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State/Territory Name: Michigan

State Plan Amendment (SPA)#: 24-0004

This file contains the following documents in the order listed

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

September 18, 2024

Meghan E. Groen
Senior Deputy Director
Behavioral and Physical Health and Aging Services Administration
Michigan Department of Health and Human Services
400 S Pine St 7th Fl
Lansing, MI 48933-2250

Re: Michigan State Plan Amendment (SPA) 24-0004

Dear Director Groen:

The Centers for Medicare & Medicaid Services (CMS) reviewed your State Plan Amendment (SPA) submitted under transmittal number (TN) 24-0004. This SPA provides authority to cover targeted case management services for Children's Special Health Care Services (CSHCS) beneficiaries under 21 years of age with qualifying medical complexity.

We conducted our review of your submittal according to the statutory requirements at 42 CFR 440.60. We hereby inform you that Medicaid State plan amendment 24-0004 is approved effective October 1, 2024. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please contact Keri Toback at 312-353-1754 or via email at keri.toback@cms.hhs.gov.

Sincerely,

[redacted]

Ruth A. Hughes, Acting Director
Division of Program Operations

Enclosures
cc: Erin Black

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24 — 0004

2. STATE: MI

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

3. PROPOSED EFFECTIVE DATE
October 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 440.60

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $0
b. FFY 2025 $0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Supplemental 1 to Attachment 3.1-A Pages 1-H-1 to 1-H-6
Attachment 4.19-B Page 4

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTIONOR ATTACHMENT *(If Applicable)*
Attachment 4.19-B Page 4 (TN# 22-0018)

9. SUBJECT OF AMENDMENT
This SPA provides authority to cover targeted case management services for Children's Special Health Care Services (CSHCS) beneficiaries under 21 years of age with qualifying medical complexity.

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

11. TYPED NAME
Meghan Groen

12. TITLE
Senior Deputy Director

13. DATE SUBMITTED
July 1, 2024

15. RETURN TO

Behavioral and Physical Health and Aging Services Administration
Office of Strategic Partnerships & Medicaid Administrative Services – Federal Liaison
Capitol Commons Center – 7th Floor
400 South Pine
Lansing, Michigan 48933

Attn: Erin Black

FOR CMS USE ONLY

16. DATE RECEIVED
07/01/2024

17. DATE APPROVED
09/18/2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
10/01/2024

19. SIGNATUR
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Ruth A. Hughes

21. TITLE OF APPROVING OFFICIAL
Acting Director, Division of Program Operations

22. 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 consists of medically complex individuals, under 21 years of age:

- not incarcerated in a public institution, receiving hospice services, or receiving case management services from another provider;
- have experienced in the previous 12 months:
  - one or more hospital admissions with at least one hospital stay of five or more days; or
  - ten or more visits with a medical or surgical specialist at a pediatric specialty clinic;
- receive treatment from three or more different medical and/or surgical specialties at a hospital or medical university; and
- also meet all the following criteria:
  - have at least one Michigan Department of Health and Human Services (MDHHS), Children's Special Health Care Services (CSHCS) medically eligible condition that involves three or more organ systems; and
  - have functional limitations, are technologically dependent and/or a transplant candidate.
- 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 be high, and they are not required to meet the criteria for 10 or more 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

- 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 per year, unless otherwise approved by MDHHS.

- 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 comprehensive and individualized and reflect the beneficiary's and/or parent's/guardian's preferences.

- 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.

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TARGETED CASE MANAGEMENT SERVICES

Monitoring and follow-up activities shall occur monthly, and more often if needed, to ensure individual needs are met; as well as to maintain a continuing relationship between the individual, parent and/or guardian, providers, and any entities responsible for services. Monitoring and follow-up activities include face-to-face encounters, and/or reciprocal telephonic or written contact with, or on behalf of the beneficiary/parent/guardian.

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)):

Targeted Case Management Entity Provider Qualifications:

The state Medicaid agency must approve the case management entity as qualified to render the outpatient CMC TCM services before such provider may render services. For the state to approve the case management entity, the case management entity must be an enrolled Medicaid provider that is not otherwise funded to provide similar services. A case management entity must be willing, qualified and able to demonstrate it meets the following criteria:

a. the capacity to provide all core elements of case management services outlined in 42 CFR 440.169.
b. case management experience in coordinating and linking such community resources as required by the target population;
c. the sufficient number of staff to meet the case management service needs of the target population;
d. an administrative capacity to ensure quality of services in accordance with State and Federal requirements;
e. a financial management capacity and system that provides a record of services and costs;
f. the capacity to document and maintain individual case records in accordance with State and Federal requirements; and
g. provide an interdisciplinary team which meets the targeted case management team qualifications described below.

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TARGETED CASE MANAGEMENT SERVICES

Targeted Case Management Team Qualifications:

Case Management must be provided by a multi-disciplinary team working under the authority of a targeted case management entity/provider that consists of unlicensed staff and licensed health professionals operating within their State law-defined scope of practice. Teams must have adequate knowledge and experience to provide comprehensive and specialized case management services to children with very complex medical needs. The team must provide 24/7 on-call coverage to respond to medical and care coordination needs and demonstrate referral and effective working relationships with specialists/subspecialists and other health care and social service providers who are essential to the care of beneficiaries with very complex medical needs.

At a minimum, the team must include the following:

- At least one provider with medical/surgical experience delivering pediatric hospital or specialty clinic services to medically complex individuals under the age of 21 who regularly experience hospitalization and/or surgery;
- At least one Medicaid enrolled, licensed pediatrician in possession of or eligible for pediatric specialty board certification. Experience and/or training in palliative care recommended;
- At least one Medicaid enrolled, licensed NPP with at least two years of professional pediatric experience. A NPP is a healthcare professional licensed as a nurse practitioner, physician assistant, or a clinical nurse specialist;
- At least one licensed master's prepared Clinical Social Worker with at least two years of professional pediatric experience; and
- At least one licensed Registered Nurse with at least two years of professional pediatric experience;
- At least one individual with Bachelor of Arts or science in an academic, business, or medical discipline with experience as a hospital or clinic coordinator with a background in health care who is knowledgeable about case management or care coordination services for individuals with complex health needs who have hospital admissions or have had/need surgery; and
- A program assistant with a background in health care operations, referrals, scheduling, and patient services.

A licensed pediatric behavioral health provider is recommended to be part of this team as case management will identify and require case management for all needs including psychosocial needs.

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

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**:**

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.

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TARGETED CASE MANAGEMENT SERVICES

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 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)).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Payment Rates
(Other than Inpatient Hospital and Long Term Care Facilities)

9. Case Management Services

A. Reimbursement for Targeted Group A case management services will be on a Fee-for-Service basis. For mental health, preliminary fee screens are adjusted to final once each year. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Michigan Medicaid fee schedule effective for dates of service on or after May 1, 2005, may be found at www.michigan.gov/medicaidproviders.

B. Reimbursement for Targeted Group C case management services will be on a Fee-for-Service basis. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Michigan Medicaid fee schedule effective for dates of service on or after May 1, 2005, may be found at www.michigan.gov/medicaidproviders.

C. Reimbursement for Targeted Group D case management services will be on a Fee-for-Service basis. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Michigan Medicaid fee schedule effective for dates of service on or after April 14, 2004, may be found at www.michigan.gov/medicaidproviders.

D. Reimbursement for Targeted Group E case management services will be through an Annual Reconciliation Cost based Settlement Process after the end of the school fiscal year.

E. Reimbursement for Targeted Group F case management services will be on a Fee-for-Service basis. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Michigan Medicaid fee schedule effective for dates of service on or after May 9, 2016, may be found at www.michigan.gov/medicaidproviders.

F. Reimbursement for Targeted Group G case management services will be on a fee-for-service basis. The case management services are reimbursed separate from the prospective payment system for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics and separate from the all-inclusive rate reimbursement methodology for Tribal FQHCs and Tribal Health Centers. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Michigan Medicaid fee schedule effective for dates of service on or after April 1, 2023, may be found at www.michigan.gov/medicaidproviders.

G. REIMBURSEMENT FOR TARGETED GROUP H CASE MANAGEMENT SERVICES WILL BE ON A FEE-FOR-SERVICE BASIS. EXCEPT AS OTHERWISE NOTED IN THE PLAN, STATE-DEVELOPED FEE SCHEDULE RATES ARE THE SAME FOR BOTH GOVERNMENTAL AND PRIVATE PROVIDERS. THE MICHIGAN MEDICAID FEE SCHEDULE EFFECTIVE FOR DATES OF SERVICE ON OR AFTER OCTOBER 1, 2024, MAY BE FOUND AT WWW.MICHIGAN.GOV/MEDICAIDPROVIDERS.