State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

Telehealth Service

1) Telehealth service is defined as the practice of health care delivery by a provider to a beneficiary who is under the care of a provider at a different geographical location.

2) The Division of Medicaid covers medically necessary health services to eligible Medicaid beneficiaries as specified in the State Plan. If a service is not covered in an in-person setting, it is not covered if provided through telehealth.

3) Telehealth service must be delivered in a real-time communication method that is:
    a. Live;
    b. Interactive; and
    c. Audiovisual.

4) The originating or spoke site is defined as the physical location of the beneficiary at the time the telehealth service is provided via telecommunications system. Telehealth services are covered in the following originating sites:
    a. Office of a physician or practitioner;
    b. Outpatient Hospital (including a Critical Access Hospital (CAH));
    c. Rural Health Clinic (RHC);
    d. Federally Qualified Health Center (FQHC);
    e. Community Mental Health/Private Mental Health Centers;
    f. Therapeutic Group Homes;
    g. Indian Health Service Clinic; or
    h. School-based clinic.

5) The distant or hub site is defined as the physical location of the provider delivering the telehealth service via telecommunications system.

6) Telehealth services must be delivered by a participating Medicaid provider acting within their scope-of-practice at both the originating and distant site.

7) The following are not considered telehealth services and are not covered:
    a. Telephone conversations;
    b. Chart reviews;
    c. Electronic mail messages;
    d. Facsimile transmission;
    e. Internet services for online medical evaluations; or
    f. The installation or maintenance of any telecommunication devices or systems.

State of Mississippi
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

   Provided: ☐ No Limitations ☒ With Limitations

2. a. Outpatient hospital services.

   Provided: ☐ No Limitations ☒ With Limitations

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State plan).

   Provided: ☐ No Limitations ☒ With Limitations

   ☐ Not Provided

   c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-5).

   Provided: ☐ No Limitations ☒ With Limitations

3. Other laboratory and x-ray services.

   Provided: ☐ No Limitations ☒ With Limitations

State/Territory: MISSISSIPPI

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: No limitations X With limitations

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found. *

4.c. Family planning services and supplies for individuals of child-bearing age.

Provided: No limitations X With limitations*

4.d. Face-to-face Tobacco Cessation Counseling Services for Pregnant Women

Provided: No limitations X With limitations*

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: No limitations X With limitations*

5.b. Medical and surgical services furnished by a dentist (in accordance with section 1905 (a) (5) (B) of the Act.)

Provided: No limitations X With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

Provided: No limitations X With limitations *

Not provided ___

* Description provided on attachment.

State/Territory: Mississippi

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

___ Provided: ___ No limitations ___ With limitations*

_X_ Not provided.

c. Chiropractors' services.

_X_ Provided: ___ No limitations _X_ With limitations*

___ Not provided.

d. Other practitioners' services.

_X_ Provided: Identified on attached sheet with description of limitations, if any.

___ Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: __ No limitations _X_ With limitations*

b. Home health aide services provided by a home health agency.

Provided: __ No limitations _X_ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: __ No limitations _X_ With limitations*

* description provided on attachment.

State/Territory: Mississippi

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/X/ Provided: /_/ No limitations /X/With limitations*

/_/ Not provided.

8. Private duty nursing services.

/_/ Provided: /_/ No limitations /_/With limitations*

/X/ Not provided.

*Description provided on attachment.

State Mississippi

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. **Clinic services.**

[x] Provided: [ ] No limitations [x] With limitations*

[ ] Not provided.

10. **Dental services.**

[x] Provided: [ ] No limitations [x] With limitations*

[ ] Not provided.

11. **Physical therapy and related services.**

a. Physical therapy.

[✓] Provided: [ ] No limitations [✓] With limitations*

[ ] Not provided.

b. Occupational therapy.

[✓] Provided: [ ] No limitations [✓] With limitations*

[ ] Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

[✓] Provided: [ ] No limitations [✓] With limitations*

[ ] Not provided.

*Description provided on attachment.

State Mississippi

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. **Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.**

a. Prescribed drugs.

[x] Provided: [ ] No limitations [x] With limitations*

[ ] Not provided.

b. Dentures.

[ ] Provided: [ ] No limitations [ ] With limitations*

[x] Not provided.

c. Prosthetic devices.

[x] Provided: [ ] No limitations [x] With limitations*

[ ] Not provided.

d. Eyeglasses.

[x] Provided: [ ] No limitations [x] With limitations*

[ ] Not provided.

13. **Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.**

a. Diagnostic services.

[x] Provided: [ ] No limitations [x] With limitations*

[ ] Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

c. Preventive services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

d. Rehabilitative services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

/ / Provided: / / No limitations / / With limitations*

/X/ Not provided.

b. Nursing facility services.

/ / Provided: / / No limitations / / With limitations*

/X/ Not provided.

*Description provided on attachment.

State of Mississippi
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15. Services in an intermediate care facility for the mentally retarded (other than in an institution for mental diseases) for individuals who are determined in accordance with section 1902(a)(31)(A), to be in need of such care.

Provided: ☐ No Limitations ☒ With Limitations*

☐ Not Provided

16. Inpatient psychiatric facility services for individuals under 22 years of age.

Provided: ☐ No Limitations ☒ With Limitations*

☐ Not Provided

17. Nurse-midwife services.

Provided: ☐ No Limitations ☒ With Limitations*

☐ Not Provided

18. Hospice care (in accordance with section 1905(o) of the Act).

Provided: ☐ No Limitations ☒ With Limitations*

☒ Provided in accordance with section 2302 of the Affordable Care Act

☐ Not Provided

*Description provided on attachment

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

X Provided: X With limitations

___ Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

___ Provided: ___ With limitations*

X Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

X Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

___ Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

State/Territory: Mississippi

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

/__/ Provided: /__/ No limitations /__/ With limitations*

/X/ Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

/__/ Provided: /__/ No limitations /__/With limitations*

/X/ Not provided.

23. Certified Pediatric or family nurse practitioners' services.

Provided: /__/ No limitations /X/With limitations*

*Description provided on attachment.

State/ Territory: Mississippi

AMOUNT, DURATION, AND SCOPE OF MEDICAL

AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.
☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Services of Christian Science nurses.
☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

c. Care and services provided in Christian Science sanitoria.
☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

d. Nursing facility services for patients under 21 years of age.
☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

e. Emergency hospital services.
☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

f. Personal care services in recipient's home prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.
☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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24. Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

a 1. Transportation

___ No limitations

X_ With limitations

Transportation services will be provided to beneficiaries with the exception of those beneficiaries in the following Categories of Eligibility:

- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Beneficiary (SLMB)
- Qualified Individual (QI-1)
- Family Planning

a 2. Brokered Transportation

X_ Provided under section 1902(a)(70)

The State assures it has established a non-emergency medical transportation program in order to more cost-effectively provide transportation.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a):

____ (1) statewideness (indicate areas of State that are covered)

A single Broker will operate the NET program statewide.

____ (10)(B) comparability (indicate participating beneficiary groups)

Transportation services will be provided to all Medicaid beneficiaries with the exception of those beneficiaries in the following Categories of Eligibility:

X__ (23) freedom of choice (indicate mandatory population groups)

The Broker will be responsible for arranging transportation with a NET provider capable of meeting the transportation needs of the beneficiary. The beneficiary will not have freedom of choice in regards to the actual transportation provider.

(2) Transportation services provided will include:

X__ wheelchair van
X__ taxi
____ stretcher car
X__ bus passes
X__ tickets
____ secured transportation
X__ such other transportation as the Secretary determines appropriate (please describe): Private automobiles, non-profit transit system, specialty carriers for non-emergency ambulatory disoriented persons, and specialty carriers using lift equipped vehicles in compliance with the Americans with Disabilities Act certified to transport non-emergency, non-ambulatory persons.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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(3) The State assures that transportation services will be provided under a contract with a broker who:

(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;
(ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transport personnel are licensed, qualified, competent, and courteous;
(iii) Is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services;
(iv) Complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate).

The State assures that each requirement will be met.

(4) The broker contract will provide transportation to the following categorically needy mandatory populations:

X Low-income families with children (section 1931)
X Low-income pregnant women
X Low-income infants
X Low-income children 1 through 5
X Low-income children 6 – 19
X Qualified pregnant women
X Qualified children
X IV-E Federal foster care and adoption assistance children
X TMA recipients (due to employment)
X TMA recipients (due to child support)
X SSI recipients

All mandatory populations will be covered.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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(5) The broker will provide transportation to the following categorically needy optional populations:

X Optional low-income pregnant women
X Optional low-income infants
___ Optional targeted low-income children
X Individuals under age 21 who are under State adoption assistance agreements
X Individuals under age 21 who were in foster care on their 18th birthday
___ Individuals who meet income and resource requirements of AFDC or SSI
___ Individuals who would meet the income & resource requirements of AFDC if child care costs were paid from earnings rather than by a State Agency
___ Individuals who would be eligible for AFDC if State Plan had been as broad as allowed under Federal law
X Individuals who would be eligible for AFDC or SSI if they were not in a medical institution
___ Individuals infected with TB
X Individuals screened for breast or cervical cancer by CDC program
___ Individuals receiving COBRA continuation benefits
X Individual in special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300% of SSI income standard
X Individuals receiving home and community based waiver services who would only be eligible under State Plan if in a medical institution
___ Individuals terminally ill if in a medical institution and will receive hospice care
___ Individuals aged or disabled with income not above 100% FPL
___ Individuals receiving only an optional State supplement in a 209(b) State
X Individuals working disabled who buy into Medicaid (BBA working disabled group)
X Employed medically improved individuals who buy into Medicaid under TWWIIA Medical Improvement Group
X Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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(6) The State will pay the contracted broker by the following method:

X (i) risk capitation
___ (ii) non-risk capitation
___ (iii) other (e.g., brokerage fee and direct payment to providers)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

The State has elected to provide non-emergency transportation services through a brokerage program in accordance with section 1902(a)(70) of the Social Security Act. The contracted broker provides services state-wide and is reimbursed on a per member per month capitated rate. The broker is responsible for administrating and operating the NET Program including but not limited to:

- Authorization – the broker is responsible for operating a call center in the City of Jackson and appropriately staffing it to ensure that beneficiaries have access to request NET services. The broker is responsible for ensuring that only eligible Medicaid beneficiaries receive transportation services to Medicaid medical providers for covered medical services.
- Coordination and Scheduling – the broker is responsible for contracting with NET providers and ensuring that a sufficient number of vehicles and drivers are available to transport beneficiaries based on their individual needs. The broker is responsible for ensuring that appropriate modes of transportation are utilized to deliver the beneficiaries to their medical appointments in a timely manner.
- Management – the broker is responsible for maintaining appropriate documentation to support all NET services provided or denied. In addition, the broker is responsible for providing timely payment to each contracted NET provider for the services rendered.
- Education – the broker is responsible for developing and implementing a plan for informing and educating beneficiaries, NET providers and medical providers about the NET broker program. The education process includes a complaint and grievance process for beneficiaries, medical providers, and NET providers.
- Monitoring – the broker is responsible for developing and implementing a plan for monitoring NET providers' compliance with all applicable local, State and Federal laws and regulations, the terms of their subcontracts and all NET provider related requirements of the broker's contract with the agency. In addition, the broker is responsible for providing the agency with specific reports that the agency will utilize to monitor the broker to ensure NET services are being provided in accordance with the terms and conditions of their contract.

State: Mississippi

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____ provided ___X___ not provided

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State _____Mississippi_____

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: ____ No limitations ____With limitations __X__None licensed or approved

Please describe any limitations:

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: ___No limitations ___With limitations (please describe below)

__X__ Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

Please check all that apply:

____ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).:

____ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

____ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

* For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

Inpatient Hospital Services

Prior authorization (PA) by the Utilization Management and Quality Improvement Organization (UM/QIO) is required on all hospital admissions except newborns at birth. Upon approval of a hospital admission, a treatment authorization number (TAN) is issued for an inpatient stay up to nineteen (19) consecutive days. If a beneficiary is discharged during these nineteen (19) days and requires another inpatient stay, a new PA request must be submitted to the UM/QIO for a new TAN.

Continued stay authorizations by the UM/QIO are required when the beneficiary remains hospitalized more than nineteen (19) days.

All hospital admissions for deliveries must be reported to the UM/QIO to receive an automatic TAN for an inpatient stay up to nineteen (19) consecutive days.

Newborns do not require a PA for admission at birth. Well or sick newborns hospitalized more than five (5) days from the date of delivery require a PA with the begin date of the hospital stay as the newborn's date of birth. If a newborn is discharged and requires another inpatient stay, a PA by the UM/QIO must be obtained on admission.

The Division of Medicaid covers all medically necessary services for EPSDT-eligible beneficiaries without regard to service limitations and with prior authorization.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 3.1-A
Exhibit 1a

STATE Mississippi

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

1a. Inpatient Hospital Services - Swing Bed:

Statutory Authority. Provision of swing bed services is authorized by Section 1913, Title XIX of the Social Security Act, as enacted by Congress through Section 904 of Public Law 96-499 and implemented by the Department of Health and Human Services through regulations 42 CFR Parts 405, 435, 440, 442 and 447.

Definition of Services. Swing bed services are extended care services provided in a hospital bed that has been designated as such and consist of one or more of the following:

a. Skilled nursing care and related services for patients requiring medical or nursing care.
b. Rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
c. On a regular basis, health related care and services to individuals who, because of their medical status, require care and services above the level of room and board which can be made available to them only through institutional facilities.

Eligible Providers. Hospitals granted an approval to participate in the swing bed program by the Health Care Financing Administration and holding a valid certificate of need to provide swing bed care from the Mississippi State Department of Health may provide swing bed services to Medicaid recipients.

Duration of Service. Medicaid recipients will be eligible for swing bed care to the same extent allowed or provided under the Long Term Care program, except that swing-bed providers will not be reimbursed for hospital leave days or therapeutic home leave days. Prior to the admission of a Medicaid recipient, the swing bed facility must call the Mississippi Foundation For Medical Care (PRO) to receive certification or non-certification for the swing bed. Seven (7) days prior to the thirtieth (30th) consecutive swing bed day, the hospital must complete the Medicaid Swing Bed Extension Form and forward it to PRO along with the entire patient record for review. PRO will notify the swing bed facility if the swing bed extension has been approved or disapproved.

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

2a. Outpatient Hospital Services

Visits for medically necessary outpatient hospital services are allowed for all beneficiaries.

Prior authorization is required for outpatient hospital physical therapy, occupational therapy, speech therapy and mental health services. Prior authorization is performed by the Utilization Management and Quality Improvement Organization (UM/QIO) contractor for the Division of Medicaid.

Emergency room services are allowed for all beneficiaries without limitations.

The Division of Medicaid covers all medically necessary services for EPSDT-eligible beneficiaries without regard to service limitations and with prior authorization.

State of Mississippi
DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

2b. Rural Health Clinic Services:

Rural Health Clinic (RHC) services are limited to those services provided in rural health clinics as described in the Social Security Act, Section l86l (aa). RHC services also include services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner or nurse midwife, and, for visiting nurse care, related medical supplies other than drugs and biologicals. Limitations on other ambulatory services furnished in the RHC are the same limitations as defined for those services in the state plan.

In order to participate in a Rural Health Clinic Program, a clinic must meet the certification requirements of 42 CFR 491 Subpart A and have an approved agreement to participate in the Medicaid program.

Scope of Services

A. Staffing Requirements

1. The RHC staff must include one or more physicians and one or more physician assistants or nurse practitioners.
2. The physician, physician assistant, nurse practitioner, nurse-midwife, clinical social worker, or clinical psychologist may be an owner or an employee of the clinic, or may furnish services under contract to the clinic.
3. The staff may also include ancillary personnel who are supervised by the professional staff. The staff must be sufficient to provide the services essential to the operation of the clinic.
4. The RHC must have a physician, nurse practitioner, physician assistant, nurse-midwife, clinical social worker, or clinical psychologist available at all times to furnish patient care services during the clinic's hours of operation. The RHC must also have a nurse practitioner, physician assistant, or certified nurse midwife available to furnish patient care services at least 60 percent of the time the RHC operates.
5. The physician must provide medical direction for the clinic's health care activities and consultation for, and medical supervision of, the health care staff.

6. The physician, in conjunction with the physician assistant and/or nurse practitioner, must participate in developing, executing, and periodically reviewing the clinic's written policies and the services provided to Medicaid beneficiaries, and must periodically review the clinic's patient's records, provide medical orders, and provide medical care services to the patients of the clinic.
7. A physician must be present for sufficient periods of time, at least once in every two week period (except in extraordinary circumstances), to provide the medical direction, medical care services, consultation and supervision and must be available through direct telecommunication for consultation, assistance with medical emergencies, or patient referral. The extraordinary circumstances are to be documented in the records of the clinic or center.
8. The RHC program requires state licensure for physicians and nurses, as well as compliance with state law for all clinical staff credentialing. In addition, the clinic should establish written clinical protocols for managing healthcare problems. These protocols should be approved by the State Board of Nursing.
9. The RHC program has no requirements for hospital admitting privileges, but a practice must demonstrate that hospital services are available to patients.

B. Direct Services

Medicaid will reimburse those diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at the entry point into the health care system. These include medical history, physical examination, assessment of health status, and treatment for a variety of medical conditions. In addition, the RHC must provide the following basic laboratory services on site:

1. Chemical examination of urine by stick or tablet
2. Hemoglobin or hematocrit
3. Blood sugar
4. Examination of stool specimens for occult blood
5. Pregnancy tests
6. Primary cultures for transmittal to a certified lab

Descriptions of Limitations as to Amount, Duration and Scope of Medical Care and Services Provided

C. Visits

1. Encounter

   A visit at an RHC can be a medical visit or an "other health" visit. A medical visit is a face-to-face encounter between a clinic patient and a physician, physician assistant, nurse practitioner, or nurse midwife. An "other health" visit is a face-to-face encounter between a clinic patient and a clinical psychologist, clinical social worker, or other health professional for mental health services. Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit, except when the following circumstances occur:

   a. After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment.

   b. The patient has a medical visit and a visit with a mental health professional, a dentist, or an optometrist. In these instances, the clinic is paid for more than one encounter on the same day.

2. Hospital and Nursing Home Visits

   RHC services are not covered when performed in a hospital (inpatient or outpatient). A physician employed by an RHC and rendering services to clinic patients in a hospital must file under his own individual provider number. Nursing home visits will be reimbursed at the RHC PPS rate.

State of Mississippi
DESCRIPTION OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

2c. Federally Qualified Health Centers Services:

Federally Qualified Health Centers services are limited to those services provided in federally qualified health centers as described in the Social Security Act, Section 1861 (aa). FQHC services also include services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner or nurse midwife, and, for visiting nurse care, related medical supplies other than drugs and biologicals. Limitations on other ambulatory services furnished in the FQHC are the same limitations as defined for those services in the state plan.

A center must meet the conditions set forth in 42 CFR 491 Subpart A and have an approved agreement to participate in the Medicaid program.

Scope of Services

A. Staffing Requirements

1. The FQHC staff must include one or more physicians and one or more physician assistants or nurse practitioners.

2. The physician, physician assistant, nurse practitioner, nurse-midwife, clinical social worker, or clinical psychologist may be an owner or an employee of the clinic, or may furnish services under contract to the center.

3. The staff may also include ancillary personnel who are supervised by the professional staff. The staff must be sufficient to provide the services essential to the operation of the center.

4. The FQHC must have a physician, nurse practitioner, physician assistant, nurse-midwife, clinical social worker, or clinical psychologist available at all times to furnish patient care services during the center's hours of operation. The physician must provide medical direction for the clinic's health care activities and consultation for, and medical supervision of, the health care staff except for services furnished by a clinical psychologist, which state law permits to be provided without physician supervision.

5. The physician, in conjunction with the physician assistant and/or nurse practitioner, must participate in developing, executing, and periodically reviewing the clinic's written policies and the services provided to Medicaid beneficiaries, and must periodically review the center's patient's records, provide medical orders, and provide medical care services to the patients of the center.

6. A physician must be present for sufficient periods of time, at least once in every two week period (except in extraordinary circumstances), to provide the medical direction, medical care services, consultation and supervision and must be available through direct telecommunication for consultation, assistance with medical emergencies, or patient referral. The extraordinary circumstances are to be documented in the records of the center.

7. The FQHC program requires state licensure for physicians and nurses, as well as compliance with state law for all clinical staff credentialing.

8. The FQHC program has no requirements for hospital admitting privileges, but a practice must demonstrate that hospital services are available to patients.

B. Direct Services

Medicaid will reimburse those diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at the entry point into the health care system. These include medical history, physical examination, assessment of health status, and treatment for a variety of medical conditions.

C. Visits

1. Encounter

A visit at a FQHC can be a medical visit or an "other health" visit. A medical visit is a face-to-face encounter between a clinic patient and a physician, physician assistant, nurse practitioner, or nurse midwife. An "other health" visit is a face-to-face encounter between a clinic patient and a clinical psychologist, clinical social worker, or other health professional for mental health services. Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit, except when the following circumstances occur:

a. After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment.

b. The patient has a medical visit and a visit with a mental health professional, a dentist, or an optometrist. In these instances, the clinic is paid for more than one encounter on the same day.

2. Hospital and Nursing Home Visits

FQHC services are not covered when performed in a hospital (inpatient or outpatient). A physician employed by a FQHC and rendering services to clinic patients in a hospital must file under his own individual provider number. Nursing home visits will be reimbursed at the FQHC PPS rate.

D. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

The Division of Medicaid covers all medically necessary services for EPSDT-eligible beneficiaries ages birth to twenty-one (21) in accordance with 1905 (a) of the Act, without regard to service limitations and with prior authorization.

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3. For dates of service on or after July 1, 2013, prior authorization is required for certain advanced imaging procedures. Prior authorization is performed by a Utilization Management and Quality Improvement Organization (UM/QIO) contractor for the Division of Medicaid.

   Prior authorization for certain advanced imaging procedures, as specified in the MS Administrative Code, Title 23, Part 220, is required except when performed during an inpatient hospitalization, during an emergency room visit or during a twenty-three (23) hour observation period.

   The Division of Medicaid covers all medically necessary services for EPSDT-eligible beneficiaries without regard to service limitations and with prior authorization.

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4a. Nursing Facility Services:

The Division of Medicaid covers Nursing Facility services provided in a facility licensed and certified by the state survey agency as a Medicaid Nursing Facility and meets all the requirements in 42 CFR Part 483.

A Nursing Facility is defined as an institution, or distinct part thereof, that meets the requirements of Sections 1919(a), (b), (c) and (d) of the Social Security Act. The Nursing Facility primarily provides the following three (3) types of services and is not primarily for the care and treatment of mental diseases:

1. Skilled nursing care and related services for residents who require medical or nursing care,

2. Rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

3. Health-related care and services on a regular basis to individuals with mental or physical conditions requiring care and services that can only be made available through institutional facilities.

A nursing facility must provide, or arrange for, nursing or related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as outlined in 42 CFR Part 483.

4b. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under the Age of Twenty-one (21): Limited to Federal Requirements.

EPSDT Screenings:

The Division of Medicaid covers early and periodic screening and diagnosis of Medicaid-eligible beneficiaries under age twenty-one (21) to ascertain physical, mental, psychosocial and/or behavioral health conditions and provides treatment to correct or ameliorate physical, mental, psychosocial and/or behavioral health conditions found in accordance with Sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Social Security Act. The Division of Medicaid has established procedures to:

1. Inform all eligible individuals, or their families, of the EPSDT program,
2. Provide or arrange for requested screening services including necessary transportation and scheduling assistance, and
3. Arrange for appropriate treatment of health problems found as a result of a screening.

EPSDT screenings must be provided by currently enrolled Mississippi Medicaid providers who have signed an EPSDT specific provider agreement and must adhere to the periodicity schedule of the American Academy of Pediatrics (AAP) Bright Futures for physical, mental, psychosocial and/or behavioral health, vision, hearing, adolescent, and developmental screenings and the American Academy of Pediatric Dentistry (AAPD) for dental screenings. EPSDT screening providers include, but are not limited to:

1. The Mississippi State Department of Health (MSDH),
2. Public schools and/or public school districts certified by the Mississippi Department of Education,
3. Physicians,
4. Federally Qualified Health Centers (FQHC),
5. Rural Health Clinics (RHC),
6. Comprehensive health clinics, and
7. Similar agencies which provide various components of EPSDT screenings.

EPSDT screenings include:

1. An initial or established age appropriate medical screening which must include at a minimum:
   - A comprehensive health and developmental history including assessment of both physical and mental health development,
   - A comprehensive unclothed physical examination,
   - Appropriate immunizations according to the Advisory Committee on Immunization Practices (ACIP) and according to age and health history,
   - Laboratory tests adhering to the AAP Bright Futures periodicity schedule,
   - Sexual development and sexuality screening adhering to the AAP Bright Futures periodicity schedule, and
   - Health education, including anticipatory guidance.
2. Adolescent counseling and risk factor reduction intervention to include diagnosis with referral to a Mississippi Medicaid provider for diagnosis and treatment for defects discovered.
3. Developmental screening to include diagnosis with referral to a Mississippi Medicaid provider for diagnosis and treatment for defects discovered.
4 Psychosocial/behavioral assessment to include referral to a Mississippi Medicaid provider for diagnosis and treatment for defects discovered.
5. Vision screening at a minimum to include diagnosis with referral to a Mississippi Medicaid optometry or ophthalmology provider for diagnosis and treatment for defects in vision, including eyeglasses.
6. Hearing screening at a minimum to include diagnosis with referral to a Mississippi Medicaid audiologist, otologist, otolaryngologist or other physician hearing specialists for diagnosis and treatment for defects in hearing including hearing aids.
7. Dental screening at a minimum to include diagnosis with referral to a Mississippi Medicaid dental provider for beneficiaries at the eruption of the first tooth or by twelve (12) months of age for diagnosis and referral to a dentist for treatment and relief of pain and infections, restoration of teeth and maintenance of dental health.

EPSDT screening providers must refer beneficiaries under the age of twenty-one (21) to other Mississippi Medicaid enrolled licensed practitioners for services necessary to correct or ameliorate physical, mental, psychosocial and/or behavioral health conditions discovered by the screening services, whether or not such services are covered under the State plan.

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4b. Early and Periodic Screening and Diagnosis of Individuals under 21 Years of Age. Treatment of Conditions Found: Exceeds General Requirements.

I. **Medical Risk Assessment**

In addition to the periodic screen, medical risk assessment (screening) is done by a physician, or by a registered nurse/nurse practitioner or a physician assistant under a physician's direction, to determine if the infant is high risk for mortality or morbidity. An infant is considered high risk if one or more risk factors are indicated on the Risk Screening Form, Mississippi Perinatal Risk Management/Infant Services System, or the Hollister Maternal/Newborn Record System, and is eligible for enhanced services, as specified in Section III, Enhanced EPSDT Services for High-Risk Infants.

An infant may be assessed (screened) for medical risk a maximum of two (2) times during the first year, i.e., at birth and again if risk factors are present, within the first year by the physician providing care. If the infant is found to be high risk, the physician is to make a referral to the High-Risk Case Management Agency of the client's choice. The physician may send a copy of the screening form to the High-Risk Case Management Agency or make a telephone referral. The High-Risk Case Management Agency will document referral information on the Risk Screening Form, if the referral is made by telephone.

Reimbursement for the medical risk assessment is to an approved physician provider.

II. **Enhanced EPSDT Services For High-Risk Infants**

Enhanced services (infant nutrition, infant psychosocial, and health education to the infant's caretaker) are to be provided on the basis of medical necessity to lessen the risk of infant mortality or morbidity through the EPSDT Program. Infants found to be at such risk shall be referred to as high-risk infants.

These services are currently provided in a lesser amount to all children receiving EPSDT Services. In order to prevent the demise or morbidity of the high-risk infant, the number of possible EPSDT

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screenings will be increased to one (1) per calendar month with a maximum of twelve (12) during the first year of life. At the discretion of the attending physician, abbreviated screenings may be provided to a high-risk infant and the full screening provided at the next visit. If the medical or medically-related risk factor(s) cease to exist during the first year of life, as determined by the infant's physician, the infant will return to the regular screenings as prescribed in the EPSDT periodicity schedule.

The screenings may be provided to the infant in any appropriate setting, such as home or office. Home visits are particularly encouraged.

The Child Health Record will be utilized for comments regarding feeding, development and other identified problems and will be subject to audit by the Division of Medicaid for quality of care purposes, as is currently done for the regular EPSDT Program.

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III. Medical Necessity

The only limitation on services covered is that they are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered during an EPSDT screen, periodic or interperiodic, whether or not such services are covered or exceed the benefit limits in the State Plan. Services not covered in the State Plan are covered provided they are described in Section 1905(a) of the Social Security Act. All services determined to be medically necessary will be covered. The Division of Medicaid will require that prior approval be obtained by the provider for medically necessary services which are not covered in the State Plan or which exceed the benefit limits addressed in the State Plan. Prior approval is through plans of care which are submitted by a physician for Division of Medicaid approval. Services requested and approved as a result of the plan of care may be provided by any Medicaid approved provider, as appropriate for the service.

Services in Section 1905(a) available to EPSDT recipients, if medically necessary, and not addressed elsewhere in the State Plan include:

1) Podiatrists' Services
2) Optometrists' Services
3) Chiropractors' Services
4) Dentists'
5) Private Duty Nursing
6) Christian Science Nurses
7) Personal Care Services
8) Case Management Services
9) Respiratory Care Services
10) Organ Transplants
11) Rehabilitative Services

IV. **Rehabilitative Services**

42 CFR 441.57
42 CFR 440.130 (d)

Medically necessary rehabilitative services include a range of coordinated services provided to children under 21 years of age in order to correct, reduce or prevent further deterioration of identified deficits in the child=s mental health.

Deficits are identified through comprehensive screening, assessment and evaluations by qualified mental health professionals and/or medical professionals. Services provided must be face-to-face, medically necessary, within the scope of practice of the provider and address identified problems in order that the beneficiary may attain the best level of functioning for him/her. Services include provision of direct one-on-one treatment with the child and a provision for collaborations with and instruction to parents and/or other caregivers in addressing the child=s identified needs, as outlined on a treatment plan. Services provided to family members or caregivers that are independent of meeting the identified needs of the child or which are primarily focused on academic education are not covered by Medicaid.

Services must be community based and may be provided in a day care, at home, at school, in a doctor=s office, at a hospital outpatient clinic or in another appropriate clinical setting

Eligible Providers:

An eligible provider must enroll as a Medicaid individual provider. Eligible providers must be a physician who specializes in child/addescent psychiatry, a clinical psychologist, a licensed certified social worker or other mental health practitioner licensed independently to practice in the State and recognized by the Division of Medicaid. Providers of Day Treatment must be certified by the Department of Mental Health, meet the Minimum Standards for Day Treatment providers and have a Alead@ day treatment provider who meets the independent practice qualification.

Benefits and Limitations:

Day Treatment is a behavioral intervention, provided in the context of a therapeutic milieu, which provides the intensive treatment necessary to enable children to live in the community. It is the most intensive community-based treatment available. Day Treatment may be provided up to a maximum of 5 days per week with the maximum number of hours per day specified in the current Medicaid Provider Policy Manual. The minimum and maximum number of participants in each day treatment program are also specified in the Medicaid Provider Policy Manual. All Day Treatment program must be certified by the Department of Mental Health and each Medicaid beneficiaries participation in a Day Treatment program must be prior authorized. Prior authorization is granted by the Medicaid Agency and determined based upon the recommendation and documentation submitted by an appropriate mental health professional.

Evaluative Services are time-limited, formal processes that collect clinical information from many

sources in order to reach a diagnosis, determine a prognosis, render a biopsychosocial formulation, and determine treatment. Evaluative Services are used to assess personality, intelligence, and the presence, degree, and type of neuropsychological brain dysfunction. All Evaluative Services exceeding four (4) hours require prior authorization based on the recommendation of an appropriate mental health practitioner. Prior authorization may be required for any Evaluative Service as outlined in the Medicaid Provider Policy Manual.

Psychotherapeutic Services are intentional face-to-face interactions between a provider and a beneficiary in which a therapeutic relationship is established to help resolve symptoms of the beneficiary=s mental and/or emotional disturbance. Psychotherapeutic Services are directed toward helping the beneficiary attain the highest level of functioning in a community-based setting. Psychotherapeutic services include at a minimum, Individual psychotherapy, Group psychotherapy, and Family Psychotherapy. Psychotherapeutic services require prior authorization when the services provided exceed 100 hours per fiscal year or when services are provided to individuals under the age of three (3).

Mental Health services that are considered Amedically necessary@ must be (1) consistent with the diagnosis or treatment of the beneficiary=s condition or illness; (2) in accordance with the standards of good medical practice; (3) required for reasons other than the convenience of the beneficiary, beneficiary=s parents or legal guardian, or the servicing provider; (3) the most appropriate level of mental health services which can be safely and efficiently provided to the beneficiary in a community-based setting. Medical necessity for mental health services outlined as standard services in the Mississippi Medicaid Provider Policy Manual will be verified based on established post utilization review protocol.

Prior authorization may be requested through the submission of an authorization request by a qualified Medicaid provider. Additional documentation to substantiate medical necessity may be requested by the Medicaid Agency.

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4.d. 1) Face-to-Face Tobacco Cessation Counseling Services provided (by):

(i) By or under supervision of a physician;

(ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; or*

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.)

2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

Provided: ☐ No limitations* ☐X With limitations**

*The State is providing at least four (4) counseling sessions per quit attempt.

**Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt should be explained below.

Please describe any limitations:

*Face-to-Face tobacco cessation counseling services for pregnant women are limited to one (1) counseling session per quit attempt with mandatory referral to the MS Tobacco Quitline.

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5. **Physicians' Services:** Hospital visits limited to one (1) per day, except visits to patients in Intensive or Coronary Care Units (ICU or CCU) limited to two (2) per day. Medicaid will pay for services of additional physicians during inpatient hospitalization provided the primary physician certifies to the Division that it was medically necessary for the care of the patient. Physicians will not be reimbursed for hospital visits after the patient has used all allowed hospital days. Nursing home visits limited to thirty-six (36) per fiscal year. Medicaid reimbursement for physician services rendered in the physician's office, outpatient department of a hospital or services rendered in a rural health clinic are limited to a combined total of twelve (12) visits per fiscal year. Ancillary diagnostic procedures are not covered after expiration of twelve (12) authorized physician visits.

All physician services that an optometrist is legally authorized to perform are included in physicians' services under this plan and are reimbursed whether furnished by a physician or an optometrist.

Psychiatric therapeutic procedures provided by a psychiatrist are not included in the twelve (12) physician office visits/fiscal year. Medicaid reimbursement for psychiatric services rendered in the doctor's office, outpatient department of a hospital or services rendered in a rural health clinic are limited to a combined total of twelve (12) visits per fiscal year.

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5b Medical and surgical services by a dentist

Medical and surgical services furnished by a dentist in accordance with section 1905 (a) (5) (B) of the Social Security Act are limited to those to services which a dentist is legally authorized to perform and are covered in the Plan.

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Podiatry services are covered for all Medicaid eligible recipients. This means that the professional services provided by a doctor of podiatric medicine within the scope of applicable state law and licensing requirements (except those services such as routine foot care which are specifically excluded) are reimbursable by the Division of Medicaid.

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Chiropractic services are covered for all Medicaid eligible recipients. This means that a chiropractor's manual manipulation of the spine to correct a subluxation, if an x-ray demonstrates that a subluxation exists for which manipulation is the appropriate treatment, is reimbursable by Medicaid. There shall be no reimbursement for x-rays or other diagnostic of therapeutic services furnished or ordered by a chiropractor.

6d. Other Practitioners' Services:

Nurse Practitioner Services: Services furnished by a registered nurse who is licensed and certified by the Mississippi Board of Nursing as a nurse practitioner including, but not limited to nurse anesthetists, nurse midwives, family nurse practitioners, family planning nurse practitioners, pediatric nurse practitioners, obstetrics-gynecology nurse practitioners and neonatal nurse practitioners, under regulations adopted by the Division.

Physician Assistant Services: Physician assistant services are those provided by physician assistants who are licensed by the State Board of Medical Licensure and are practicing with physician supervision under regulations adopted by the Division.

Pharmacy Disease Management Services: Disease management services are those provided by specially credentialed pharmacists for Medicaid recipients with specific chronic disease states of diabetes, asthma, lipids, or coagulation. It is a patient-centered concept integrating the pharmacist into the health care team with shared responsibility for disease management and therapeutic outcome. The process provides cost-effective, high-quality health care for patients referred by their physician. The referring physician requests disease management services from any credentialed participating pharmacist in Mississippi. With the appropriate transfer of pharmacy care records, including a written referral from the physician to the pharmacist, the referral is considered documented. All laboratory test results must be included because the pharmacist is not allowed reimbursement for laboratory procedures. In order to be cost-effective for the Medicaid program, the disease management services performed by the pharmacist cannot duplicate those provided by the physician.

The pharmacist is knowledgeable about pharmaceutical products and the design of therapeutic approaches which are safe, effective, and cost-efficient for patient outcomes. The pharmacist evaluates the patient and consults with the physician concerning the suggested/prescribed drug therapy. After the drug therapy review with the physician, the pharmacist counsels the patient concerning such topics as compliance and provides the patient with educational and informational materials specific to the disease or drug. The pharmacist functions in an educational capacity to ensure the patient understands and complies with the proper usage of all drugs prescribed by the physician. The involvement with the patient and the education of the patient about lifestyle changes and improved drug regimen compliance are aimed at reduction of or avoidance of costly hospitalizations and emergency care.

The State Pharmacy Practice Act in its Disease Management Protocol requires communication with the referring physician. Disease management services follow a protocol developed between the pharmacist and patient's physician. When nationally accepted clinical practice guidelines are introduced, they will be incorporated into the individual patient's therapy plan.

The primary components of this service are as follows:

1. Patient evaluation
2. Compliance assessment
3. Drug therapy review
4. Disease state management according to clinical practice guidelines
5. Patient/caregiver education

A copy of the pharmacy care records, including the documentation for services, is shared with the patient's physician and remains on file in the pharmacist's facility available for audit by the Division of Medicaid.

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To provide this service, a pharmacist must be a registered pharmacist with a doctorate in pharmacy or a registered pharmacist who has completed a disease specific certification program approved by the Mississippi Board of Pharmacy practicing within the scope as defined by state law. The present certification courses approved by the Board of Pharmacy are from twenty-four (24) to thirty (30) hours.

All pharmacists, both the registered pharmacist with a doctorate and the registered, certified pharmacist must renew their specific disease management certifications every two years as required by Board of Pharmacy regulations. The present recertification course approved by the Board of Pharmacy is twenty to thirty hours.

Additionally, the pharmacist must provide a separate distinct area conducive to privacy, e.g., a partitioned booth or a private room. Also the pharmacist must complete an enrollment packet and a provider agreement and receive a provider number from the Division of Medicaid.

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7.A, B., & D. Home Health Care Services: Limited to a combined total of twenty-five (25) visits per fiscal year for intermittent or part-time nursing service provided by a home health agency (or a registered nurse when no home health agency exists in the area), or home health aide services provided by a home health agency. Physical therapy, speech pathology services, occupational therapy and audiology services provided by a home health agency are not covered. Home health aide services may be provided without a requirement for skilled services.

The home health agency must be certified to participate as a home health agency under Title XVIII (Medicare) of the Social Security Act, and meet all applicable state laws and requirements.

For skilled nursing services, the registered nurse must be a graduate of an approved school of professional nursing, who is licensed as a registered nurse by the State in which practicing.

For aide services, the home health aide must be a non-professional individual who has successfully completed a state-established or other home health aide training program. The home health aide provides personal care services under the supervision of a registered nurse.

7.C. Medical Supplies, Equipment, and Appliances Suitable for Use in the Home: Medical supplies, equipment, and appliances are provided if they (1) are relevant to the beneficiary's plan of care, (2) are medically necessary, (3) primarily serve a medical purpose, (4) have therapeutic or diagnostic characteristics enabling a patient to effectively carry out a physician's prescribed treatment for illness, injury, or disease, and (5) are appropriate for use in the patient's home. These items must be prescribed by a physician or other individual practitioner authorized under state law to prescribe such items and must be prior authorized unless specifically exempted from this requirement. Equipment and appliances must be provided through qualified DME providers. Medical supplies may be provided through a qualified home health agency or DME provider. Medical supplies, equipment, and appliances may be provided regardless of whether a beneficiary is receiving services from a home health agency.

9. Clinic Services: Clinic services are limited to those services as described in CFR 42 § 440.90 provided in the Mississippi State Department of Health (MSDH) clinics.

   Clinic services are preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished by a facility not part of a hospital but organized and operated to provide medical care to outpatients at the clinic by or under the direction of a physician or dentist, or to outpatients outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

   MSDH clinic services are covered for all Medicaid eligible beneficiaries and limited to one (1) encounter per day unless the beneficiary suffers illness or injury requiring additional diagnosis or treatment, or the beneficiary has a medical visit and a visit with a dentist. In these instances, the clinic is paid for more than one (1) encounter on the same day.

   The Division of Medicaid covers for all medically necessary services for EPSDT-eligible beneficiaries without regard to service limitations and with prior authorization.

   Only medically necessary services are covered under the Medicaid program.

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

9a. Ambulatory Surgical Center

Ambulatory surgical center or ASC means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed twenty-four (24) hours following an admission. The entity must have an agreement with CMS to participate in Medicare as an ASC, and must meet the conditions set forth in subparts B and C of 42 CFR Part 416.

Effective January 1, 2008, ASC services means the combined facility services and covered ancillary services that are furnished in an ASC in connection with covered surgical procedures.

Covered ancillary services means items and services that are integral to a covered surgical procedure performed in an ASC as provided in 42 CFR § 416.164(b), for which payment may be made under 42 CFR § 416.171 in addition to the payment for the facility services.

Effective January 1, 2008, covered surgical procedures means those surgical procedures that meet the criteria specified in 42 CFR § 416.166.

Effective January 1, 2008, facility services means services that are furnished in connection with covered surgical procedures performed in an ASC as provided in 42 CFR § 416.164(a) for which payment is included in the ASC payment established under 42 CFR § 416.171 for the covered surgical procedure.

Only medically necessary services are covered under the Medicaid program.

The Division of Medicaid covers for all medically necessary services for EPSDT-eligible beneficiaries without regard to service limitations and with prior authorization.

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9b. End-Stage Renal Dialysis (ESRD) Services

The Division of Medicaid covers all end-stage renal dialysis (ESRD) services and items used to furnish outpatient maintenance dialysis in an ESRD facility or in a beneficiary's home. According to Section 1881 of the Act and 42 CFR § 413.174, ESRD facilities are classified as either:

(a) Hospital-Based ESRD Facilities as defined in 42 CFR § 413.174(c), or

(b) Freestanding ESRD Facilities as defined in 42 CFR § 413.174(b).

There is no distinction between the two facility types for the purposes of payment under the ESRD Prospective Payment System (PPS).

A renal dialysis facility or renal dialysis center must provide dialysis services, as well as adequate laboratory, social, and dietetic services to meet the needs of the ESRD beneficiary according to 42 CFR § 405.2102.

The Division of Medicaid covers for all medically necessary services for EPSDT-eligible beneficiaries without regard to service limitations and with prior authorization.

10. Dental Services:

Adults (beneficiaries age twenty-one (21) and over): Dental care that is an adjunct to treatment of an acute medical or surgical condition; services of oral surgeons and dentists in connection with surgery related to the jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone; and emergency dental extractions and treatment related thereto are covered services.

Children (beneficiaries under age twenty-one (21): Dental services are a necessary component of overall health services provided to children who are eligible for services. Beneficiaries under age twenty-one (21) are eligible for medically necessary dental services, including diagnostic, preventive, therapeutic, emergency, and orthodontic services.

Dental Benefit Limits:
For dates of service beginning July 1, 2007, dental services (except orthodontia) are limited to $2,500 per beneficiary per fiscal year. Additional dental services in excess of the $2,500 annual limit may be provided with prior approval from the Division of Medicaid.

Orthodontia Services:
Orthodontia services are covered with prior approval for beneficiaries under age twenty-one (21) only. Orthodontia-related services are limited to $4,200 per beneficiary per lifetime. Additional dental services in excess of the $4,200 lifetime limit may be provided with prior approval from the Division of Medicaid.

Dentures: Dentures may be covered for beneficiaries under age twenty-one (21) with prior approval.

Medicaid Eligibles Not Covered for Dental Benefits: The following Medicaid eligibles are not covered for dental benefits:

- Women who are eligible for Medicaid only because of pregnancy (pregnancy-related eligibles) and who are age twenty-one (21) or older;
- Beneficiaries in the Healthier Mississippi Waiver who are age twenty-one (21) or older;
- Medicare beneficiaries who are not eligible for full Medicaid benefits.

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I. **Physical Therapy** and related services are provided to all eligible individuals as follows:

A. Services are performed by a physical therapist who meets the state and federal licensing and certification requirements to perform physical therapy services. Physical therapists must meet the qualifications in 42 CFR §440.110 in order to provide these services.

B. Services are medically necessary for the treatment of the beneficiary's illness, condition, or injury.

C. Services for beneficiaries age 21 and over are performed in an individual therapy office or a therapy clinic, physician's office or clinic, nursing facility, or outpatient department of hospital.

D. Services for beneficiaries age 21 and over are performed in an individual therapy office or a therapy clinic, physician's office or clinic, nursing facility, or outpatient department of hospital.

E. Services are prior authorized through the agency's Utilization Management and Quality Improvement Organization as medically necessary.

F. Services are ordered by a physician, physician assistant, or nurse practitioner and provided in accordance with a written plan of care approved by the prescribing provider.

II. **Occupational Therapy** and related services are provided to all eligible individuals as follows:

A. Services are performed by an occupational therapist who meets the state and federal licensing and certification requirements to perform occupational therapy services. Occupational therapists must meet the qualifications in 42 CFR §440.110 in order to provide these services.

B. Services are medically necessary for the treatment of the beneficiary's illness, condition, or injury.

C. Services for beneficiaries age 21 and over are performed in an individual therapy office or a therapy clinic, physician's office or clinic, nursing facility, or outpatient department of hospital.

D. Services for beneficiaries under age 21 are performed in an individual therapy office or therapy clinic, physician's office or clinic, school, home, nursing facility, or outpatient department of hospital.

E. Services are prior authorized through the agency's Utilization Management and Quality Improvement Organization as medically necessary.

F. Services are ordered by a physician, physician assistant, or nurse practitioner and provided in accordance with a written plan of care approved by the prescribing provider.

III. **Speech-Language Pathology** and related services are provided to all eligible individuals as follows:

A. Services are performed by a speech-language pathologist or audiologist who meets the state and federal licensing and certification requirements to perform speech-language pathology or audiologist services. Speech therapists and audiologists must meet the qualifications in 42 CFR §440.110 in order to provide these services.

B. Services are medically necessary for the treatment of the beneficiary's illness, condition, or injury.

C. Services for beneficiaries age 21 and over are performed in an individual therapy office or a therapy clinic, physician's office or clinic, nursing facility, or outpatient department of hospital.

D. Services for beneficiaries under age 21 are performed in an individual therapy office or therapy clinic, physician's office or clinic, school, home, nursing facility, or outpatient department of hospital.

E. Services are prior authorized through the agency's Utilization Management and Quality Improvement Organization as medically necessary.

F. Services are ordered by a physician, physician assistant, or nurse practitioner and provided in accordance with a written plan of care approved by the prescribing provider.

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

12a. **Prescribed Drugs**:

(1) Covered outpatient drugs are those produced by any manufacturer which has entered into and complies with an agreement under Section 1927 (a) of the Act which are prescribed for a medically acceptable indication. Compounded prescriptions (mixtures of two (2) or more ingredients) except for hyperalimentation are not covered.

(2) All Medicaid beneficiaries age 21 and older are limited to five (5) prescriptions per month with no more than two (2) brand name (single source or innovator multiple source) drugs per month for each non-institutionalized Medicaid beneficiary.

(3) As provided in Section 1935 (d) (1) of the Act, effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible under Part A or Part B.

(4) As provided by Sections 1927 (d)(2) and 1935 (d)(2) of the Act, the Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses, to all Medicaid beneficiaries including full benefit dual eligible beneficiaries under the Medicare prescription Drug Benefit-Part D.

☐ (a) Agents when used for anorexia, weight loss or weight gain;

☐ (b) Agents when used to promote fertility;

☐ (c) Agents when used for cosmetic purposes or hair growth;

☐ (d) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee;

☐ (e) Those drugs designated less than effective by the FDA as a result of the Drug Efficacy Study Implementation (DESI) program;

☐ (f) Nonparticipating rebate manufacturers;

☒ (g) Select agents when used for symptomatic relief of cough and colds: antihistamines, decongestants, antihistamine/decongestant combination products, legend antitussive benzonate;

☒ (h) Select prescription vitamins and mineral products, except prenatal vitamins and fluoride:
vitamin K, cyanocobalamin injection, vitamin D, folic acid as a single entity;

☒ (i) Select nonprescription (OTC) drugs:
Insulin, allergy and sinus products, analgesics/antipyretics, antitussives, antitussive/expectorants, digestive medications, ophthalmic agents, topical antibiotics, topical antiparasitics, topical antifungals, and vaginal antifungals.

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICE PROVIDED

Supplemental Rebate Agreements:

The state, or the state in consultation with the Sovereign States Drug Consortium, may negotiate supplemental rebate agreements that would reclassify any drug not designated as preferred in the baseline listing for as long as the agreement is in effect. A rebate agreement between the state and a drug manufacturer for drugs provided to the Medicaid program, submitted to the Centers for Medicare & Medicaid Services (CMS) on December 27, 2005 and entitled, "State of Mississippi Supplemental Rebate Agreement", has been authorized by CMS. CMS authorized the State of Mississippi to enter into the "Sovereign States Drug Consortium (SSDC)" multi-state purchasing pool. The supplemental rebate agreement submitted to CMS on September 7, 2012, entitled, "State of Mississippi Supplemental Rebate Agreement", has been authorized by CMS. CMS authorized the revised multi-state SSDC agreement submitted on March 17, 2014, for the Division of Medicaid population to cover supplemental rebates for fee-for-services and coordinated care Medicaid programs, effective July 1, 2014.

An Agreement may not be amended or modified without the authorization of CMS.

Based on the requirements for Section 1927 of the Act, the Division of Medicaid will comply with the following policies for drug rebate agreements:

- The drug file permits coverage of participating manufacturers' drugs.
- The Division of Medicaid may require prior authorization for covered outpatient drugs. Non-preferred drugs are available with prior authorization.
- The prior authorization process for covered outpatient drugs will conform to the provisions of section 1927 (d) (5) of the Social Security Act.
- The Division of Medicaid will comply with the drug reporting requirements for state utilization information and restriction to coverage.
- Supplemental rebate agreement between the DOM and a pharmaceutical manufacturer will be separate from federal rebates and are in excess of those required under the national drug rebate agreement.
- The state agrees to report all rebates from manufacturers to the Secretary for Health and Human Services. The state will remit the federal portion of any state supplemental rebates collected.
- The Division of Medicaid will allow all participating manufacturers to audit utilization data.
- The unit rebate amount will be held confidential and will not be disclosed for purposes other than rebate invoicing and verification.

Preferred Drug List:

In accordance with Section 1927 of the Social Security Act, the state has established a preferred drug list (PDL).

The Preferred Drug List (PDL) is a list of drugs, which have been reviewed and recommended by the Pharmacy and Therapeutics (P&T) Committee, a group of physicians, pharmacists, and nurse practitioners, and approved by the Executive Director of the Division of Medicaid.

The Preferred Drug List contains a wide range of generic and preferred brand name products that have been approved by the FDA. A medication becomes a preferred drug based first on safety and efficacy, then on cost-effectiveness. Drugs on the PDL are as effective as non-preferred drugs, but offer economic benefits for the beneficiaries and the State of Mississippi.

Drugs must be prescribed and dispensed in accordance with medically accepted indications for uses and dosages. No payment will be made under the Medicaid program for services, procedures, supplies or drugs which are still in clinical trials and/or investigative or experimental in nature.

As of July 1, 2014, the Division of Medicaid's coordinated care organizations (CCO), otherwise known as MississippiCan, will follow the Division of Medicaid's PDL.

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

12a. **Physician Administered Drugs and Implantable Drug System Devices:**

The Division of Medicaid defines Physician Administered Drugs and Implantable Drug System Devices as any covered diagnostic or therapeutic radiopharmaceutical, contrast imaging agent, drug, biological or implantable drug system device that is administered in a clinically appropriate manner to a beneficiary by a Mississippi Medicaid provider other than a pharmacy provider.

The Division of Medicaid covers Physician Administered Drugs and Implantable Drug System Devices as listed on the Physician's Fee Schedule located at www.medicaid.ms.gov/FeeScheduleLists.aspx.

Attachment 3.1-A

Exhibit 12c

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: MISSISSIPPI

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

12c. Orthotics and Prosthetic Devices - Orthotics and prosthetic devices are provided to children under 21 years of age when prescribed by a physician and medically necessary.

TN # 98-14

Superseded TN # 86-3

Date Received 12/7/98

Date Approved 12/21/98

Date Effective 1/1/99

Attachment 3.1-A

Exhibit 12d

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: MISSISSIPPI

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED.

12d. Eyeglasses:

Eligible beneficiaries age 21 years and over are qualified for eyeglasses as prescribed by an ophthalmologist or optometrist (including eyeglasses needed after eye surgery). The beneficiary is allowed one (1) pair of eyeglasses every five (5) years. Beneficiaries under age 21 are eligible for eyeglasses as determined through the EPSDT Screening Program.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 3.1-A
Exhibit 13

State: Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

13. Other Diagnostic, Screening, Preventive, and Rehabilitative Services, i.e., other than those provided elsewhere in the plan.

Limited to preventive and rehabilitative services (42CFR440.130[a] [b] [c] [d] and the following procedures:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 3.1-A
Exhibit 13a

State: Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

13a. Diagnostic Services: Diagnostic services, except as otherwise provided in this Plan, includes any medical procedures or supplied recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, top enable them to identify the existence, nature, or extent of illness, injury, or other health deviation in a recipient.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 3.1-A
Exhibit 13b

State: Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

13b. Screening Services: Screening services means the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases.

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

13c. Preventive Services: Preventive services mean services provided by a physician or other licensed practitioner of the healing arts within the scope of his practice under State law to:

1) Prevent disease, disability, and other health conditions or their progression;
2) Prolong life; and
3) Promote physical and mental health and efficiency.

Annual Physical Examination: The Division of Medicaid will cover annual physical examinations. Through this provision, eligible Mississippi Medicaid beneficiaries will be encouraged to choose a medical home and undertake a physical examination to establish a base-line level of health. Beneficiaries under age 21 will access the mandatory periodic screening services through EPSDT providers in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

A medical home is defined as the usual and customary source that provides both preventative and treatment or diagnosis of a specific illness, symptom, complaint, or injury. The medical home will serve as the focal point for a beneficiary's health care, providing care that is accessible, accountable, comprehensive, integrated, and patient-centered.

Dual eligibles whose Medicare Part B effective date is prior to January 1, 2005 will be eligible for the physical examination. For dual eligibles whose Medicare Part B effective date is on or after January 1, 2005, the annual physical examination is covered after twelve months have elapsed from the original effective date of Medicare Part B coverage. Beneficiaries enrolled in Medicare Part B coverage on and after January 1, 2005 are entitled to a one time only "Welcome to Medicare" physical examination with the first six months of Medicare coverage.

Radiology and laboratory procedures which are a standard part of a routine adult age/gender physical examination or well child periodic screening may be billed by the provider performing the procedure, and coverage will be determined based on current Mississippi Medicaid policies for the individual procedures.

Medication Checks: Regular and periodic monitoring by a psychiatrist or physician of the therapeutic effects of medications prescribed for mental health purposes.

Providers of medication checks must meet the standards as established under Sections 41-19-31 through 41-19-39 and/or Section 41-4-7(g), Mississippi code of 1972, as amended.

13.d. Rehabilitative Services: Rehabilitative services, except as otherwise provided under this Plan, includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level (42 CFR 440.130 (d)).

A. Assurances

1. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services:
   The Division of Medicaid covers all medically necessary services for EPSDT-eligible beneficiaries ages birth to twenty-one (21) in accordance with 1905 (a) of the Act, without regard to service limitations and with prior authorization.
2. Adequacy of Service Provisions:
   The CMHC providers are responsible for ensuring that each individual's mental health needs are met throughout the course of treatment. If all mental health services reimbursable by Medicaid during the state fiscal year are exhausted, CMHC providers will continue servicing adults on a sliding scale fee based on income.
2. Freedom of Choice:
   Participants have freedom of choice of qualified enrolled provider agencies and team members within that agency.

B. Agency Requirements

1. All rehabilitative services are provided by quasi-governmental or private Community Mental Health Center (CMHC) agencies certified according to Mississippi state law and by the Mississippi Department of Mental Health (DMH). Quasi-governmental CMHCs are defined as entities operated under the supervision of regional commissions appointed by county boards of supervisors comprising their respective catchment areas.
   a. DMH issues a three (3) year certification for the agency and the services provided unless stated otherwise at the time of certification.
   b. DMH certification is based on the following:
      1) Adherence to DMH standards, DMH grant requirement guidelines, contracts, memoranda of understanding, and memoranda of agreement;
      2) Compliance with DMH fiscal management standards and practices outlined in the DMH Operational Standards based on a risk-based audit system;
      3) Evidence of fiscal compliance with external funding sources;

4) Compliance with ethical practices and codes of conduct of professional licensing entities related to provision of services and management of the organization; and
5) Evidence of solid business and management practices.

C. Team Member Qualifications

1. Psychiatrists must be a graduate of a medical or osteopathic school, be board-certified in psychiatry and be licensed by the Mississippi State Board of Medical Licensure.
2. Physicians must be a graduate of a medical or osteopathic school and have a minimum of five (5) years' experience in mental health and be licensed by the Mississippi State Board of Medical Licensure.
3. Psychologists must hold a Ph.D. degree in psychology and be licensed by the Mississippi Board of Psychology.
4. Licensed Certified Social Workers (LCSW) must hold a Master's degree in social work and be licensed by the Mississippi State Board of Examiners for Social Workers and Marriage and Family Therapists at the LCSW level.
5. Licensed Master Social Workers (LMSW) must hold a Master's degree in social work, be licensed by the Mississippi State Board of Examiners for Social Workers and Marriage and Family Therapists at the LMSW level, and supervised by a LCSW, psychiatrist, physician or a psychologist.
6. Licensed Professional Counselors (LPC) must hold a Master's degree in counseling and be licensed by the Mississippi State Board of Examiners for Licensed Professional Counselors.
7. Licensed Marriage and Family Therapists (LMFT) must hold a Master's degree in marriage and family therapy and be licensed by the Mississippi State Board of Examiners for Social Workers and Marriage and Family Therapists.
8. Professional Art Therapists (ATR-BC) must hold a Master's degree in art therapy and be licensed by the Mississippi Department of Health.
9. Psychiatric Mental Health Nurse Practitioners (PMHNP) must hold a Master's degree in nursing with a specialty in psychiatry, be licensed by the Mississippi Board of Nursing, and must practice within a collaborative/consultative relationship with a physician within an established protocol or practice guidelines.
10. Physician Assistants (PA) must hold a Master's degree in a health related or science field, be licensed by the Mississippi Board of Medical Licensure, must be under the supervision of a psychiatrist or a physician and in order to provide medication management must have two (2) years of psychiatric training.
11. Registered Nurses (RN) must be a graduate from an approved or accredited RN nursing program, be licensed by the Mississippi Board of Nursing, and must be under the supervision of a psychiatrist, physician, PMHNP, or PA.
12. Licensed Practical Nurses (LPN) must be a graduate from an approved or accredited LPN nursing program, be licensed by the Mississippi Board of Nursing and supervised by a psychiatrist, physician, PMHNP, PA or RN.
13. DMH certifies the following team members:
    a. Certified Mental Health Therapists (CMHT), Certified Intellectual and Developmental Disabilities Therapists (CIDDT) and Certified Addiction Therapists (CAT) must hold a Master's degree in mental health, human services, intellectual disabilities, addictions, or behavioral health related fields from an approved educational institution. The Master's degree must be comprised of at

least thirty (30) semester hours or its equivalent. There are two (2) levels of certification:

1) Provisionally certified therapists are temporarily certified while fulfilling all the certification requirements, provide the same services as a CMHT, CIDDT and CAT and must be under the supervision of certified therapist of the same discipline. Provisional certification is valid for up to two years (24 consecutive months) from the date of issuance.
2) The certified credential is full certification and renewable every four (4) years as long as renewal requirements are met.

b. Community Support Specialists must hold a minimum of a Bachelor's degree in a mental health field, be certified by DMH as a Community Support Specialist and must be under the supervision of a psychiatrist, physician, PMHNP, PA, LCSW, LMSW, LPC, LMFT, CMHT, CIDDT, or a CAT.
c. Psychosocial Rehabilitation Program Director must hold a minimum of a Bachelor's degree in a mental health field, be certified by DMH as a Psychosocial Rehabilitation Program Director and must be under the supervision of a psychiatrist, physician, PMHNP, PA, LCSW, LMSW, LPC, LMFT, CMHT, CIDDT, or a CAT.
d. Peer Support Specialists must hold a minimum of a high school diploma or GED equivalent, demonstrate a minimum of six (6) months in self-directed recovery from mental illness or substance abuse within the last year, complete an initial and ongoing peer support training, such as Family-to-Family or Family Time Out, be certified by DMH as a Certified Peer Support Specialist and must be under the supervision of a psychiatrist, physician, PMHNP, PA, LCSW, LPC, LMFT, CMHT, CIDDT, CAT or a Peer Support Specialist Supervisor who has been trained as a Peer Support Specialist with an emphasis on supervision.
e. Certified Wraparound Facilitators must hold a minimum of a high school diploma or GED equivalent, complete the "Introduction to Wraparound" 3-day training, be certified by DMH, and must be under the supervision of a psychiatrist, physician, PMHNP, PA, LCSW, LPC, LMFT, CMHT, CIDDT, or a CAT who has completed the "Introduction to Wraparound" 3-day training and hold a DMHs High Fidelity Wraparound certificate.

D. Rehabilitative Services medically necessary for the treatment of the individual's illness, condition, or injury are provided to all eligible individuals as follows.

1. Treatment Plan Development and Review

a. Treatment plan development and review is defined as the process through which a group of clinical team members meet to discuss the individual's treatment plan with the individual and his/her family members. The review utilizes a strengths-based approach and addresses strengths and natural resources, presenting symptoms/problems, diagnostic impressions, and initiate/update a treatment plan that includes goals, objectives and treatment strategies.
b. The clinical purpose of treatment plan development and review is to meet the needs of the individual by addressing the behaviors and making recommendations for treatment.
c. This process may also be called an individual's service plan, plan of care or wraparound plan.
d. The composition of the team members must include one of the following: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, or PA, and may include any other team member listed in C. above.
e. The treatment plan must be approved by one of the following: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, or PA.
f. Treatment plan development and review is limited to four (4) services per state fiscal year.

2. Medication Management

a. Medication management includes the evaluation, administration and monitoring of psychotropic medications.
b. Medication evaluation is performed by psychiatrists, physicians, PMHNP or PA. The clinical purpose is to assess an individual's mental health needs and to evaluate if psychopharmacological treatment of a mental disorder is necessary.
c. Only psychiatrists, physicians, PMHNP and PA can prescribe psychotropic medications.
d. Medication administration is defined as the administering of a prescribed medication. Only a psychiatrist, physician, PMHNP, PA, RN or LPN can administer medications.
e. Medication monitoring is defined as regular and periodic monitoring of the therapeutic and side effects of psychotropic medications prescribed for the treatment of a mental disorder.
f. Monitoring is performed by psychiatrists, physicians, PMHNP or PA.
g. The clinical purpose of medication monitoring is to ensure the individual receives the proper dosage and adjustment of medications resulting in the appropriate therapeutic effects of the medication.
h. Medication management is limited to seventy-two (72) services per state fiscal year.

3. Psychosocial Assessment

a. Psychosocial assessment is defined as the documentation of information from the individual and/or collaterals describing the individual's family background, educational/vocational achievements, presenting problem(s), history of problem(s), previous treatment, medical history, current medication(s), source of referral and other pertinent information to determine the nature of the individual's or family's problem(s), the factors contributing to the problem(s), and the most appropriate course of treatment.
b. The clinical purpose of a psychosocial assessment is to create a comprehensive picture of the individual in order to develop treatment goals.
c. One of the following team members is required to provide this service: psychiatrist, physician, psychologist, LCSW, LMSW, LPC, LMFT, PA, PMHNP, CMHT, CIDDT, and CAT.
d. Psychosocial assessments are limited to four (4) hours per state fiscal year.

4. Psychological Evaluation

a. Psychological evaluation is defined as an evaluation for the purpose of assessing the individual's cognitive, emotional, behavioral and social functioning using standardized tests, interviews and behavioral observations.
b. The clinical purpose of a psychological evaluation is to identify therapy needs, highlight issues presented in treatment, recommend forms of intervention, and offer guidance about potential outcomes of treatment.
c. Psychological evaluations must be completed by a psychologist.
d. Psychological evaluations are limited to four (4) hours per state fiscal year.

5. Nursing Assessment

a. Nursing assessment is defined as an assessment of an individual's psychological, physiological and sociological history.
b. The clinical purpose of the nursing assessment is to assess and evaluate the medical history, medication history, current symptoms, effectiveness of the current medication regime, extra-pyramidal symptoms, progress or lack of progress since the last contact, and provide education about mental illness and available treatment to the individual and family.
c. A nursing assessment is completed by an RN.
d. Nursing assessment is limited to one hundred forty-four (144) fifteen (15) minute units per state fiscal year.

6. Individual Therapy

a. Individual therapy is defined as one-on-one therapy for the purpose of treating a mental disorder.
b. The clinical purpose of individual therapy is to assess, prevent, and relieve psychologically-based distress or dysfunction and to increase the individual's sense of well-being and personal development.

c. Individual therapy services must be included in a treatment plan approved by one of the following team members: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, or PA. Team members who may provide individual therapy include a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, ATR-BC, PMHNP, PA, LMSW, CMHT, CIDDT, or CAT.
d. Individual therapy is limited to thirty six (36) services per state fiscal year.

7. Family Therapy

a. Family therapy is defined as therapy for the family which is exclusively directed at the individual's needs and treatment. The individual is not required to be present during family therapy.
b. The clinical purpose of family therapy is to identify and treat family problems that cause dysfunction.
e. Family therapy services must be included in a treatment plan approved by one of the following team members: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, or PA. Team members who may provide family therapy include a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, ATR-BC, PMHNP, PA, LMSW, CMHT, CIDDT, or CAT.
c. Family therapy is limited to twenty-four (24) services per state fiscal year.

8. Group Therapy/Multi-Family Group Therapy

a. Group therapy is defined as face-to-face therapy addressing the needs of several individuals within a group.
b. The clinical purpose of group therapy is to prevent deterioration, to encourage remediation and to provide rehabilitation.
c. Multi-family group therapy is defined as therapy taking place between a mental health team member and family members of at least two different individuals in a group setting. It combines the power of a group process with the systems focus of family therapy. The individuals are not required to be present.
d. The clinical purpose of multi-family group therapy is to give individuals and/or the family a safe and comfortable place to work out problems and emotional disorders, gain insight into their own thoughts and behavior, and offer suggestions and support to others.
f. Group therapy/multi-family group therapy services must be included in a treatment plan approved by one of the following team members: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, or PA. Team members who may provide group therapy/multi-family group therapy include a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, ATR-BC, PMHNP, PA, LMSW, CMHT, CIDDT, or CAT.
e. Group therapy/multi-family group therapy is limited to forty (40) services per state fiscal year.

9. Psychosocial Rehabilitation

a. Psychosocial rehabilitation is defined as a rehabilitative service based on active treatment and is the most intensive day program available for individuals eighteen (18) and older, designed to support individuals requiring extensive clinical services to support community inclusion, prevent re-hospitalization, and alleviate psychiatric decompensation, confusion, anxiety, feelings of low self-worth, isolation and withdrawal.

b. The clinical purpose of psychosocial rehabilitation is to assist individuals attain their highest level of functioning in their community.

c. Psychosocial rehabilitation services are provided in a program that provides active treatment through evidence-based curriculum, such as Illness Management and Recovery, and the components include:
   1) Treatment plan development and review.
   2) Individual therapy.
   3) Group therapy.
   4) Skill building groups such as social skills training, coping skills, reality orientation, social adaptation, physical coordination, daily living skills, time and resource management, task completion.

g. Psychosocial rehabilitation services must be included in a treatment plan approved by one of the following team members: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, or PA. The Psychosocial Rehabilitation Program Director provides administrative services for individuals receiving psychosocial rehabilitation. Team members who may provide psychosocial rehabilitation include a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, PA, LMSW, CMHT, CIDDT, or CAT.

d. Psychosocial rehabilitation services must be prior authorized as medically necessary by the Division of Medicaid's Utilization Management and Quality Improvement Organization (UM/QIO).

e. Psychosocial rehabilitation is limited to five (5) hours per day, five (5) days a week.

f. Similar services are available to individuals from birth to age twenty one (21) through Day Treatment services.

10. Day Treatment

a. Day treatment is the most intensive outpatient program available all individuals under the age of twenty-one (21) and is defined as a behavioral intervention program, provided in the context of a therapeutic milieu, which enables them to live in the community.

b. The clinical purpose of day treatment is to improve emotional, behavior, social and educational development of all individuals under the age of twenty-one (21) who need significant coping skills to appropriately function in the home, school, and community.

c. The service components for day treatment include:
   1) Treatment plan development and review.
   2) Individual therapy.
   3) Group therapy.
   4) Skill building groups such as social skills training, self-esteem building, anger control, conflict resolution and daily living skills.

d. Day treatment services must be included in a treatment plan approved by one of the following team members: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, or PA. Team member who may provide day treatment include a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, PA, LMSW or CMHT.

e. Services must be prior authorized as medically necessary by the UM/QIO.

f. Day treatment is limited to five (5) hours per day, five (5) days a week.

11. Acute Partial Hospitalization Services

a. Acute Partial Hospitalization Services are available only in a community based setting and not through the outpatient department of a hospital and defined as a non-residential treatment program for individuals who are experiencing a period of such acute distress that their ability to cope with normal life circumstances is severely impaired. These individuals require more intensive and comprehensive services offered in an outpatient treatment program but require less than twenty-four (24) hour care provided on inpatient basis.

b. The clinical purpose of acute partial hospitalization is to provide an alternative to hospitalization for individuals not requiring twenty-four (24) hour supervision but still requiring a high degree of therapeutic support in order to return to normal daily activities in the home, school, work, and community.

c. The service components for acute partial hospitalization include:
   1) Treatment plan development and review.
   2) Medication management.
   3) Nursing assessment.
   4) Individual therapy.
   5) Group therapy.
   6) Skill building groups such as social skills training, self-esteem building, anger control, conflict resolution and daily living skills.

d. Acute partial hospitalization must be prior authorized as medically necessary by the UM/QIO.

e. Acute partial hospitalization must be included in a treatment plan approved by one of the following team members: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, or PA. Team member who may provide acute partial hospitalization include a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, PA LMSW, CMHT, CIDDT, or CAT.

f. Acute Partial Hospitalization is limited to one hundred (100) days per state fiscal year.

12. Crisis Response Services

a. Crisis Response is defined as supports, services and treatments necessary to provide integrated crisis response, crisis stabilization, and prevention interventions available twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days a year. These services provide immediate evaluation, triage and access to services, treatment, and support in an effort to reduce symptoms and harm and, if appropriate, safely transition individuals in an acute crisis to the appropriate level of care for stabilization.

b. The clinical purpose of crisis response services is to assist the individual cope with immediate stressors, identify and use available resources and the individual's strengths, and develop treatment options in order to avoid unnecessary hospitalization and return to the individual's prior level of functioning.

c. The service components for crisis response services include:
   1) Treatment plan development and review.
   2) Medication management.
   3) Nursing assessment.
   4) Individual therapy.
   5) Family therapy.

d. Team members must be certified in a professionally recognized method of crisis intervention and de-escalation and must include one of the following: a psychiatrist, physician, psychologist, LCSW, LMSW, LPC, LMFT, PMHNP, PA, RN, CMHT, CIDDT, and CAT.

e. Crisis Response Services must be available by phone with a mobile crisis response team twenty-four (24) hours a day, seven (7) days a week.

h. Crisis response services must be included in a treatment plan approved by one of the following team members: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, or PA. Team members who may provide crisis response services include a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, PA, LMSW, CMHT, CIDDT, CAT, or Community Support Specialist.

f. Crisis Response service is limited to thirty-two (32) fifteen (15) minute units per day with a state fiscal year limit of two hundred twenty-four (224) fifteen (15) minute units.

13. Crisis Residential Services

a. Crisis residential services are defined as services provided in a setting other than an acute care hospital or a long term residential treatment facility which consists of no more than sixteen (16) beds. The program provides medically monitored residential services for the purpose of providing psychiatric stabilization on a short-term basis serving as a transition or diversion from inpatient hospitalization.
b. The clinical purpose of crisis residential services is to provide treatment to an individual not requiring twenty-four (24) hour medical and nursing care, but may benefit from a twenty-four (24) hour supervised, structured living arrangement in order to return them to their pre-crisis level of functioning.
c. The service components for crisis response services include:
    1. Treatment plan development and review.
    2. Medication management.
    3. Nursing assessment.
    4. Individual therapy,
    5. Family therapy.
    6. Group therapy.
    7. Crisis response.
    8. Skill building groups such as social skills training, self-esteem building, anger control, conflict resolution and daily living skills.
d. The services must be ordered by a psychiatrist, physician, psychologist, PMHNP or PA.
e. The composition the team members must include one of the following: a psychiatrist, physician, psychologist, LCSW, LMSW, LPC, LMFT, PMHNP, PA, RN, CMHT, CIDDT, and CAT.
f. Services must be prior authorized as medically necessary by the UM/QIO.
g. Crisis Residential service is limited to sixty (60) days per state fiscal year.
h. Service does not include room and board (payment).

14. Peer Support Services

a. Peer support is defined as an evidenced-based person centered mental health model of care which allows individuals the opportunity to direct their own recovery of any mental illness or substance abuse.
b. The clinical purpose of peer support services is to provide peer-to-peer support assisting an individual with recovery from mental illness or substance abuse.
c. The service components of peer support services include:
   1) Treatment plan development and review.
   2) Skill building for coping with and managing symptoms while utilizing natural resources, and the preservation and enhancement of community living skills.
d. Services are provided by a Peer Support Specialist.
e. Peer support services must be included in a treatment plan approved by one of the following team members: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP or PA.
f. Peer support is limited to six (6) fifteen (15) minute units per day with a state fiscal year limit of two hundred (200) fifteen (15) minute units.

15. Community Support Services

a. Community support services are defined as services provided by a mobile community-based Community Support Specialist which addresses the mental health needs of the individual, are focused on the individual's ability to succeed in the community and to identify and assist with accessing services.

b. The clinical purpose of community support services is to assist the individual in achieving and maintaining rehabilitation, resiliency, and recovery goals.

c. The service components for community support services include:
   1) Resource Coordination that directly increase the acquisition of skills needed to accomplish the goals set forth in the treatment plan.
   2) Monitoring and evaluating the effectiveness of interventions, as evidenced by symptom reduction and progress toward goals.
   3) Psychoeducation on the identification and self-management of prescribed medication regimen and communication with the prescribing provider.
   4) Direct interventions in escalating situations to prevent crisis.
   5) Home and community visits for the purpose of monitoring the individual's condition and orientation.
   6) Assisting the individual and natural supports in implementation of therapeutic interventions outlined in the treatment plan.
   7) Psychoeducation and training of family, unpaid caregivers, and/or others who have a legitimate role in addressing the needs of the individual.

d. Services are provided by a Community Support Specialist.

e. Community support services must be included in a treatment plan approved by one of the following team members: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP or PA.

f. Services are limited to six (6) fifteen minute units per day with a state fiscal year limit of four hundred (400) fifteen (15) minute units per year.

16. Wraparound Facilitation

a. Wraparound facilitation is defined as the development and implementation of a treatment plan which addresses the prioritized needs of an individual up to the age of twenty-one (21). The treatment plan empowers the individual to achieve the highest level of functioning through the involvement of family, natural and community supports.

b. The clinical purpose of wraparound facilitation is to assist an individual to function at the highest level at home, school, and the community through an intensive, individualized treatment plan.

c. The service components for wraparound facilitation include:
   1) Treatment plan development and review.
   2) Identifying providers of services and other community resources to meet family and the individual's needs.
   3) Making necessary referrals for the individual.

d. Services are provided by a Certified Wraparound Facilitator.

e. Wraparound services must be included in a treatment plan approved by one of the following team members: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP or PA. Team members who may provide wraparound services include: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP or PA.

f. Services are limited to sixteen (16) fifteen (15) minute units per day with a fiscal year limit of two hundred (200) fifteen (15) minute units.

g. Similar services are provided to individuals over the age of twenty-one (21) through Program of Assertive Community Treatment (PACT).

17. Intensive Outpatient Psychiatric Services

a. Intensive outpatient psychiatric services are defined as treatment provided in the home or community to individuals up to the age of twenty-one (21) with serious mental illness for family stabilization to empower the individual to achieve the highest level of functioning. Based on a wraparound model, this service is a time-limited intensive family intervention to diffuse the current crisis, evaluate its cause, and intervene to reduce the likelihood of a recurrence.

b. The clinical purpose of intensive outpatient psychiatric services is to stabilize the living arrangement, promote reunification and prevent the utilization of out-of-home therapeutic resources to allow the individual to remain at home and in the community.

c. The components of intensive outpatient psychiatric services, based on an all-inclusive model that covers all mental health services the individual may need, may include:
   1) Treatment plan development and review.
   2) Medication management.
   3) Intensive individual therapy and family therapy provided in the home.
   4) Group therapy.
   5) Day Treatment.
   6) Peer support services.
   7) Skill building groups such as social skills training, self-esteem building, anger control, conflict resolution and daily living skills.
   8) Wraparound facilitation.

d. Intensive outpatient must be included in a treatment plan and approved by one of the following team members: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, or PA. Team members who may provide day treatment include: a LMSW, CMHT, CIDDT, or CAT.

e. Services must be prior authorized as medically necessary by the UM/QIO.

f. Intensive outpatient psychiatric services are limited to two hundred seventy (270) days per fiscal year.

18. PACT

a. Program of Assertive Community Treatment (PACT) is defined as an individual-centered, recovery-oriented mental health service delivery model for facilitating community living, psychosocial rehabilitation and recovery for individual over the age of twenty-one (21) with severe and persistent mental illness, severe symptoms and impairments who have not benefited from traditional outpatient programs. PACT is a multi–disciplinary, self-contained clinical team approach with team members providing long-term intensive care in community settings. The team members provide all mental health services rather than referring individuals to different mental health providers, programs, and other agencies.

b. The clinical purpose of PACT is to provide community-based interdisciplinary care to improve the individual's overall functioning at home, work, and in the community.

c. The components of PACT services, based on an all-inclusive evidence-based model that may include, but are not limited to, one or more of the following:
   1) Treatment plan review and development.
   2) Medication management.
   3) Individual therapy.
   4) Family therapy.
   5) Group therapy.
   6) Crisis response.
   7) Crisis response.
   8) Community support.
   9) Peer Support.

d. The composition of the ACT team members must include a psychiatrist, physician or PMHNP, and an RN, CAT and peer support specialist and must include one or more of the following: psychologist, LCSW, LMSW, LPC, or LMFT. The ACT team leader must be a psychiatrist, physician, psychologist, LCSW, or PMHNP and is the clinical and administrative leader of the team. The team leader, in conjunction with the psychiatrist, is responsible for supervising and directing all team members.

e. PACT services must be included in a treatment plan, approved by the team leader, and provided by one of the following team members: a psychiatrist, physician, psychologist, LCSW, LMSW, LPC, LMFT, PMHNP, PA, CMHT, CIDDT, or CAT.

f. Services must be prior authorized as medically necessary by the UM/QIO.

g. Similar services provided to individuals up to age twenty-one (21) through intensive outpatient psychiatric services.

h. PACT is limited to forty (40) fifteen (15) minute units per day with a state fiscal year limit of sixteen hundred (1600) fifteen (15) minute units.

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

15. Intermediate Care Facilities for Individuals with Intellectual Disabilities

The Division of Medicaid covers Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) that meet the requirements of the State and 42 CFR Part 483.

According to Section 1905(d) of the Social Security Act, ICF/IIDs are defined as institutions, or distinct part thereof, for individuals with intellectual disabilities or persons with related conditions in which the facilities primary purpose is to provide health or rehabilitative services and provide active treatment as defined in 42 CFR Part 483 in the least restrictive setting. Services must be provided in a protected residential setting and must include ongoing evaluations, twenty-four (24) hour supervision, and coordination and integration of health or rehabilitative services to help each individual function at his/her greatest ability.

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

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16. Inpatient Psychiatric Services:

Inpatient psychiatric services for individuals under age 21 provided under the direction of a physician who is at least board eligible in psychiatry and has experience in child/adolescent psychiatry provided in either a licensed psychiatric hospital that meets the requirements of 42 CFR 482.60 and 1861(f) of the Social Security Act or a psychiatric unit of a general hospital that meets the requirements of subparts B and C of 42 CFR 482 and Subpart D of 42 CFR 441 or a licensed psychiatric residential treatment facility (PRTF) that meets the requirements Section 1905(h) of the Act. Licensed psychiatric hospitals must have Joint Commission on Accreditation of Health Care Organization (JCAHO) accreditation. Psychiatric Residential Treatment Facilities must be accredited by the Joint Commission on Accreditation of Health Care Organization (JCAHO) or Council on Accreditation of Services for Families and Children (COA). The psychiatric service must be provided in accordance with an individual comprehensive services plan as required by 42 CFR 441.155(b) before the individual reaches age 21 or, if the individual was receiving the services immediately before obtaining age 21, before the earlier of the date the individual no longer requires the services or the date the individual reaches age 22. The setting in which the psychiatric services are provided shall be certified in writing to be necessary as required by 42 CFR 441.152. The psychiatric services must be prior approved as medically necessary.

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

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17. Nurse-midwife services - refers to services furnished by a nurse midwife within the scope of practice authorized by state law or regulation.

Certified nurse midwives may bill Medicaid for the covered services within the scope of practice allowed by their protocol. All services and procedures provided by certified nurse midwives should be billed in the same manner and following the same policy and guidelines as like physician services.

The reimbursement for certified nurse midwifery services shall not exceed ninety percent (90%) of the reimbursement rate for comparable services rendered by a physician.

State of Mississippi

Descriptions of Limitations as to Amount, Duration and Scope of Medical Care and Services Provided

18. Hospice Benefit

I. The hospice benefit is provided in accordance with Title 18, Section 1861 (dd) of the Social Security Act for the palliation or management of an individual's terminal illness. An individual is considered terminally ill if the medical prognosis is life expectancy of six (6) months or less. Election of the hospice option causes the beneficiary to forfeit all other Medicaid program benefits provided for in the State Plan that may also be available under the hospice benefit related to the treatment of the individual's terminal illness, except for children under the age of 21.

II. Hospice care provides the following items and services to a terminally ill individual by, or by others under arrangements made by, a hospice program under an individualized written plan of care established and periodically reviewed by the individual's attending physician, the medical director, and the hospice program interdisciplinary team:

a. nursing care provided by a registered nurse,
b. physical or occupational therapy, or speech-language pathology services,
c. medical social services under the direction of a physician,
d. services of a
    i. hospice aide who has successfully completed an approved training program, and
    ii. homemaker services,
e. medical supplies (including drugs and biologicals) and the use of medical appliances, while under such a plan,
f. physicians' services,
g. short-term inpatient care (including both respite care and procedures necessary for pain control and acute symptom management) in an inpatient facility meeting the special hospice standards regarding staffing and patient areas, but such respite care may be provided only on an intermittent, nonroutine, and occasional basis and may not be provided consecutively over longer than five days,
h. counseling (including dietary counseling) with respect to care of the terminally ill individual and adjustment to his death, and
i. any other item or service which is specified in the plan and for which payment may otherwise be made under this title.

The care and services described in subparagraphs a. and d. as noted above may be provided on a 24-hour, continuous basis only during periods of crisis and only as necessary to maintain the terminally ill individual at home.

III. The following providers and practitioners who furnish hospice services must meet all requirements in accordance with the rules and regulations as defined in the Minimum Standards of Operations for Hospice per the Mississippi State Department of Health including Miss.

Descriptions of Limitations as to Amount, Duration and Scope of Medical Care and Services Provided

Code §41-85-1 through §41-85-25 (1972, as amended):

a. Medical Director – must be a Doctor of Medicine or Osteopathy licensed to practice in the State of Mississippi. May be an employee or a volunteer of the hospice agency or contractual agreement.
b. Registered Nurse – must be licensed to practice in the State of Mississippi with no restrictions, at least one (1) year full-time experience and is an employee of the hospice or contracted by the hospice.
c. Bereavement Counselor – Must have documented evidence of appropriate training and experience in the care of the bereaved received under the supervision of a qualified professional.
d. Dietary Counselor - Must be a registered dietician licensed in the State of Mississippi who meets the qualification standards of the Commission on Dietetic Registration of the American Dietetic Association;
e. Spiritual Counselor – Must have documented evidence of appropriate training and skills to provide spiritual counseling, such as Bachelor of Divinity, Master of Divinity or equivalent theological degree or training.
f. Social Worker – Must have a minimum of a Bachelor's Degree from a school of social work accredited by the council of Social Work Education and licensed in the State of Mississippi with a minimum of one (1) year documented clinical experience appropriate to the counseling and casework needs of the terminally ill and be an employee of the hospice.
g. Hospice Aide/Homemaker – Must be a qualified person who provides direct patient care and/or housekeeping duties in the home or homelike setting under the direct supervision of a registered nurse. Documentation of all training and competence is required.
h. Occupational Therapist - Must be licensed by the State of Mississippi
i. Physical Therapist - Must be licensed in the State of Mississippi.
j. Speech Pathologist - Must be licensed by the State of Mississippi, or completed the academic requirements as directed by the State Certifying Body and work experience required for certification.

IV. Medicaid beneficiaries under the age of 21 may receive hospice benefits including curative treatment without foregoing any other service to which the child is entitled under the Medicaid program pursuant to section 2302 of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act.

V. Hospice election periods are: (1) An initial 90-day period; (2) A subsequent 90-day period; or (3) an unlimited number of subsequent 60-day periods are available provided a physician certifies that the recipient is terminally ill or that the condition of the beneficiary has not changed since the previous certification of terminal illness.

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

19a Targeted case management services to chronically mentally ill community based recipients.

All Medicaid services are provided to the chronically mentally ill within the limits and policy of the Medicaid Program, as set forth in the State Plan.

Case management services may be provided as a component part of the service by any qualified Medicaid provider.

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

19b Targeted Case Management services for beneficiaries with intellectual/ developmental disabilities (IDD) in community-based settings.

All Medicaid services are provided to IDD beneficiaries within the limits and policies of the Medicaid Program, as set forth in the State Plan. [Refer to Supplement 1C to Attachment 3.1-A]

Targeted Case Management services are only provided by a service provider certified by the Mississippi Department of Mental Health (DMH) as meeting the Operational Standards for Targeted Case Management for beneficiaries with IDD. [Refer to Supplement 1C to Attachment 3.1-A]

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICE PROVIDED

20a. & 20b. Extended services to pregnant women. Pregnancy-related and postpartum services for 60 days after the pregnancy ends.

All Medicaid services are provided to pregnant women within the limits and policy of the Medicaid Program, as set forth in the State Plan.

Extended services may be provided as component parts of the services of any qualified Medicaid provider.

Extended Services (Nutrition,
Psychosocial, Health
Education, Home Visits)

*Description of services provided on following pages.

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICE PROVIDED

EXTENDED SERVICES

1. **Medical Risk Assessment**

A medical risk assessment (screening) is done by a physician, a registered nurse/nurse practitioner under a physician's direction, or a certified nurse-midwife to determine if the patient is high risk. A pregnant woman is considered high risk if one or more risk factors are indicated on the form used for risk screening. The enhanced services are made available in cases of medical necessity when a medical risk assessment has determined that a pregnant woman has one or more factors which may adversely affect the pregnancy outcome.

A pregnant woman may be assessed (screened) for medical risk a maximum of two (2) times per pregnancy. A second medical risk assessment (screening) would be necessary only if the woman changed the provider responsible for her obstetrical care, and the new provider was unable to obtain the prior records.

Reimbursement for the medical risk assessment (screening) is to an approved physician or certified nurse-midwife provider. This is a separate fee, just as lab services are reimbursed apart from an office visit.

Providers of medical risk assessment (screening) have the option of using the Hollister Maternal Record or the Risk Screening Form, Mississippi Perinatal Risk Management/Infant Service System. Attached is a copy of high-risk referral criteria that includes the guidelines for use of the Hollister Maternal Record and the Risk Screening Form. Referral may be made to a Case Management Agency by submitting a copy of the Risk Screening Form, or by making a telephone call. When a telephone call is made, the Case Management Agency will document the referral on the Risk Screening Form.

2. **Nutritional Assessment/Counseling**

A. **Definition:**

Assessment is a review of the pregnant woman's dietary pattern and intake, her resources for obtaining and preparing food and evaluation of her nutritional needs.

B. **Counseling means services to include:**

(1) The development of a nutritional care plan based on the health risks identified due to nutritional factors.

(2) The follow-up and reassessment needed to carry out the nutritional care plan.

(3) The Division of Medicaid will utilize guidelines as promulgated in Maternal and Infant Health Guidelines, prepared by the Association of Maternal and Child Health Programs in association with the State Medicaid Directors' Association, as criteria for monitoring this service.

Nutritional assessment/counseling is covered for pregnant women with one or more medical risk factors which may adversely affect the pregnancy outcome. Counseling is appropriate for women whose complications require the services of a dietician/nutritionist for treatment of a pregnancy-related complication, e.g., diabetes, over/under weight. The services are provided by a registered dietician or licensed nutritionist. A combination of this service and/or psychosocial assessment/counseling may be provided a maximum of eight (8) times during the pregnancy and postpartum. The nutritional assessment is done by the registered dietician or licensed nutritionist, and is considered as one unit of nutritional assessment/counseling. If the pregnant woman is eligible for WIC, the nutritional assessment for this program will build upon the WIC assessment in order to prevent two programs from doing duplicate assessments. A second nutritional assessment will be allowed during the pregnancy, if the woman changes her provider, and the new provider is unable to obtain records for the previous provider.

3. Psychosocial Assessment/Counseling

A. Definition:

Assessment is an evaluation of the pregnant woman and her environment to identify psychosocial factors that may adversely affect the woman's health status.

B. Counseling means services to include:

(1) The development of a social work care plan based upon the health risks due to psychosocial factors.

(2) The follow-up, appropriate intervention, and referrals to carry-out the social work care plan.

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICE PROVIDED

(3) The Division of Medicaid will utilize guidelines as promulgated in Maternal and Infant Health Guidelines, prepared by the Association of Maternal and Child Health Programs in association with the State Medicaid Directors' Association, as criteria for monitoring this program.

Psychosocial assessment/counseling is covered for pregnant women with one or more medical risk factors which may adversely affect the pregnancy outcome. Counseling is appropriate for women whose complications require psychosocial intervention as an essential element of treatment in dealing with the complications, e.g., pregnant 15 year old with no place to live, battered woman. The services are provided by the MSW social worker licensed in Mississippi, a BSW social worker licensed in Mississippi in consultation with a MSW, or other Mississippi licensed social worker who is supervised by a MSW social worker. A combination of this service and/or nutritional assessment/counseling may be provided a maximum of eight (8) times during the pregnancy and postpartum period. The psychosocial assessment is done by a social worker, as specified above, and is considered as one unit of psychosocial assessment/counseling. A second psychosocial assessment will be allowed during the pregnancy, if the woman changes her provider, and the new provider is unable to obtain records from the previous provider.

4. Health Education

A. Health education is provided during pregnancy and the postpartum period on a one-to-one or group basis with the pregnant women who have one or more medical risk factors which may advsersely affect the pregnancy outcome. Health education is provided based on a written plan or written curriculum.

B. Education may include, but is not limited to, the following information:

(1) Prenatal care

(2) Danger signs in pregnancy

(3) Labor and delivery

(4) Nutrition

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Mississippi

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

(5) Pregnancy risk reduction (smoking, substance abuse)

(6) Postpartum care

(7) Reproductive health

Health education is designed to prevent the development of further complications during pregnancy and to provide educational information to the pregnant woman in caring for herself during pregnancy. This service may be provided by a registered nurse, nurse practitioner, physician assistant, certified nurse-midwife, nutritionist/dietitian, or social worker. This service may be provided a maximum of ten (10) times during the pregnancy and postpartum period.

5. Home Visit

A. This service is provided at the pregnant woman's place of residence as part of the assessment and follow-up. The purpose of the home visit is to provide extended services and to address environmental factors that impinge upon her high-risk factors.

B. The services may be provided by a nurse, nurse practitioner, physician assistant, nutritionist/dietician, or social worker.

Home visit service for pregnant women and the need for home visits must be documented in the Plan of Care. It is designed to provide necessary services to the woman in the home. This service may be provided a maximum of five (5) times with at least one during the postpartum period.

STATE Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

23. Certified Pediatric or Family Nurse Practitioners' Services

Services provided by certified pediatric or family nurse practitioners are limited to those services authorized in the Plan and which a nurse practitioner is legally authorized to perform.

State Mississippi

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

23d. Skilled Nursing Facility Services for Patients under 21 years of Age:
Prior Approval required.

Beginning coverage limited to day authorization (MMC 260) form signed by admitting physician, unless eligibility occurs after admission for a retroactive period.

App. 12/2/83 Eff. 4/1/87

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

24a. Transportation - The State Agency will assure necessary transportation of recipients to and from providers of services through the following methods:

Ambulance Services:

Emergency Ground Ambulance – Medically necessary emergency ambulance service is defined as all of the following components:

- Emergency ambulance (ALS or BLS) transport to the closest hospital where the patient will be accepted and treatment is available for an accidental injury or medical emergency, and
- The use of other means of transportation is medically contraindicated because it would endanger or be detrimental to the patient's health, and
- The injury or medical emergency is sudden, of such severity that the absence of immediate medical care could reasonably result in permanently placing the patient's health in jeopardy, and/or serious impairment of bodily functions, and/or serious and permanent dysfunction of any body organ or part, or other serious medical consequence.

Emergency Air Ambulance (Helicopter)- Medically necessary emergency air ambulance service is defined as all of the following components:

- Emergency ambulance (ALS or BLS) transport to the closest hospital where the patient will be accepted and treatment is available for an accidental injury or medical emergency, and
- The use of other means of transportation is medically contraindicated because it would endanger or be detrimental to the patient's health, and
- The injury or medical emergency is sudden, of such severity that the absence of immediate medical care could reasonably result in permanently placing the patient's health in jeopardy, and/or serious impairment of bodily functions, and/or serious and permanent dysfunction of any body organ or part, or other serious medical consequences.

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

Urgent Air Ambulance (Fixed Wing) – Medically necessary urgent air ambulance service is defined as:

- Urgent ambulance transport to the appropriate facility that will accept the patient and is capable of providing the required level and type of care for the patient's condition, and
- The use of other means of transportation is medically contraindicated because it would endanger or be detrimental to the patient's health, and
- The patient's condition is of such severity that the absence of transfer to an appropriate facility for treatment could reasonably result in permanently placing the patient's health in jeopardy, and/or serious impairment of bodily functions, and/or serious and permanent dysfunction of any body organ or part, or other serious medical consequence.

Non-Emergency Ground Ambulance - Medically necessary non-emergency ambulance service is defined as all of the following components:

- Ambulance transport to or from the closest appropriate facility for the beneficiary to receive non-emergency medical care that cannot be provided in their place of residence or medical facility where the patient is an inpatient, and
- The use of other means of transportation is medically contraindicated because it would endanger or be detrimental to the patient's health, and
- The patient suffers from an injury or debilitated physical condition that results in the patient being totally bedridden or bed confined.

Non-emergency Transportation - Necessary non-emergency transportation (NET) for eligible Medicaid recipients is arranged and coordinated through the Division of Medicaid. Services are furnished through contracts between the Division of Medicaid and qualified providers. NET providers can be public or private entities or individual providers, volunteers. NET services are available to beneficiaries who have no other means of accessing Medicaid funded medical services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 3.1-A
Exhibit 24c

State Mississippi

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

Care and services provided in Christian Science sanitoria - Confinement limited to ten (10) days per fiscal year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 3.1-A

Exhibit ~~23d~~ 24d

State Mississippi

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

24d
~~23d~~. Skilled Nursing Facility Services for Patients under 21 years of Age:
Prior Approval required.

Beginning coverage limited to day authorization (MMC 260) form signed by admitting physician, unless eligibility occurs after admission for a retroactive period.

App. 12/2/87 eff. 4/1/87

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION, AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

25. Licensed Physician Assistants

Services provided by licensed physician assistants are limited to those services authorized in the Plan and which a physician assistant is legally authorized to perform.

State of Mississippi

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION, AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

Family Planning Services and Supplies for Individuals of Child-Bearing Age

Family planning services shall include counseling services, medical services, and pharmaceutical supplies and devices to aid those who decide to prevent or delay pregnancy. In-vitro fertilization, artificial insemination, sterilization reversals, sperm banking and related services, hysterectomies, and abortions shall not be considered family planning services.

State MISSISSIPPI

HIGH-RISK CASE MANAGEMENT SERVICES

A. **Target Group:** Pregnant women who have been shown on the basis of a medical risk assessment to need High-Risk Case Management Services.

B. **Areas of State in which services will be provided:**

X Entire State;

_____ Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than Statewide):

C. **Comparability of Services:**

_____ Services are provided in accordance with Section 1902(a)(10)(B) of the Act;

X Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is involved to provide services with regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. **Definition of Services:**

High-Risk Case Management is a set of interrelated activities under which responsibility for locating, coordinating, and monitoring appropriate services for an individual rests with a specific person within the High-Risk Case Management Agency. The purpose of High-Risk Case Management Services for pregnant women is to assist those eligible for Medicaid in gaining access to needed medical services and the enhanced services of nutritional and psychosocial assessment and counseling and health education to reduce low birthweight infants and infant mortality or morbidity; to encourage the use of cost-effective medical care by referrals to appropriate providers; and to discourage over-utilization or duplication of costly services. High-Risk Case Management Services will provide necessary coordination with providers of nonmedical services such as nutrition, psychosocial or health education programs, when services provided by these entities are needed. The Case Manager will coordinate these services with needed medical services.

The set of interrelated activities are as follows:

1. Medical risk assessment is done by the medical provider and is described in Exhibit 20a. and 20b., Attachment 3.1-A, Medical Risk Assessment.

2. Evaluation of the client's individual situation to determine the need for High-Risk Case Management when a physician has determined that the pregnant woman has one or more medical risk factors which may adversely affect the pregnancy outcome. The Case Manager must establish that the pregnant woman has Medicaid eligibility, is at medical risk, and has selected that particular High-Risk Case Management Agency. An explanation of High-Risk Case Management Services must be given to the woman.

   High-Risk Case Management Services include direct contact with the client as well as indirect work on the client's behalf. The client will be allowed one (1) initial High-Risk Case Management Service and nine (9) subsequent High-Risk Case Management Services per pregnancy. Once the woman is determined by her physician to no longer be at medical risk, High-Risk Case Management Services must be discontinued;

3. Needs assessment is the process by which the Case Manager identifies the service needs of the pregnant woman in order to assist in gaining access to the needed services, such as psychosocial, nutritional, medical, and educational;

4. Development and implementation of an individualized Plan of Care to meet the service needs of the client. A Plan of Care is needed by the Case Manager to:

   a. Determine how to assist in gaining access to needed services,

   b. Keep track of important activities over the course of time, and

   c. Know if the events that did occur met the goals as stated in the Plan of Care;

   This Plan of Care does not constitute a Medicaid prior authorization for Case Management Services.

5. Coordination of delivery of service when multiple providers and/or programs are involved to reduce travel and multiple appointments as much as possible by careful scheduling;

6. Assistance in locating providers and/or programs and making referrals to the providers and/or programs that can meet the service needs;

7. Monitoring and follow-up to ensure that services are received, are adequate to meet the client's needs, and are consistent with good quality of care.

E. Qualification of Providers:

1. Case Manager Qualifications:

   a. Physician licensed in Mississippi; or,

   b. Nurse-midwife certified in Mississippi; or,

   c. R.N. licensed in Mississippi with a minimum of one (1) year of experience in community nursing and knowledgeable about perinatal care; or,

   d. Medical Social Worker with a minimum of one (1) year of experience in health and/or human services and one of the following:

      (1) M.S.W. Medical Social Worker licensed in Mississippi;

      (2) B.S.W. Medical Social Worker licensed in Mississippi in consultation with a M.S.W.; or

      (3) Other Mississippi licensed Medical Social Worker supervised by a M.S.W.

      (4) Nutritionist licensed in Mississippi, or a Registered Dietician, each with a minimum of one (1) year's experience in providing nutrition services to pregnant women for whom nutritional needs are the high-risk factor.

2. High-Risk Case Management Qualifications:

   a. Must have qualified Case Manager(s);

   b. Must meet applicable State and Federal laws governing the participation of providers in the Medicaid Program;

   c. Must meet the criteria established by the Division of Medicaid as a provider of High-Risk Case Management Agency Services (Section 3, Enrollment Process) and be enrolled by the Division of Medicaid as a qualified High-Risk Case Management Agency provider.

Enrollment is open to all providers who can meet these qualifications. The Division of Medicaid will enter into Provider Agreements that establish criteria for High-Risk Case Management Services to this target group. The purpose of this activity is to help assure that High-Risk Case Management Services are provided by professionally qualified providers in accordance with Section 1902(a)(23) of the Act.

3. Enrollment Process

The Division of Medicaid will implement methods and procedures to enroll all agency providers for Case Management to pregnant women that can demonstrate:

a. Capacity to provide High-Risk Case Management Services;

b. Experience with delivery and/or coordination of services for pregnant women and children;

c. Maintenance of financial accountability rules as for any other provider participating in the Medicaid Program;

d. Capacity to provide full range of extended services, as specified in Exhibit 20a and 20b or demonstrate the ability to secure them, in a timely manner, through an agreement with another provider. However, nothing in this plan will be construed to require a Case Management Agency or a Case Manager to provide any other service under the Medicaid Program.

e. Agreement to maintain regular contact with the primary-care physician.

Enrollment is open to all providers who can meet these requirements.

F. The State assures that the provision of High-Risk 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 recipients will have free choice of the providers of High-Risk Case Management Services. Although the High-Risk Case Management Agency may have the capacity to provide the full range of extended services or demonstrate the ability to secure them, in a timely manner, through

an agreement with another provider, the eligible recipient may choose to receive any extended services through another High-Risk Case Management Agency.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. **Payment for High-Risk 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.

HIGH-RISK CASE MANAGEMENT FOR CHILDREN UNDER ONE YEAR

A. **Target Group:** High-risk infants, age birth to one (1) year old, as determined by a physician by using the Risk Screening Form, Mississippi Perinatal Risk Management/Infant Services System or the Hollister Maternal/Infant Record.

B. **Areas of State in which services will be provided:**

X Entire State;

____ Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than Statewide):

C. **Comparability of Services:**

____ Services are provided in accordance with Section 1902(a)(10)(B) of the Act;

X Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. **Definition of Services:**

High-Risk Case Management is a set of interrelated activities under which responsibility for locating, coordinating, and monitoring appropriate services for an individual rests with a specific person within the High-Risk Case Management Agency. The purpose of High-Risk Case Management Services for high-risk infants is to assist those eligible for Medicaid in gaining access to needed medical, social, educational, and other services; to reduce infant mortality or morbidity; to encourage the use of cost-effective medical care by referrals to appropriate providers; and to discourage over-utilization or duplication of costly services. High-Risk Case Management Services will provide necessary coordination with providers of nonmedical services such as nutrition, psychosocial, educational programs or early intervention when services provided by these entities are needed. The Case Manager will coordinate these services with needed medical services.

The high-risk infant will be allowed one (1) High-Risk Case Management Service a calendar month with a maximum of twelve (12) High-Risk Case Management Services during the first year of life. High-Risk Case Management Services include direct contact with the client as well as indirect work on the client's behalf. The High-Risk Case Management Services will return to the services for a well-baby if the medical or medically related risk factor(s) cease to exist during the first year of life, as determined by the infant's physician.

The Case Manager's services are to be noted in the infant's Plan of Care.

The set of interrelated activities are as follows:

1. Evaluation of the client's individual situation to determine the need for High-Risk Case Management due to known medical or other medically related risk factors. The Case Manager must establish that the infant has Medicaid eligibility, is at medical risk, and that the parent/guardian/custodian has selected that particular agency. An explanation of High-Risk Case Management Services must be given to the parent/guardian/custodian to determine whether High-Risk Case Management Service is wanted. Once the infant is determined by the physician to no longer be at medical risk, High-Risk Case Management as a separate service will no longer be provided. Case Management as a required component of regular EPSDT services will continue to be provided to the extent permitted;

2. Needs assessment is the process by which the Case Manager identifies the service needs of the infant in order to assist in gaining access to the needed services, such as psychosocial, nutritional, medical, and educational;

3. Development and implementation of an individualized Plan of Care to meet the service needs of the infant. A Plan of Care is needed by the Case Manager to:

   a. Determine how to assist in gaining access to needed services,

   b. Keep track of important activities, and

c. Know if the events that did occur met the goals as stated in the Plan of Care;

This Plan of Care does not constitute Medicaid prior authorization for High-Risk Case Management Services.

4. Coordination of delivery of service when multiple providers and/or programs are involved to reduce travel and multiple appointments as much as possible by careful scheduling;

5. Assistance in locating providers and/or programs and making referrals to the providers and/or programs that can meet the service needs;

6. Monitoring and follow-up to ensure that services are received, are adequate to meet the client's needs, and are consistent with good quality of care.

E. Qualifications of Providers:

1. Case Manager Qualifications:

a. Physician licensed in Mississippi, or

b. R.N. licensed in Mississippi with a minimum of one (1) year of experience in community nursing, or

c. Medical Social Worker with a minimum of one (1) year of experience in health and/or human services, and one of the following:

(1) M.S.W. Medical Social Worker licensed in Mississippi,

(2) B.S.W. Medical Social Worker licensed in Mississippi in consultation with M.S.W., or

(3) Other Mississippi licensed Medical Social Worker supervised by a M.S.W.; or

d. Nutritionist licensed in Mississippi or a Registered Dietician, each with a minimum of one (1) year of experience in providing

infant nutrition service when nutritional needs are the high-risk factor.

2. High-Risk Case Management Agency:

   a. Must have qualified Case Manager(s);

   b. Meet applicable State and Federal laws governing the participation of providers in the Medicaid Program;

   c. Must meet the criteria established by the Division of Medicaid as a provider of High-Risk Case Management Services (Section 3, Enrollment Process).

   Qualifications for the providers of targeted Case Management to infants will be the same as qualifications for EPSDT providers. The Division of Medicaid will enter into Provider Agreements that establish criteria for High-Risk Case Management Agencies and services to this target group. The Division of Medicaid will enroll providers that are qualified to render High-Risk Case Management Services in accordance with professionally recognized standards for good care. The purpose of this activity is to help assure that High-Risk Case Management Services are provided by professionally qualified providers in accordance with Section 1902(a)(23) of the Act. Nothing in this plan will be construed to require a Case Management Agency or a Case Manager to provide any other service under the Medicaid Program.

3. Enrollment Process:

   The Division of Medicaid will implement methods and procedures to enroll all providers of EPSDT Services for High-Risk Case Management to high-risk infants that can demonstrate:

   a. Capacity to provide High-Risk Case Management Services;

   b. Experience with delivery and/or coordination of services for children;

   c. Maintenance of financial accountability rules as for any other provider participating in the Medicaid Program;

d. Agreement to maintain regular contact with the primary-care physician when the physician is not the Case Manager.

F. Freedom of Choice

The State assures that the provision of High-Risk 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 recipients will have free choice of the providers of EPSDT High-Risk Case Management.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for High-Risk 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.

TARGETED CASE MANAGEMENT FOR CHRONICALLY MENTALLY ILL COMMUNITY BASED RECIPIENTS.

A. **Target Group:** Chronically mentally ill individuals who need community based mental health services to reduce dysfunction and attain their highest level of independent living or self care.

B. **Areas of State in which services will be provided:**

X Entire State;

____ Only in the following geographic areas (authority of Section 1915 (g) (1) of the Act is invoked to provide services less than Statewide):

C. **Comparability of Services:**

____ Services are provided in accordance with Section 1902 (a) (10) (B) of the Act;

X Services are not comparable in amount, duration and scope. Authority of Section 1915 (g) (1) of the Act is invoked to provided services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

D. **Definition of Services:**

Case management is the provision and coordination of services which are an integral part of aiding eligible recipients to gain access to needed medical, social, educational and other services in order to attain their highest level of independent functioning. Case management services provide to the maximum extent possible that the person served has access to all available resources and receives available services necessary to reach and maintain an optimal level of functioning. Activities include client identification, assessment, reassessments, service planning, linkage to needed services, monitoring service delivery, supportive counseling and outreach services designed to seek out persons who have been screened and referred for case management and to make every effort to engage such persons in the receipt of case management services.

E. **Qualifications of Providers:**

Providers of case management services are to be persons with a minimum of a B.A. or B.S. degree or comparable degree level in the field of nursing, social work, counseling or other such qualification and training and who meet the standards established under Sections 41-19-31 through 41-19-39 and/or Section 41-4-7(g), Mississippi Code of 1972, as amended.

F. Freedom of Choice:

The state assures that the provision of case management services to the chronically mentally ill will not restrict an individual's free choice of providers in violation of Section 1902 (a) (23) of the Act:

1. Case management services will be available at the option of the eligible recipient.

2. An eligible recipient who wishes to receive case management services will have free choice to receive case management services from any qualified provider of these services.

3. Eligible recipients will have free choice of the providers of other medical care as covered elsewhere in this Plan.

G. Payment for targeted case management for the chronically mentally ill does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

TARGETED CASE MANAGEMENT SERVICES FOR BENEFICIARIES WITH INTELLECTUAL AND/OR DEVELOPMENTAL DISABILITIES (IDD) IN COMMUNITY-BASED SETTINGS

A. Target Group:

Beneficiaries with a confirmed diagnosis of Intellectual and/or Developmental Disabilities (IDD) as defined by 42 CFR § 483.102 and 45 CFR § 1385.3, and is likely to continue indefinitely resulting in substantial functional limitations with three (3) or more life activities which include receptive and expressive language, learning, self-care, mobility, self-direction, capacity for independent living, and economic self-sufficiency, and meets two (2) of the following needs-based criteria:

1. Unemployment, or employment in a sheltered setting, or has markedly limited skills and a poor or non-existent work history,

2. Severe inability to establish or maintain beneficial, meaningful personal social support systems,

3. Requires help in basic Instrumental Activities of Daily Living (IADL), including, but not limited to:

   a) Money management,

   b) Housekeeping,

   c) Meal planning and preparation,

   d) Shopping for food, clothing and other essential items,

   e) Communicating by phone or other media, and

   f) Traveling around and participating in the community.

4. Exhibits inappropriate social behavior that results in the need for intervention, and

5. Requires financial assistance to live successfully in the community and may be unable to procure this assistance without help.

The target group does not include individuals between ages twenty-two (22) and sixty-four (64) who are served in Institutions for Mental Disease (IMD) or individuals who are inmates

of public institutions.

B. Areas of the State in which services will be provided:

_X_ Entire State,

___ Only in the following areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than Statewide),

C. Comparability of Services:

____ Services are provided in accordance with Section 1902(a)(10)(B) of the Act,

_X_ Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Targeted Case Management services are defined as the coordination of services to assist beneficiaries, eligible under the State Plan within the IDD targeted group, in gaining access to needed medical, social, educational and other services. Targeted Case Management is responsible for identifying individual problems, needs, strengths, resources and coordinating and monitoring appropriate services to meet those needs. Targeted 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 beneficiary 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 beneficiary's needs (42 CFR § 440.169(e)). Targeted Case Management ensures the changing needs of the beneficiary with IDD are addressed on an ongoing basis, that appropriate choices are provided from the widest array of options for meeting those needs, and includes the following services:

1. A Comprehensive Assessment

A comprehensive assessment is completed annually to determine a beneficiary's needs for services and supports including identification of any medical, educational, social, or other service needs. The assessment must include obtaining a beneficiary's history, identifying and documenting the needs of the beneficiary, and gathering information from sources such as family members, medical providers, social workers, and educators, as

appropriate. Reassessments are conducted when there is a significant change in the beneficiary's circumstances that may affect his/her level of functioning and needs.

2. Plan of Services and Supports

An individualized Plan of Services and Supports (PSS) is developed based on the information collected through the comprehensive assessment. The PSS will be reviewed at a minimum every twelve (12) months or when there is a significant change in the beneficiary's circumstances that may affect his/her level of functioning and needs which includes the following:

a) Specific goals to address the medical, social, educational, and other services needed by the beneficiary,

b) Activities to meet identified goals ensuring the active participation of the beneficiary and/or the beneficiary's authorized representative for health care decisions, and

c) A course of action to respond to the assessed needs of the beneficiary.

3. Referral and Related Activities

Referral and related activities help the beneficiary to obtain needed medical, social, and educational services by scheduling appointments and coordinating resources with providers and other programs to address identified needs and achieve specified goals from the PSS.

4. Monitoring and Follow-up Activities

Performance of monitoring and follow-up activities include activities and contacts necessary to ensure that the PSS is effectively implemented and adequately addresses the needs of the beneficiary. Monitoring and follow-up activities may include involvement of the beneficiary, family members, service providers, or other entities or individuals. Contacts with a beneficiary's family or others for the purpose of helping the beneficiary access services are included in Targeted Case Management. Monitoring and follow-up activities are conducted monthly, or more often, depending on the needs of the beneficiary, with quarterly face-to-face visits to determine if:

a) Services are being furnished in accordance with the beneficiary's PSS,

b) Services in the PSS are adequate to meet the beneficiary's needs, and

c) Changes in the needs or status of the beneficiary require adjustments to the PSS and service arrangements.

E. Qualifications of Providers:

Targeted Case Management services must be provided by a service provider certified by the Mississippi Department of Mental Health (DMH) as meeting the Operational Standards for Targeted Case Management for beneficiaries with IDD.

1. Targeted Case Managers must:

   a) Have a minimum of a Bachelor's degree in a mental health/IDD related field and possess a Provisionally Certified Community Support Specialist (PCCSS) or Certified Community Support Specialist (CCSS) certification,

   or

   b) Be a Qualified Developmental Disabilities Professional (QDDP).

2. All Targeted Case Management staff must successfully complete training in Person-Centered Planning. Targeted Case Managers must demonstrate competencies in the application of the principles of Person Centered Thinking (PCT) and Person Centered Facilitation (PCF) in Plans of Services and Supports (PSS) as identified in the DMH Record Guide. All PSSs are submitted to DMH for approval. The PSS must adhere to the DMH Record Guide requirements in order to demonstrate competencies in PCP.

3. The Division of Medicaid will implement methods and procedures to enroll DMH Targeted Case Management service providers who serve beneficiaries with IDD. Targeted Case Management providers must demonstrate:

   a) Capacity to provide Targeted Case Management services,

   b) At least two (2) years experience with coordination of services for individuals with IDD, and

   c) Maintenance of financial accountability rules as for any other provider participating in the Medicaid program.

F. Freedom of Choice:

The state assures that the provision of Targeted Case Management services to the IDD target

group will not restrict an individual's freedom of choice of providers in violation of Section 1902(a)(23) of the Act.

1. Targeted Case Management services will be available at the option of the beneficiary.

2. A beneficiary who wishes to receive Targeted Case Management services will have freedom of choice to receive Targeted Case Management services from any qualified provider of these services.

3. Beneficiaries will have freedom of choice of the qualified Medicaid providers of other medical care as covered elsewhere in this Plan.

G. Targeted Case Management services are not provided to beneficiaries who are in institutions.

H. Limitations:

Targeted Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in 42 CFR § 440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Targeted Case Management does not include, and FFP is not available in expenditures for, services defined in 42 CFR § 440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which a beneficiary 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 is only available for 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 Mississippi

Targeted Case Management Services for children birth to 3 participating in the Mississippi Early Intervention Program.

A. Target Groups: by invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:

1. Children birth to three years of age who have developmental disabilities and who are enrolled and participating in the Mississippi Early Intervention Program.

The individuals in the target groups may not be receiving case management services under an approved waiver program.

B. Areas of State in which services will be provided:

X Entire State

__ Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is involved to provide services less than statewide):

C. Comparability Services:

__ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Acts is invoked to provide services with out regard to the requirements of Section 1902(a)(10)(B).

D. Definition of Services: Case management is a service which allows providers to assist eligible individuals in gaining access to needed medical, social, educations, and other services. Consistent with the requirements of Section 1902(a)(23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred.

State Mississippi

Case management is an active, ongoing process that involves activities carried out by a case manager to assist and enable a child enrolled and participating in the Mississippi Early Intervention Program gain access to needed medical, social, educational and other services. Service Coordination assist the child and child's family, as it relates to the child's needs, from the notice of referral through the initial development of the child's needs identified on the Individualized Family Services Plan(IFSP). Additionally, Service Coordination assists the child and child's family, as it relates to the child's needs, with ongoing service coordination, for the child, provided by the individual service coordinator selected at the time the IFSP is finalized.

These activities include:

1. Arranging for evaluation and assessment activities to determine the identification of services as it relates to the child's medical, social, educational and other needs.
2. Arranging for and coordinating the development of the child's IFSP;
3. Arranging for the delivery of the needed services as identified in the IFSP;
4. Assisting the child and his/her family, as it relates to the child's needs, in accessing needed services for the child and coordinating services with other programs;
5. Monitoring the child's progress by making referrals, tracking the child's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child's changing service needs;
6. Obtaining, preparing and maintaining case records, documenting contacts, service needed, reports, the child's progress etc.;
7. Providing case consultation (i.e., with the service providers/collaterals in determining child's status and progress);
8. Coordinating crisis assistance (i.e., intervention on behalf of the child, making arrangements for emergency referrals, and coordinating other needed emergency services); and
9. Coordinating the transition of an enrolled child to on going services prior to the child's third birthday.

State Mississippi

Mississippi Division of Medicaid will assure that the state agencies, private and public providers meet the criteria to ensure case management services to children with developmental disability targeted group, will be given equal consideration. Enrollment in the case management program will be open to all state agencies, private and public providers who can meet the qualifications. The Division of Medicaid will participate in the review of the applications for provider enrollment.

E. Qualifications of Providers:

As provided for in Section 1915(g)(1) of the Social Security Act, qualified providers shall be state agencies, private and public providers and their subcontractors meeting the following Medicaid criteria to ensure that case managers for the children with developmental disabilities are capable of providing needed services to the targeted group:

1. Demonstrated successfully a minimum of three years of experience in all core elements of case management including:

   a) assessment;

   b) care/services plan development;

   c) linking/coordination of services; and

   d) reassessment/follow-up.

2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population;

3. Demonstrated experience with the target population;

4. Demonstrated the ability to provide or has a financial management system that documents services delivered and costs associated.

State Mississippi

F. Qualifications of Case Managers (only the following can be case managers):

Each case manager must be a Mississippi Early Intervention Program certified service provider, and:

1. a. Have a bachelor's degree in child development, early childhood education, special education, social work; or
   b. Be a registered nurse;

2. a. Two years experience in service coordination for children with disabilities up to age 18; or
   b. Two years experience in service provision to children under six years of age.

G. The state assures that the provision of case management services will not unlawfully restrict an individual's free choice of providers in violation of Section 1902(2)(23) of the Act.

A. Enrolled and participating recipients will have free choice of the available providers of case management services.

B. Enrolled and participating recipients will have free choice of the available providers of other medical care under the plan.

H. Payments for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.