria; meet requirements of the Americans with Disabilities Act and all Medicaid regulations; and ensure that only individuals enrolled in the State plan HCBS benefit receive State plan HCBS once they leave/are taken off of the waiting list.

Financial Eligibility

1. [X] **Income Limits.** *(By checking this box the State assures that):* Individuals receiving State plan HCBS are in an eligibility group covered under the State's Medicaid State plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL). Individuals with incomes up to 150% of the FPL who are only eligible for Medicaid because they are receiving 1915(c) waiver services may be eligible to receive services under 1915(i) provided they meet all other requirements of the 1915(i) State plan option. The State has a process in place that identifies individuals who have income that does not exceed 150% of the FPL.

2. **Medically Needy.** *(Select one):*

○	The State does not provide State plan HCBS to the medically needy.	
●	The State provides State plan HCBS to the medically needy *(select one):*	
	○	The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
	●	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III).

Needs-Based Evaluation/Reevaluation

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual according to the requirements of 42 CFR §441.556(a)(1) through (5). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*select one*):

●	Directly by the Medicaid agency
○	By Other (*specify State agency or entity with contract with the State Medicaid agency*):

2. **Qualifications of Individuals Performing Evaluation/Reevaluation.** The independent evaluation is performed by an agent that is independent and qualified as defined in 42 CFR §441.568. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

The1915(i) program will use Wisconsin's Functional Eligibility Screen for Mental Health and Mental Health & AODA (Co-Occurring) Services in doing the independent evaluation of needs based criteria. This will be conducted by a trained certified screen administrator. Certified screeners are knowledgeable about mental health issues, interviewing skills needed to gather information, conducting a holistic dialogue, recovery-based best practices, including learning what the person needs help with within a larger, recovery-focused dialogue that includes the person's strengths, values, goals and perspectives. All persons administering the functional screen must meet the following conditions:

1. Meet the following **minimum criteria for education and experience**:
– Nursing license or a BA or BS, preferably in a health or human services related field, and at least one year of experience working with people with chronic needs, or
– Prior approval from the Department based on a combination of post-secondary education and experience or on a written plan for formal and on-the-job training to develop the required expertise; and
2. Meet all **training requirements** as specified by the Department. Currently that means:
– Completing the online course, or
– Attending an in-person training by Department staff (or watching video of same), **and**
– Reading and following screen instructions.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

Wisconsin's Mental Health and AODA functional screen has been in use since 2005 to identify individual's functional needs. The screen has three sections: Community living skills inventory, crisis and situational factors (factors such as a history of inpatient stays, emergency detentions, suicide attempts etc.) and risk factors (substance use, housing instability etc.). The functional screen is web based and can be completed only by certified screeners. The needs based eligibility criteria are incorporated into the screen logic to provide an automated determination of eligibility or ineligibility. The functional screen will be completed annually. Screen reports are available showing when annual screens are due or are late.

4. ☒ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the State assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

Wisconsin's 1915(i) needs based criteria requires an individual to have a variety of combinations of risk factors and functional need for assistance with community living skills such that those needs cannot be met by an outpatient clinic service. ("Assistance" is defined as including any kind of support from another person (monitoring, supervising, reminders, verbal cueing, or hands-on assistance) needed because of a physical, cognitive, or mental health condition disorder)
The following is the minimum possible combinations of factors that demonstrate 1915i eligibility:

The criteria for eligibility group seven (the lowest level of eligibility) are that the individual's needs can not be met by an outpatient clinic service plus they meet the following:

- Applicant meets at least one Eligibility Group Two criteria

OR

- Applicant meets at least one Eligibility Group Three criteria

-AND-

At least 3 of the following are true for the applicant

- Needs assistance to work or to find work less than monthly OR needs assistance with schooling less than monthly
- Needs help with home hazards 1 to 4 times a month
- Needs help to use effective social/interpersonal skills
- Needs help with money management 1 to 4 times a month
- Needs help with maintaining basic nutrition 1 to 4 times a month
- Needs help with transportation because person cannot drive due to physical, psychiatric or cognitive impairment.

Group Two eligibility criteria normally require two of the following but any one of these criteria meets the first part of the group seven requirement.

- Needs help in maintaining basic safety
- Needs assistance to manage psychiatric symptoms more than once a week
- Needs assistance with taking medications 2 to 6 days per week OR needs monitoring medication effects 2 to 6 days per week
- Has required use of emergency rooms, crisis intervention or detox units 4 or more time in the past year OR has had 1 to 3 psychiatric inpatient stays within the past year OR has had 1 to 3 emergency detentions within the past year
- Has had 4 or more psychiatric inpatient stays within the past 13 months to 3 years OR has made 4 or more suicide attempts within the past 13 months to 3 years
- Has had incidents of physical aggression 4 or more times within the past year OR has had involvement with the corrections system 4 or more times within the past year

Group 3 eligibility requires three of the following but for Group seven only one of the following is sufficient to meet the first part of the eligibility.

- Needs assistance to work more than 1 time per week
- Needs help with home hazards more than once a week
- Needs help with money management more than once a week
- Needs help with basic nutrition more than once a week
- Needs help performing general health maintenance at least 1 to 4 times a month
- Needs help managing psychiatric symptoms 1 to 4 times a month

- Needs assistance with taking medications 1 to 4 days a month or needs monitoring medication effects 1 to 4 days a month
- Has required use of emergency rooms, crisis intervention, or detox units at least 1 time in the past year; or has had 1 to 3 psychiatric inpatient stays within the past year
- Has required use of emergency rooms, crisis intervention, or detox units 4 or more times within the past 13 months to 3 years; OR has had at least 1 psychiatric inpatient stay within the past 13 months to 3 years OR has made at least one suicide attempt within the past 13 months to 3 years.
- Has had at least 1 emergency detention within the past 13 months to 3 years
- Has had at least 1 incident of physical aggression in the past year; OR has had involvement with the correctional system 4 or more times within the past 13 months to 3 years
- Currently homeless (on the street or no permanent address) OR has been evicted 2 or more times in the past year; OR homeless more than half of the time in the past year; OR currently homeless, not in transitional housing OR in Transitional Housing – Mental Health, Substance Abuse or Corrections System
- Has demonstrated self-injurious behaviors within the past year; OR has demonstrated self-injurious behaviors 13 months to 3 years ago
- Has at least one Substance-Related diagnosis except nicotine dependence or other related disorder; OR in the past 12 months, person has experienced negative consequences in legal (including OWI), financial, family, relational, or health domains that are linked to substance use

5. ☒ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the State assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the State has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
The needs based eligibility criteria are described in #4.	Wisconsin Law allows reimbursement to nursing homes for eligible persons who require skilled, intermediate, or limited levels of nursing care. Wis. Stat. § 49.45(6m)(i). Those levels are defined in Wis. Adm. Code § DHS 132.13. Wisconsin's BC waiver criteria for nursing home level of care are as follows: A person is functionally eligible at the nursing home level if the person requires ongoing care, assistance or supervision from another person, as is evidenced by any of the following findings from application of the functional screening: 1. The person cannot safely or appropriately perform 3 or more activities of daily living. 2. The person cannot safely or appropriately perform 2 or more ADLs and one or more instrumental activities of daily living. 3. The person cannot safely or appropriately perform 5 or more IADLs.	ICF_MR referred to in Wisconsin as FDD (Facility serving people with developmental disabilities) Wis. Adm. Code § DHS 134.13 contains the following definitions: (13) "FDD" or "facility serving people with developmental disabilities" means a residential facility with a capacity of 4 or more individuals who need and receive active treatment and health services as needed. (2) "Active treatment" means an ongoing, aggressive and consistently applied program of training and treatment services to allow the client to function as independently as possible and maintain his or her maximum functional	For inpatient hospital psychiatric emergency detention or involuntary commitment, state statutes require that: 1) The individual is mentally ill, drug dependent, or developmentally disabled; 2) The individual presents an immediate danger of harm to self or others based on a recent act or omission; and 3) Inpatient hospitalization is the least restrictive placement consistent with the requirements of the individual (i.e., the individual's needs can only be met on an inpatient basis). IMD hospital admissions nearly always occur on an emergency detention or involuntary commitment basis. For a voluntary admission (to a psychiatric unit of a general hospital), the inpatient services must: 1) Directed by a

		abilities. (9) "Developmental disability" means mental retardation or a related condition such as cerebral palsy, epilepsy or autism, but excluding mental illness and infirmities of aging, which is: (a) Manifested before the individual reaches age 22; (b) Likely to continue indefinitely; and (c) Results in substantial functional limitations in 3 or more of the following areas of major life activity: 1. Self-care; 2. Understanding and use of language; 3. Learning; 4. Mobility; 5. Self-direction; and 6. Capacity for independent living.	physician or dentist; and 2) Be medically necessary as certified by a physician or dentist. Among the criteria in the state definition of "medical necessity" is the requirement that the service (e.g., inpatient hospitalization) is the most appropriate level of service that can safely and effectively be provided to the recipient/individual.

*Long Term Care/Chronic Care Hospital

(By checking the following boxes the State assures that):

6. [X] **Reevaluation Schedule**. Needs-based eligibility reevaluations are conducted at least every twelve months.

7. [X] **Adjustment Authority**. The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

8. X **Residence in home or community**. The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving State plan HCBS:

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

(ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State. *(If applicable, specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):*

Wisconsin's 1915i services will expect recovery, outcome based services that are individualized based on the needs identified through the comprehensive assessment and person-centered planning process. This includes identifying the type of community setting most able to meet the individuals assessed support needs and individual choice. There is not an automatic placement into a service. An individual choice may require that professionals assess the housing choice and assist with recommendations for modifications that promote both independence and safety. A care manager is required to use a person centered planning process. The consumer and the care manager decide together on the appropriateness of the community setting.

The choice of the home and the decoration of personal space by the individual as well as the neighborhood are basic rights promoted through the use of person centered planning. Opportunity to exercise personal freedom in all domains will be promoted through training of qualified staff. Participation in community events, activities and resources will be supported and limits exercised only where required to assure safety. As an example, if a person is at risk around sharp knives they would not be excluded from activities in their kitchen. Instead the knives would be stored safely. Community integration has many features and are dependent on the person's preferences and availability. Establishing choices for each person is a process of asking, learning in a trusting relationship, and providing the means to access services, supports and naturally occurring activities offered to anyone in the community at large. Many of the services offered to gain such participation will be skill building and self management strategies. Peer Specialists are often the best teachers and models supporting this type of service. They are part of the state work force to bring about system and person specific transformation.

The type of residential setting needed would be determined by the person-centered assessment. Allowable settings other than the individuals own home or apartment are Adult Family Homes (AFH), Residential care apartment complex (RCAC), and community based residential facilities (CBRF).

RCACs are by definition independent apartments with a lockable entrance and exit, a kitchen including a stove and individual bathroom, sleeping and living areas. RCAC settings are apartment complexes that offer additional services and supports to its residents. These settings are the individual's home apartment. As in any apartment setting, the owner/manager of the building may have rules or limitations to manage the building and the day to day management of the environment and services. The state has administrative rules and quality oversight that assure individuals' rights and safety in such settings.

Care Managers would be responsible for determining that AFH's offer individuals opportunity to participate in community activities. AFH's would need to offer private personal quarters or the choice of whom to share their room with and access to food and food preparation areas.

CBRF's are the most restrictive of the community residential options which is a facility that provides from 5 to 16 beds (inclusive). For this reason, only individuals whose health and safety are at risk without 24hr supervision will receive 1915(i) services in a CBRF. The care manager together with the person receiving 1915(i) services will determine that the residence is a community setting and offers opportunities for independence, choice and community integration. Wisconsin has developed standards to ensure that these facilities are community based.

Person-Centered Planning & Service Delivery

(By checking the following boxes the State assures that):

1. X There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:

- An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified as defined in 42 CFR §441.568;
- Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;
- An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the plan of care as required in 42 CFR §441.565;
- An examination of the individual's physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the plan of care, a caregiver assessment;
- If the State offers individuals the option to self-direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
- A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.

2. X Based on the independent assessment, the individualized plan of care:

- Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
- Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;
- Prevents the provision of unnecessary or inappropriate care;
- Identifies the State plan HCBS that the individual is assessed to need;
- Includes those services, the purchase or control of which the individual elects to self-direct, meeting the requirements of 42 CFR §441.574(b) through (d);
- Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
- Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.

3. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. *(Specify qualifications):*

The assessment will be completed by a care manager.

1. A care manager shall have the skills and knowledge typically acquired:

a. Through a course of study and practice experience that meets requirements for state certification/licensure as a social worker and also one year experience working with persons living with mental illness, or

b. Through a course of study leading to a BA/BS degree in a health or human services related field and one year of experience working with persons living with mental illness, or

c. Through a minimum of four years experience as a care manager, or

d. Through an equivalent combination of training and experience that equals four years of long term support and/or mental health practice in care management, or

e. The completion of a course of study leading to a degree as a registered nurse and one year employment working with persons living with mental illness.

2. The care manager shall be knowledgeable of person centered planning, the service delivery system, the needs of persons living with mental illness, and the availability of mental health recovery focused services and resources or the need for such services and resources to be developed.

3. Providers of care management are subject to the required criminal, caregiver and licensing background checks and hiring prohibitions as prescribed by the SMA.

4. **Responsibility for Plan of Care Development**. There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. *(Specify qualifications):*

The service plan will be developed by the care manager with the participant and other appropriate parties determined appropriate by the participant.

1. A care manager shall have the skills and knowledge typically acquired:

a. Through a course of study and practice experience that meets requirements for state certification/licensure as a social worker and also one year experience working with persons living with mental illness, or

b. Through a course of study leading to a BA/BS degree in a health or human services related field and one year of experience working with persons living with mental illness, or

c. Through a minimum of four years experience as a care manager, or

d. Through an equivalent combination of training and experience that equals four years of long term support and/or mental health practice in care management, or

e. The completion of a course of study leading to a degree as a registered nurse and one year employment working with persons living with mental illness.

2. The care manager shall be knowledgeable of person centered planning, the service delivery system, the needs of persons living with mental illness, and the availability of mental health recovery focused services and resources or the need for such services and resources to be developed.

3. Providers of care management are subject to the required criminal, caregiver and licensing background checks and hiring prohibitions as prescribed by the SMA.

5. **Supporting the Participant in Plan of Care Development**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the plan of care development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

The care manager will provide information both verbally and in writing to the participant about the person-centered planning process, their opportunity to include others to participate in the planning, the services available through the program and that they will be able to select qualified service providers of their choice. The care manager will ensure that the participant and others they choose are fully involved in the plan development. Service plan meetings are conducted at times and places that are convenient for the participant. The care manager will document on the service plan those in attendance at the plan development. The care manager will ensure that the participant and legal representative sign and date the service plan and that they receive a copy of the completed plan.

6. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the plan of care):*

The care manager will provide information and answer questions before and during the service plan development about the qualified service providers available to meet the assessed needs of the participant. The care manager will assist the participant in contacting and /or visiting the service provider to determine if they are a good match. On an ongoing basis thereafter, the care manager will assist the participant in interactions with service providers, including but not limited to selecting different providers who may prove to be a better match for them. All willing providers will have the opportunity to register with the DHS. The care manager will assist the person on an ongoing basis to assure that the service plan continues to meet their needs.

7. **Process for Making Plan of Care Subject to the Approval of the Medicaid Agency.** *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

The care manager will submit the completed and signed service plan to the DHS. Services are not authorized until DHS has approved the service plan.

8. **Maintenance of Plan of Care Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

X	Medicaid agency		Operating agency	X	Case manager
☐	Other *(specify):*				

Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Psychosocial Rehabilitation
Service Definition (Scope):	

Community Living Supportive Services (CLSS)

This service covers activities necessary to allow individuals to live with maximum independence in community integrated housing. Activities are intended to assure successful community living through utilization of skills training, cuing and/or supervision as identified by the person-centered assessment. Community Living supportive services consist of meal planning/preparation, household cleaning, personal hygiene, reminders for medications and monitoring symptoms and side effects, teaching parenting skills, community resource access and utilization, emotional regulation skills, crisis coping skills, shopping, transportation, recovery management skills and education, financial management, social and recreational activities, and developing and enhancing interpersonal skills. CLSS tasks, such as meal planning, cleaning, etc. are not done for the individual, but rather they are delivered through training, cueing, and supervision to help the participant become more independent in doing these tasks.

Wisconsin would make these services available in a variety of community locations that encompass residential, business, social and recreational settings. Residential settings are limited to an individual's own apartment or house, supported apartment programs, adult family homes (AFH), residential care apartment complexes (RCAC), and community based residential facilities (CBRF's) of from 5 to 16 beds (inclusive). The type of residential setting needed would be as agreed upon in the person-centered assessment. Individuals needing services in a CBRF setting would be those whose health and safety are at risk without 24hr supervision. Payment is not made for room and board including the cost of building maintenance.

The services provided under 1915(i) will not be duplicative of other State Plan services, including but not limited to personal care and transportation.