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**State/Territory Name: MI**

**State Plan Amendment (SPA) #: 08-0008**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Chicago Regional Office  
233 N. Michigan  
Suite 600  
Chicago, Illinois 60601

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September 19, 2018

Kathy Stiffler, Acting State Medicaid Director  
Medical Services Administration  
Michigan Department of Health and Human Services  
400 South Pine Street, P.O. Box 30479  
Lansing, Michigan 48909-7979

ATTN: Erin Black

Dear Ms. Stiffler:

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

- Transmittal #: 08-0008: Targeted Case Management – Group C
- Effective Date: April 1, 2008
- Approval Date: September 19, 2018

If you have any questions, please contact Keri Toback at (312) 353-1754 or [keri.toback@cms.hhs.gov](mailto:keri.toback@cms.hhs.gov).

Sincerely,

/s/

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

cc: Erin Black, MDHHS

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL  
FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

08 - 08

2. STATE:

Michigan

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

TO: REGIONAL ADMINISTRATOR  
HEALTH FINANCING ADMINISTRATION  
DEPARTMENT OF HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE  
April 1, 2008

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:  
DRA Section 6052

7. FEDERAL BUDGET IMPACT:

a. FFY \_\_\_\_\_ \$ \_\_\_\_\_  
b. FFY \_\_\_\_\_ \$ \_\_\_\_\_

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  
Supplement 1 to Attachment 3.1-A, pages 1C-1 thru 1C-5

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):  
Supplement to Attachment 3.1-A, pages 1-C-1 thru 2

10. SUBJECT OF AMENDMENT:

Targeted Case Management

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:  
Paul Reinhart, Director  
Medical Services Administration

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:  
Paul Reinhart

14. TITLE:  
Director, Medical Services Administration

15. DATE SUBMITTED:  
June 30, 2008

16. RETURN TO:

Medical Services Administration  
Program/Eligibility Policy Division - Federal Liaison Unit  
Capitol Commons Center - 7<sup>th</sup> Floor  
400 South Pine  
Lansing, Michigan 48933

Attn: Nancy Bishop

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: JUN 30 2008

18. DATE APPROVED:

September 19, 2008

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:

April 1, 2008

20. SIGNATURE OF REGIONAL OFFICIAL:

/s/

21. TYPE NAME:

Ruth A. Hughes

22. TITLE:

Associate Regional Administrator

23. REMARKS:

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

**TARGETED CASE MANAGEMENT SERVICES**

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Target Group C consists of persons who are:

1. at least 60 years old and disabled, or at least 65 years old, and
2. medically eligible for Medicaid-covered nursing home services, and
3. seeking admission to, or at risk of entering such a facility, and
4. documented as having multiple, complex and diverse service needs and a lack of capacity and support systems to address those needs without case management.

\_\_\_ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to \_\_\_\_\_ **[insert a number; not to exceed 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: **[Specify 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:

- ❖ 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;
  - completing comprehensive initial assessments and periodic reassessments that evaluate a range of service needs to help establish and update what is important for the individual in a way that is important to the individual, with the following frequency:
    - a. an initial assessment
    - b. re-assessment 90 days after the initial assessment
    - c. a reassessment, or an in-person, person centered planning meeting 180 days after the first/previous re-assessment

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**TARGETED CASE MANAGEMENT SERVICES**

- d. a re-assessment 180 days after the previous reassessment or person centered planning meeting
  - e. repeat the 180 day assessment cycle as listed in c) and d)
  - f. a reassessment is conducted sooner when there are significant changes in the individual's health or functional status, or significant changes in the individual's network of allies (i.e. death of a primary caregiver)
- ❖ 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;
- ❖ 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.
- Monitoring must be an in person encounter and is provided on at least a monthly basis, unless otherwise indicated by the needs and circumstances of the individual and/or family.

**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))

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Case management may include coordinated care planning for enrolled individuals when they need to go into a nursing home or medical setting or for new individuals in such facilities, to assure a smooth transition into the community.

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

1. Case Management Provider Organizations must be certified by the single state agency as meeting the following criteria:
  - a. demonstrate a capacity to provide all core elements of case management services including
    - comprehensive client assessment
    - comprehensive care/service plan development
    - linking/coordination of services
    - monitoring and follow-up of services
    - reassessment of the client's status and need
  - b. demonstrated case management experience in coordinating and linking such community resources as required by the target population
  - c. demonstrated experience with the target population
  - d. a sufficient number of staff to meet the case management service needs of the target population
  - e. an administrative capacity to ensure quality of services in accordance with State and federal requirements
  - f. a financial management capacity and system that provides documentation of services and costs.
  - g. capacity to document and maintain individual case records in accordance with State and federal requirements.
2. Qualified case management staff include:
  - a. a Registered Nurse, Licensed to practice in the state of Michigan
  - b. a Social Worker, Licensed to practice in the State of Michigan
  - c. an individual with a minimum of two years case management experience

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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**TARGETED CASE MANAGEMENT SERVICES**

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 §440.169 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 §440.169 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

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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))

Only in person case management assessments and monitoring services are reimbursable.