PUBLIC NOTICE

August 31, 2016

Pursuant to 42 C.F.R. Part 447, public notice is hereby given to the submission of the Division of Medicaid's Access Monitoring Review Plan (AMRP).

A copy of the proposed AMRP will be available in each county health department office and in the Department of Human Services office in Issaquena County for review.

A hard copy can be downloaded and printed from www.medicaid.ms.gov or may be requested at Margaret.Wilson@medicaid.ms.gov or 601-359-2081.

Written comments will be received by the Division of Medicaid, Office of the Governor, Office of Policy, Walter Sillers Building, Suite 1000, 550 High Street, Jackson, Mississippi 39201, or Margaret.Wilson@medicaid.ms.gov for thirty (30) days from the date of publication of this notice. Comments will be available for public review at the above address and on the Division of Medicaid's website at www.medicaid.ms.gov.

MISSISSIPPI DIVISION OF MEDICAID

Access Monitoring Review Plan

Draft for Public Comment

August 31, 2016

Office of the Governor, Division of Medicaid
550 High Street, Suite 1000 | Jackson, Mississippi 39201
Website: www.medicaid.ms.gov

Introduction

Overview of Mississippi Medicaid

The Mississippi Division of Medicaid (DOM) is a state and federal program created by the Social Security Amendments of 1965 (PL 89-97), authorized by Title XIX of the Social Security Act to provide health coverage and medical assistance to eligible, low income populations. This service is in place to provide access to quality health care coverage for vulnerable Mississippians, including: children, low income parents or caretaker relatives, pregnant women, the aged and disabled. The benefits an individual may qualify for depends on the category of eligibility in which the individual qualifies and includes full Medicaid benefits, Medicare cost-sharing benefits, waiver program benefits that provide additional covered Medicaid services and benefits provided by a separate health plan under the Children's Health Insurance Program (CHIP). Eligible members do not directly receive money from Medicaid for health benefits. Enrolled and qualified Medicaid providers are reimbursed for health services. DOM has around 1,000 employees located throughout one central office, 30 regional offices and over 90 outstations *(Appendix A).*

Authorized by the state Legislature in 2011, DOM implemented a managed care program for beneficiaries called Mississippi Coordinated Access Network (MississippiCAN). MississippiCAN is designed to get a better return on Mississippi's health care investment by improving the health and well-being of Medicaid beneficiaries. DOM has contracted with two (2) coordinated care organizations (CCOs), Magnolia Health, Inc. and United Healthcare of Mississippi, Inc., responsible for providing services to beneficiaries who participate in the MississippiCAN program. There are certain beneficiaries that will qualify for this program, both mandatory and optional beneficiary populations. Beneficiaries who may choose to be a part of this program are those that receive Medicaid through:

- Supplemental Security Income (SSI) ages 0-19
- Department of Child Protective Services foster children
- Disabled Child Living at Home

MississippiCAN Mandatory Populations include:

Population	Ages
Supplemental Security Income (SSI)	19-65
Working disabled	19-65
Breast and cervical cancer	19-65
Parents and Caretakers (TANF)	19-65
Pregnant women (below 194% FPL)	8-65
Newborns (below 194% FPL)	0-1
Transition children (beginning state fiscal year 2015)	1-19
Children (TANF)	0-19
Children (below age 6, below 143% FPL)	1-5
Children (below age 19, below 100% FPL)	6-19
Quasi-CHIP (previously qualified for CHIP, age 6-19, 100-133% FPL)	6-19
Children (age 0-19, below 209% FPL)	1-19

On May 1, 2015, certain DOM beneficiaries began transitioning into MississippiCAN. In accordance with Mississippi House Bill No. 1275 (H.B. 1275, 2014 Leg., Reg. Sess. (Ms. 2014); codified at Miss. Code Ann. § 43-13-117 (2014)), DOM was authorized to implement a managed care program limited to the greater of forty-five percent (45%) of the total enrollment of DOM beneficiaries, or the categories of beneficiaries participating in the program as of January 1, 2014, plus the categories of beneficiaries composed primarily of persons younger than nineteen (19) years of age as long as the appropriate limitations are not exceeded in the aggregate. The transition did not apply to individuals who were receiving Medicare, were enrolled in a DOM waiver program, or were institutionalized. The transition was complete July 31, 2015 and affected an estimated population of 330,000 DOM beneficiaries.

Effective December 1, 2015, DOM implemented changes regarding inpatient hospital services required by Senate Bill (SB) 2588. SB 2588 directed DOM to include inpatient hospital services in MississippiCAN. The change did not apply to individuals who were receiving Medicare, were enrolled in a DOM waiver program, or were institutionalized.

Medicaid Enrollment

DOM serves nearly 1 in 4 Mississippians who receive health benefits. The charts below include enrollment numbers for the following populations: children, aged, blind & disabled, adults, and family planning waiver. The Medicaid enrollment report reflects the population counts when the report is generated at the end of the month.

Calendar Year 2016 Medicaid Enrollment

Month Year	Children	Aged	Disabled & Blind	Adults	Other	TOTAL
	Foster care children, DHS children, K-babies			Parents, pregnant women, adult refugees	Family planning waiver	For all populations
Jan-16	386,286	69,790	176,642	72,799	21,121	726,638
Feb-16	386,855	69,637	176,672	73,060	21,622	727,846
Mar-16	388,161	69,879	176,698	73,256	21,747	729,741
Apr-16	387,962	69,756	176,260	72,951	22,099	729,028
May-16	387,248	69,735	175,987	72,760	22,182	727,912
Jun-16	386,161	69,780	175,700	72,583	22,249	726,473
Jul-16	382,911	69,827	175,247	71,815	22,215	722,015

Calendar Year 2015 Medicaid Enrollment

Month Year	Children	Aged	Disabled & Blind	Adults	Other	TOTAL
	Foster care children, DHS children, K-babies			Parents, pregnant women, adult refugees	Family planning waiver	For all populations
Jan-15	400,408	69,282	177,606	77,662	19,710	744,668
Feb-15	400,232	69,443	177,798	78,174	19,870	745,517
Mar-15	400,534	69,433	177,738	78,871	19,575	746,151
Apr-15	400,337	69,088	177,585	79,192	19,573	745,775
May-15	398,190	69,180	177,366	78,851	19,775	743,362
Jun-15	395,510	69,354	177,462	78,522	20,089	740,937
Jul-15	393,505	69,302	177,277	77,946	19,824	737,854
Aug-15	390,305	69,437	177,362	76,694	19,760	733,558
Sep-15	388,142	69,551	177,336	75,458	19,867	730,354
Oct-15	385,915	69,703	177,116	74,282	20,340	727,356
Nov-15	383,938	69,660	176,942	73,377	20,463	724,380
Dec-15	384,717	68,243	176,276	73,032	21,033	723,301

Calendar Year 2014 Medicaid Enrollment

Month Year	Children	Aged	Disabled & Blind	Adults	Other	TOTAL
	Foster care children, DHS children, K-babies			Parents, pregnant women, adult refugees	Family planning waiver	For all populations
Jan-14	322,024	67,058	175,706	60,266	21,026	646,080
Feb-14	325,388	67,354	176,306	60,791	21,609	651,448
Mar-14	333,782	67,556	176,575	62,841	21,679	662,433
Apr-14	341,919	67,841	176,869	66,098	21,334	674,061
May-14	348,638	68,045	176,780	68,500	20,874	682,837
Jun-14	353,384	68,174	177,054	70,143	20,398	689,153
Jul-14	358,134	68,458	177,280	71,666	19,958	695,496
Aug-14	362,288	68,673	177,570	72,828	19,427	700,786
Sep-14	365,093	68,710	177,640	73,331	19,547	704,321
Oct-14	369,454	68,736	177,694	74,434	19,502	709,820
Nov-14	372,187	68,973	177,671	74,881	19,622	713,334
Dec-14	396,191	67,668	177,273	75,798	19,587	736,517

The charts below include enrollment numbers for MississippiCAN. The enrollment report represents the number of beneficiaries at the beginning of the month.

Calendar Year 2016 MississippiCAN Enrollment

Month Year	Magnolia Health Plan	UnitedHealthcare	Total MississippiCAN
Jan-16	252,410	250,937	503,347
Feb-16	254,125	252,673	506,798
Mar-16	254,366	253,038	507,404
Apr-16	252,600	250,946	503,546
May-16	255,473	253,420	508,893
Jun-16	254,226	252,947	507,173
Jul-16	252,114	250,162	502,276

Calendar Year 2015 MississippiCAN Enrollment

Month Year	Magnolia Health Plan	UnitedHealthcare	Total MississippiCAN
Jan-15	98,704	89,375	188,079
Feb-15	99,587	90,758	190,345
Mar-15	107,276	98,861	206,137
Apr-15	108,703	100,469	209,172
May-15	164,823	154,920	319,743
Jun-15	215,765	209,927	425,692
Jul-15	252,220	252,818	505,038
Aug-15	249,912	251,228	501,140
Sep-15	248,373	249,735	498,108
Oct-15	247,409	248,728	496,137
Nov-15	247,565	248,591	496,156
Dec-15	249,045	249,257	498,302

Calendar Year 2014 MississippiCAN Enrollment

Month Year	Magnolia Health Plan	UnitedHealthcare	Total MississippiCAN
Jan-14	79,215	65,219	144,434
Feb-14	79,309	65,300	144,609
Mar-14	79,819	65,859	145,678
Apr-14	80,239	66,157	146,396
May-14	81,112	67,144	148,256
Jun-14	82,977	68,641	151,618
Jul-14	84,754	70,370	155,124
Aug-14	85,841	71,056	156,897
Sep-14	87,381	72,432	159,813
Oct-14	87,123	72,035	159,158
Nov-14	87,550	72,450	160,000
Dec-14	97,782	87,525	185,307

Access Monitoring Review Plan (AMRP)

The Social Security Act requires state Medicaid programs to "…assure that payments to providers are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the same extent that such care and services are available to the general population in the geographic area." Pursuant to the Access to Care final rule issued by the Centers for Medicare and Medicaid Services (CMS) on November 2, 2015, states are required to submit an Access Monitoring Review Plan (AMRP) to CMS no later than October 1, 2016. The AMRP will take into account state-specific delivery systems, beneficiary characteristics, and geography based upon the appropriate measures, data sources, baselines and thresholds. The AMRP must provide for state review of the following service categories:

- Primary care
- Physician specialist services
- Behavioral health services
- Pre- and post-natal obstetric services
- Home health services

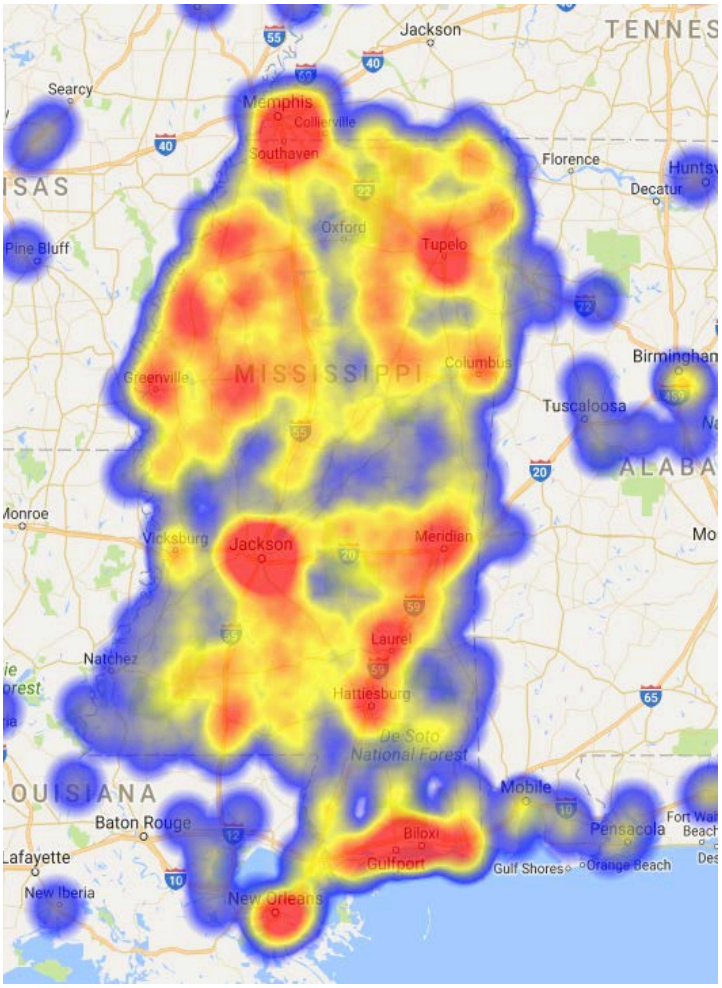
States must also document sufficient access when proposing rate reductions or changes to payment methodologies that may harm access to care and monitor access for three (3) years after the changes are approved. The AMRP is only required for services covered and paid through the Medicaid state plan on a fee-for-service basis.

Participant Population

This AMRP focuses on beneficiaries enrolled in DOM's fee-for-service (FFS) delivery system. The following benefit FFS populations were excluded from this report: Individuals enrolled in Home and Community-Based Waivers, Family Planning Waiver, Healthier Mississippi Waiver and Medicare-Medicaid dually eligible participants.

In a matter of months, DOM's beneficiary population shifted dramatically to MississippiCAN. From May 1, 2015 to July 31, 2015, an estimated 330,000 DOM beneficiaries transitioned to two (2) CCOs, Magnolia Health, Inc. and United Healthcare of Mississippi, Inc. Therefore, in an effort to ensure an accurate representation of the current DOM FFS population, DOM utilized enrollment data for the period of August 1, 2015 through June 30, 2016 for the AMRP. DOM identified 14,722 beneficiaries who met the criteria for the AMRP during the reporting period.

AMRP Beneficiaries enrolled in DOM's FFS delivery system



Red = High beneficiary population who met the criteria for the AMRP during the reporting period (8/1/2015 – 6/30/2016).

Yellow = Medium beneficiary population who met the criteria for the AMRP during the reporting period (8/1/2015 – 6/30/2016).

Blue = Low beneficiary population who met the criteria for the AMRP during the reporting period (8/1/2015 – 6/30/2016).

Service Categories

In accordance with the Access to Care final rule issued by CMS on November 2, 2015, states are required to submit an AMRP and the AMRP must provide for state review of the following service categories:

- Primary care
- Physician specialist services
- Behavioral health services
- Pre- and post-natal obstetric services
- Home health services

The following service categories and baseline data represented in DOM's AMRP demonstrates that provider payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the same extent that such care and services are available to the general population in the geographic area.

Telehealth Services

DOM began covering telehealth services on January 1, 2015. DOM reimburses medically necessary telehealth services, at the distant site, as a substitution for an in-person visit or encounter for consultations, office visits, and/or outpatient visits using the current applicable Mississippi Medicaid fees for the service provided. DOM defines telehealth services as the delivery of health care by an enrolled Medicaid provider, through a real-time communication method, to a beneficiary who is located at a different site. The interaction must be live, interactive and audiovisual. If a service in an in-person setting is not covered by DOM, it is not covered if provided through telehealth. DOM requires that the audio and video equipment and technology be sufficient enough to provide real-time interactive communications that provide the same information as if the telehealth visit or encounter was performed in-person.

Telehealth services must be delivered by enrolled Medicaid providers acting within their scope-of-practice in accordance with their professional licenses, and pursuant to state and federal guidelines, including but not limited to, authorization of prescription medications at both the originating and distant site. The following enrolled Medicaid providers are eligible to provide telehealth services at the distant site as a substitution for an in-person visit or encounter for consultations, office visits, and/or outpatient visits: Physicians,

Physician Assistants, Nurse Practitioners, Psychologists, Licensed Clinical Social Workers (LCSWs), and Licensed Professional Counselors (LPCs).

DOM reimburses the originating site the Mississippi Medicaid telehealth originating site facility fee for telehealth services per completed transmission. The following enrolled Mississippi Medicaid providers are eligible to receive the originating site facility fee for telehealth services per transmission: the office of a physician or practitioner, an outpatient hospital - including a Critical Access Hospital (CAH), a Rural Health Clinic (RHC), a Federally Qualified Health Center (FQHC), a Community Mental Health/Private Mental Health Center, a Therapeutic Group Home, an Indian Health Service Clinic, and a school-based clinic.

Rural Health Clinics (RHCs)

RHCs were established by the Rural Health Clinic Service Act of 1977 to address an inadequate supply of physicians serving Medicare beneficiaries in underserved rural areas, and to increase the utilization of Nurse Practitioners (NP) and Physician Assistants (PA) in these areas. RHCs have been eligible to participate in the Medicare program since March 1, 1978, and are paid an all-inclusive rate (AIR) per visit for primary health services and qualified preventive health services.

RHCs are defined in section 1861(aa)(2) of the Social Security Act (the Act) as facilities that are engaged primarily in providing services that are typically furnished in an outpatient clinic. To be eligible for certification as an RHC, a clinic must be located in a non-urbanized area, as determined by the U.S. Census Bureau, and in an area designated or certified within the previous four (4) years by the Secretary of Health and Human Services (HHS), in any one (1) of the four (4) types of shortage area designations that are accepted for RHC certification.

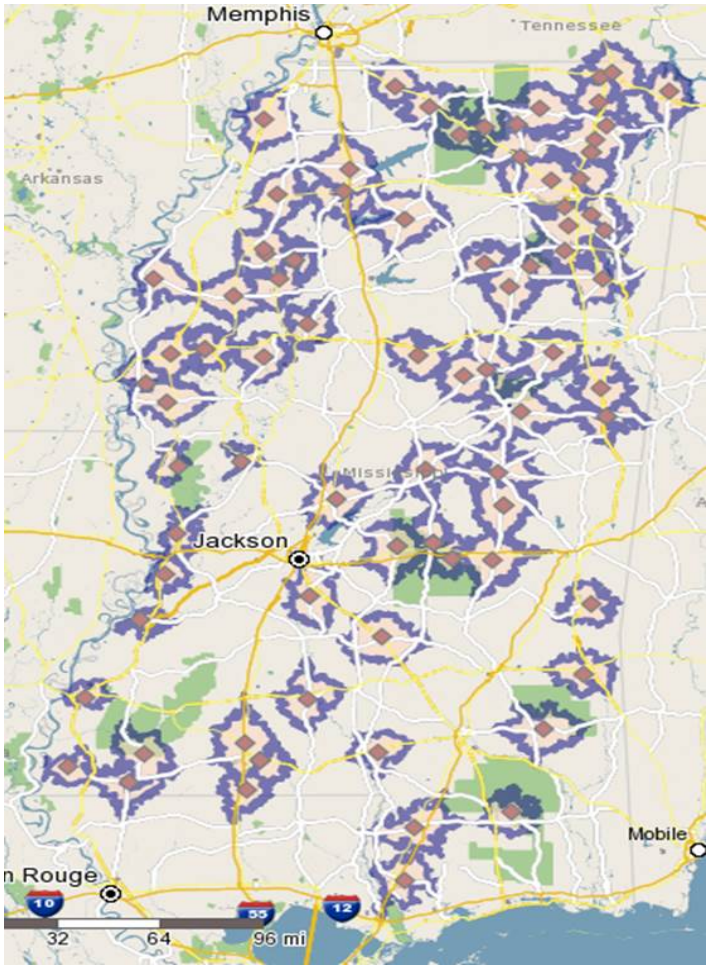
To be eligible for certification as a RHC, a clinic must be located in 1) a non-urbanized area, as determined by the U.S. Census Bureau, and 2) an area designated or certified within the previous four (4) years by the Secretary of HHS, in any one (1) of the four (4) types of shortage area designations that are accepted for RHC certification.

A clinic applying to become a Medicare-certified RHC must meet both the rural and underserved location requirements. Mobile clinics must have a fixed schedule that specifies the date and location for services, and each location must meet the location requirements.

Existing RHCs are not currently required to continue to meet the location requirements. RHCs that plan to relocate or expand should contact their Regional Office (RO) to

determine their location requirements. Mississippi currently has 179 enrolled RHCs across the state represented on the map below. *(Appendix B)*

Map of RHCs in Mississippi



Federally Qualified Health Centers (FQHCs)

Federally Qualified Health Centers (FQHCs) were established in 1990 by Section 4161 of the Omnibus Budget Reconciliation Act of 1990 and were effective beginning on October 1, 1991. As with RHCs, they are also facilities that are primarily engaged in providing services that are typically furnished in an outpatient clinic. FQHCs were paid an AIR for primary health services and qualified preventive health services until October 1, 2014, when they began to transition to the FQHC prospective payment system (PPS). Beginning January 1, 2016, all FQHCs were paid under the provisions of the FQHC PPS, as required by Section 10501(i)(3)(B) of the Affordable Care Act.

FQHCs may be located in rural or urban areas. FQHCs that are Health Center Program Grantees or Look-Alikes must be located in or serve people from a HRSA-designated medically underserved area (MUA) or medically underserved population (MUP). Mississippi currently has twenty-one (21) enrolled FQHCs across the state with additional satellite locations not included in the count. *(Appendix B)*

Primary Care Services

Pursuant to Miss. Code Ann. § § 43-13-117, 43-13-121, qualified providers enrolled as Mississippi Medicaid providers are eligible for an increased payment for certain primary care Evaluation and Management (E&M) and Vaccine Administration codes. Eligible providers must self-attest to a specialty designation in family medicine, general internal medicine, pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), and the American Osteopathic Association (AOA).

Pursuant to HB 1560, effective July 1, 2016, providers who self-attest to a specialty designation in obstetric/gynecologic medicine by the American Congress of Obstetricians and Gynecologists (ACOG) will be eligible for an increased payment for certain primary care services. Fees for Medicaid physician services are updated July 1 of each year and are reimbursed at 90% of the Medicare Physician Fee Schedule in effect as of January 1 of each year. Eligible providers who self-attest to one of the identified specialty designations will be reimbursed at 100% of the Medicare Physician Fee Schedule for certain primary care services provided. The DOM Primary Care Provider Fee Schedule is updated July 1 of each year based on 100% of the Medicare Physician Fee Schedule, which takes effect January 1 of each year.

DOM currently has 2,632 providers who self-attested to receive enhanced payments for Primary Care Services, based on certain E&M codes and Vaccine Administration codes shown in the charts below. Primary care physicians who choose not to receive the increased payment for services rendered may continue to provide services reimbursed at 90% of the Medicare Physician Fee Schedule in effect as of January 1 of each year.

DOM pays for all medically necessary services for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)-eligible beneficiaries in accordance with DOM Administrative Code, Title 23, Part 223, without regard to service limitations and with prior authorization.

Primary Care Services reimbursement applies to the following E&M procedure codes:

99201	99231	99283	99328	99358	99387	99441	99476
99202	99232	99284	99334	99359	99391	99442	99477
99203	99233	99285	99335	99360	99392	99443	99478
99204	99234	99288	99336	99363	99393	99444	99479
99205	99235	99291	99337	99364	99394	99450	99480
99211	99236	99292	99339	99366	99395	99455	99485
99212	99238	99304	99340	99367	99396	99456	99486
99213	99239	99305	99341	99368	99397	99460	99487
99214	99241	99306	99342	99374	99401	99461	99488
99215	99242	99307	99343	99375	99402	99462	99489
99217	99243	99308	99344	99377	99403	99463	99495
99218	99244	99309	99345	99378	99404	99464	99496
99219	99245	99310	99347	99379	99406	99465	99499
99220	99251	99315	99348	99380	99407	99466	
99221	99252	99316	99349	99381	99408	99467	
99222	99253	99318	99350	99382	99409	99468	
99223	99254	99324	99354	99383	99411	99469	
99224	99255	99325	99355	99384	99412	99471	
99225	99281	99326	99356	99385	99420	99472	
99226	99282	99327	99357	99386	99429	99475	

The state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 C.F.R. § 447.400(a) at the Mississippi regional maximum administration fee set by the Vaccines for Children program. Primary Care Services reimbursement applies to the following Vaccine Administration procedure codes:

90460	90471	90473
90461	90472	90474

Data: Primary Care Physician Services

Beneficiary count by E&M and Vaccine Administration procedure code:

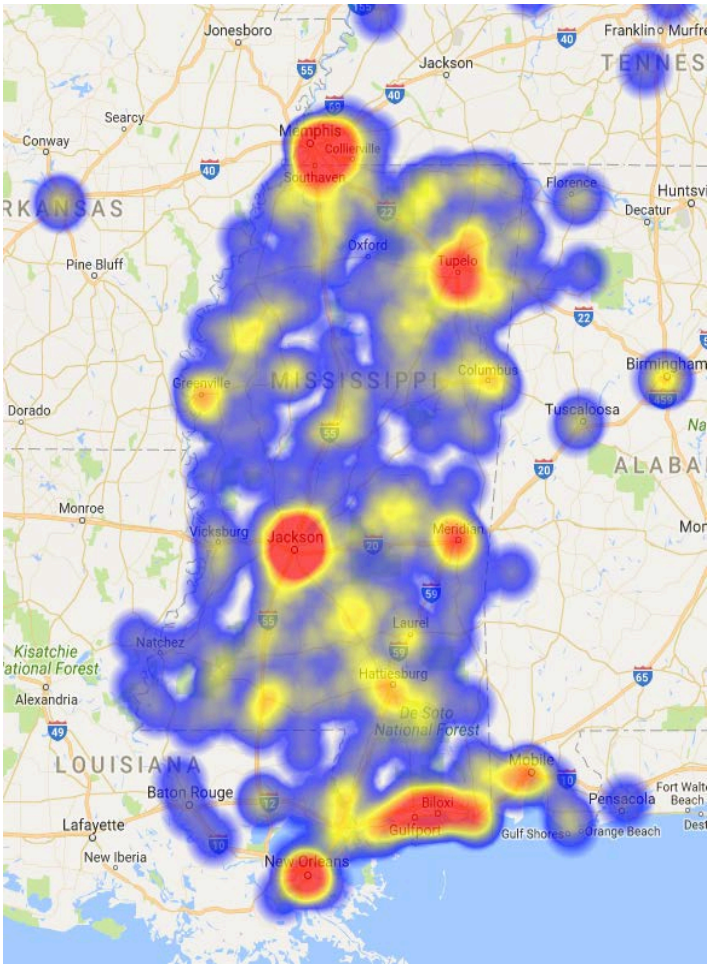
Procedure Code	Description	Beneficiary Count
90460	Imadm Any Route 1st Vac/Tox	992
90461	Inadm Any Route Addl Vac/Tox	98
90471	Immunization Admin	1,751
90472	Immunization Admin, Each Add	592
90473	Immune Admin Oral/Nasal	149
90474	Immune Admin Oral/Nasal Addl	22
99201	Office Or Other Outpatient Vis	413
99202	Office Or Other Outpatient Vis	813
99203	Office Or Other Outpatient Vis	1,526
99204	Office Or Other Outpatient Vis	731
99205	Office Or Other Outpatient Vis	122
99211	Office Or Other Outpatient Vis	1,797
99212	Office Or Other Outpatient Vis	2,364
99213	Office Or Other Outpatient Vis	7,747
99214	Office Or Other Outpatient Vis	4,934
99215	Office Or Other Outpatient Vis	1,152
99217	Observation Care Discharge Day	176
99218	Initial Observation Care, Per	41
99219	Initial Observation Care, Per	134
99220	Initial Observation Care, Per	126
99221	Initial Hospital Care, Per Day	115
99222	Initial Hospital Care, Per Day	402
99223	Initial Hospital Care, Per Day	474
99224	Sbsq Obs Care Pr D Low Sever	8
99225	Sbsq Obs Care Pr D Mod Sever	15
99226	Sbsq Obs Care Pr D High Severity	13
99231	Subsequent Hospital Care, Per	538
99232	Subsequent Hospital Care, Per	862
99233	Subsequent Hospital Care	445
99234	Observ/Hosp Same Date	18
99235	Observ/Hosp Same Date	43
99236	Observ/Hosp Same Date	23
99238	Hospital Discharge Day Managem	720
99239	Hospital Discharge Day	266
99241	Office Consultation For A New	22
99242	Office Consultation For A New	131
99243	Office Consultation For A New	506
99244	Office Consultation For A New	490
99245	Office Consultation For A New	123

99251	Inpatient Consult New Or Est Patient, Pr	20
99252	Inpatient Consult New Or Est Patient, Ex	78
99253	Inpatient Consult New Or Est Patient, De	218
99254	Inpatient Consult New Or Est Patient, Co	243
99255	Inpatient Consult New Or Est Patient, Co	95
99281	Emergency Department Visit For	311
99282	Emergency Department Visit For	1,285
99283	Emergency Department Visit For	3,174
99284	Emergency Department Visit For	2,485
99285	Emergency Dept Visit	1,358
99288	Physician Direction Of Emergen	1
99291	Critical Care, First Hour	319
99292	Critical Care, Addl 30 Min	53
99304	Nursing Facility Care, Init	113
99305	Nursing Facility Care, Init	78
99306	Nursing Facility Care, Init	32
99307	Nursing Fac Care, Subseq	561
99308	Nursing Fac Care, Subseq	792
99309	Nursing Fac Care, Subseq	420
99310	Nursing Fac Care, Subseq	103
99315	Nursing Fac Discharge Day	9
99316	Nursing Fac Discharge Day	1
99318	Annual Nursing Fac Assessmnt	312
99324	Domicil/R-Home Visit New Pat	1
99325	Domicil/R-Home Visit New Pat	1
99334	Domicil/R-Home Visit Est Pat	10
99335	Domicil/R-Home Visit Est Pat	20
99336	Domicil/R-Home Visit Est Pat	13
99344	Home Visit, New Patient	1
99354	Prolong E&M/Psyctx Serv O/P	18
99355	Prolong E&M/Psyctx Serv O/P	1
99356	Prolongd Serv Ip/Observ 1st Hr	9
99357	Prolonged Service, Inpatient	1
99360	Physician Standby Service, Req	1
99381	Prev Visit, New, Infant	13
99382	Initial Evaluation And Managem	42
99383	Initial Evaluation And Managem	167
99384	Initial Evaluation And Managem	191
99385	Initial Evaluation And Managem	27
99386	Initial Evaluation And Managem	6
99391	Prev Visit, Est, Infant	25
99392	Periodic Reevaluation And Mana	243
99393	Periodic Reevaluation And Mana	1,015
99394	Periodic Reevaluation And Mana	1,039

99395	Periodic Reevaluation And Mana	88
99396	Periodic Reevaluation And Mana	16
99397	Periodic Reevaluation And Mana	1
99401	Counseling And/Or Risk Factor	749
99402	Counseling And/Or Risk Factor	3
99406	Smok/Tob Use Cess Interm 3-10 Min	9
99407	Smok/Tob Use Cess Intensive >10 Min	3
99420	Administration And Interpretat	59
99460	Init Eval Normal Newborn Per Day	8
99462	Subs Care Per Day Normal Newborn	10
99463	Init Eval Normal Newborn Adm/Disch	1
99464	Attendance At Delivery W/Stab	2
99465	Del Room Resusc Newborn	3
99468	Init Ip Neonat Cc Per Day < 28 Days	8
99469	Subsq Ip Neonat Cc Per Day < 28 Days	9
99471	Init Ip Ped Cc Per Day Thru 24 Mos	3
99472	Subsq Ip Ped Cc Per Day Thru 24 Mos	12
99475	Init Ip Ped Cc Per Day 2-5 Yrs	20
99476	Subq Ip Ped Cc Per Day 2-5 Yrs	22
99477	Init Hosp Care/Day For E/M Of Neonate	3
99479	Subsq Icu Day Low Birth 1500-2500 G	7
99480	Subsq Icu Day Low Birth 2001-5000 G	6
99496	Trans Care Mgmt High Complexity	1
99499	Unlisted Evaluation And Manage	7
	Total Unduplicated Beneficiaries	***11,487***

The table above represents the number of beneficiaries out of the 14,722 beneficiaries enrolled in DOM's FFS delivery system who met the criteria for the AMRP who received primary care services during the reporting period (8/1/2015 – 6/30/2016). No particular access to care issue stood out in the review of the primary care services data.

Rendering Primary Care Physicians



Red = High concentration of Primary Care Physicians rendering services to beneficiaries who met the criteria for the AMRP and received primary care services during the reporting period (8/1/2015 – 6/30/2016).

Yellow = Medium concentration of Primary Care Physicians rendering services to beneficiaries who met the criteria for the AMRP and received primary care services during the reporting period (8/1/2015 – 6/30/2016).

Blue = Low concentration of Primary Care Physicians rendering services to beneficiaries who met the criteria for the AMRP and received primary care services during the reporting period (8/1/2015 – 6/30/2016).

Physician Specialists

Physician services – Fees for Medicaid physician services are updated July 1 of each year and are reimbursed at 90% of the Medicare Physician Fee Schedule in effect as of January 1 of each year.

Data- Physician Specialists

Beneficiary count by Specialty Provider code:

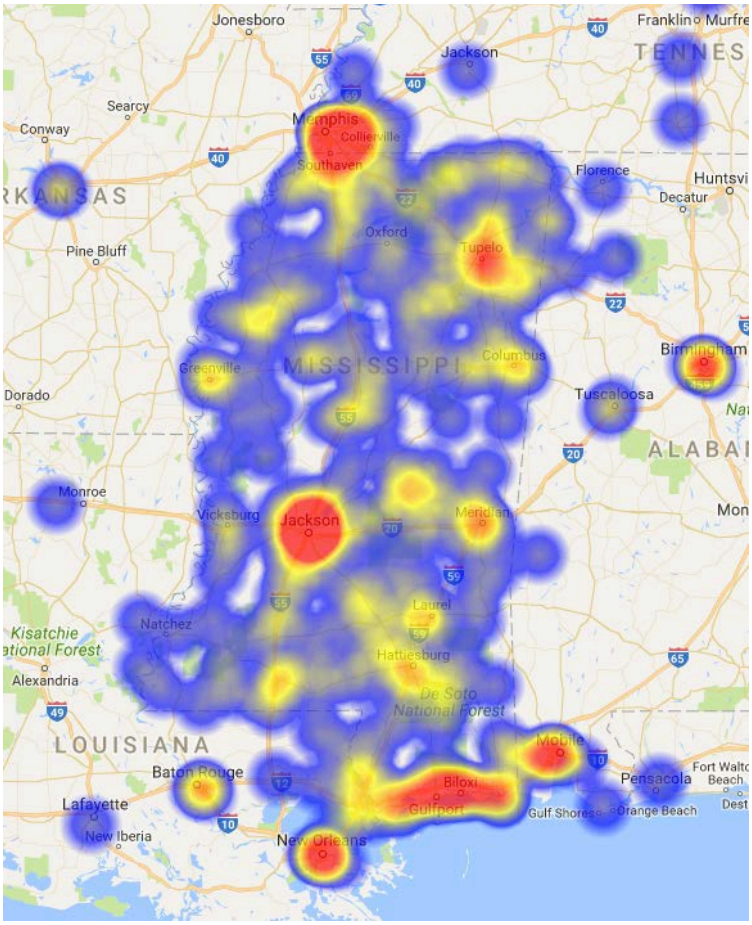
Specialty Code	Description	Beneficiary Count
000	General Practice	1,124
001	Cardiology	325
002	Radiology	2,792
003	Pathology	359
004	Pediatrics	4,633
006	Ob-Gyn	532
007	General Surgery	544
008	Orthopedic Surgery	773
009	Neurological Surgery	137
010	Thoracic Surgery	16
011	Plastic Surgery	63
012	Internal Medicine	1,588
013	General Preventative Medicine	16
014	Anesthesiology	1,275
015	Ophthalmology	1,200
016	Otolaryngology	826
017	Urology	240
018	Dermatology	152
019	Pulmonary Disease	96
022	Hematology - Internal Medicine	98
023	Gastroenterology	134
024	Allergy	160
025	Podiatrist	343
026	Oncology	86
027	Rheumatology	52
028	Endocrinology	156
029	Infectious Diseases	117
030	Nephrology	84
031	Family Practice	4,108
032	Ambulatory Surgical Center	38
033	General Dentistry	3,001
034	Orthodontics	379
035	Pediatric Dentistry	756

036	Oral & Maxillofacial Surgery	188
037	Endodontics	15
038	Periodontics	5
040	Aerospace Medicine	21
041	Pediatric Gastroenterology	71
042	Diabetes	13
043	Emergency Medicine	1,965
044	Geriatric Medicine	81
045	Laryngology	12
048	Neurology, Child	502
049	Neuropathology	7
050	Nuclear Medicine	5
053	Otology	30
054	Otorhinolaryngology	13
055	Pathology, Clinical	51
057	Pediatrics, Allergy, Immunology	1
058	Pediatrics, Cardiology	271
060	Physical Medicine Rehab	27
061	Psychiatry, Child, Adolescent	166
064	Public Health	1
065	Radiology, Diagnostic	2,405
066	Radiology, Pediatric	91
067	Radiology, Therapeutic	13
068	Roentgenology, Diagnostic	1
070	Abdominal Surgery	1
071	Cardiovascular Surgery	18
072	Colon And Rectal Surgery	3
073	Hand Surgery	8
075	Pediatric Surgery	38
076	Traumatic Surgery	7
077	Urology Surgery	10
078	Periph Vascular Surgery	7
079	Ob/Gyn Surgery	15
083	Radiation Therapy	2
084	Anatomic Pathology	41
085	Anatomical & Clinical Pathology	152
088	Pain Management Anesthesiology	12
089	Neonatal-Perinatal Medicine	39
091	Addiction Medicine	17
092	Neurology	611
097	Primary Care Phys, Casemgt Fee	40
098	Pcp, Indiv, Grp Elgi Cmgt Fee	48
099	Not A Physician	1,337
100	Cardiovascular Disease	101

103	Critical Care	60
104	Hyperbaric Medicine	1
105	Clinical Genetics	3
106	Nuclear Radiology	5
107	Pediatric Hematology-Oncology	48
109	Pulmonary Medicine	78
110	Surgery, Critical Care	12
113	Certified Nurse Midwife	1
114	Cert Regist Nurse Anesthetist	20
115	Chiropractor	1
119	Nurse Practitioner	722
120	Occupational Therapist	19
121	Optometrist	11
122	Physical Therapist	1
123	Physician Assistant	38
140	Peripheral Vascular Disease	1
	Total Unduplicated Beneficiaries	***11,266***

The table above represents the number of beneficiaries out of the 14,722 beneficiaries enrolled in DOM's FFS delivery system who met the criteria for the AMRP and who received services from a specialty provider during the reporting period (8/1/2015 – 6/30/2016). No particular access to care issue stood out in review of the specialty provider service data.

Rendering Physician Specialists



Red = High concentration of Physician Specialists rendering services to beneficiaries who met the criteria for the AMRP during the reporting period (8/1/2015 – 6/30/2016).

Yellow = Medium concentration of Physician Specialists rendering services to beneficiaries who met the criteria for the AMRP during the reporting period (8/1/2015 – 6/30/2016).

Blue = Low concentration of Physician Specialists rendering services to beneficiaries who met the criteria for the AMRP during the reporting period (8/1/2015 – 6/30/2016).

Mental Health/Behavioral Health Services

Mental health programs provide a way for people to get the mental health treatment they need in a variety of settings, depending on age and conditions. However, several programs are limited to EPSDT-eligible beneficiaries. Some services are not covered for non-EPSDT beneficiaries, while other services may require a specific diagnosis to be covered. Additionally, some services require prior authorization for coverage. Geriatric psychiatric services are not covered.

The Mississippi Medicaid State Plan (State Plan) is a detailed agreement between the State of Mississippi and the Federal Government that describes the nature and scope of Mississippi's Medicaid Program. The State Plan is based on the federal requirements and regulations found in Title XIX of the Social Security Act. Changes to the State Plan, called State Plan Amendments (SPAs), must be approved by CMS prior to implementation. Effective July 1, 2012, CMS approved DOM's revisions made to Attachment 3.1-A, Exhibit 13.d – Rehabilitative Services of the State Plan to provide more evidence-based practices in Mental Health/Behavioral Health service delivery in the community. The SPA implements service limits and prior authorizations on the most intensive services available in the community.

Title 23, Part 206, Chapter 1 of the DOM Administrative Code states:

> *As specified in 43-13-117(A)(16) of the Mississippi Code of 1972, as amended, Community Mental Health Services described in these regulations are approved therapeutic and case management services provided by (a) an approved regional mental health/retardation center established under Sections 41-19-31 through 41-19-39, or by another community mental health service provider meeting the requirements of the Department of Mental Health (DMH) to be an approved mental health/retardation center if determined necessary by DMH, using state funds which are provided from the appropriation to DMH and used to match federal funds under a cooperative agreement between the division and the department, or (b) a facility certified by DMH to provide therapeutic and case management services, to be reimbursed on a fee-for-service basis.*

DOM will provide coverage for covered mental health services when it is determined that the medically necessary criteria and guidelines listed in DOM Administrative Code Title 23, Part 206, Chapter 1 are met. DOM pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with DOM Administrative Code, Title 23, Part 223, without regard to service limitations and with prior authorization. *(Appendix B)*

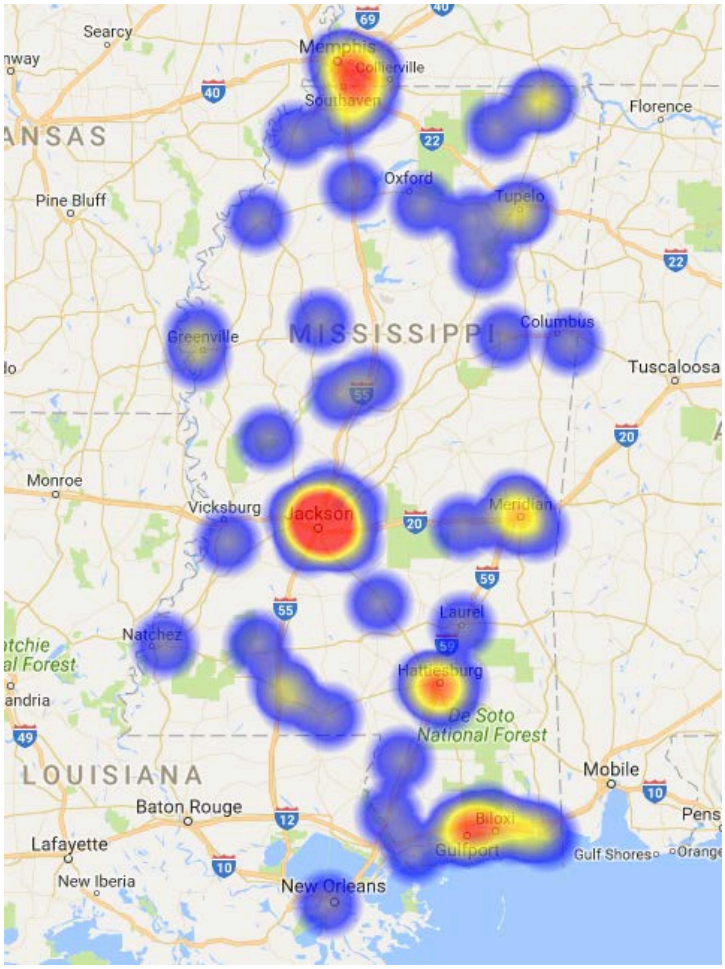
Beneficiary count by Mental Health procedure code:

Procedure Code	Description	Beneficiary Count
90785	Interactive Complexity	70
90791	Psych Diag Eval	576
90792	Psych Diag Eval W/Med Servs	109
90832	Psychotherapy, 30 Min	967
90833	Psytx Pt&/Family 30 Minutes	7
90834	Psytx Pt&/Family 45 Minutes	1,177
90836	Psytx Pt&/Fam W/E&M 45 Min	4
90837	Psytx Pt&/Family 60 Minutes	1,661
90838	Psytx Pt&/Fam W/E&M 60 Min	3
90846	Family Psytx W/O Patient	1,168
90847	Family Psychotherapy (Conjoint	1,187
90849	Multiple Family Group Psytx	8
90853	Group Psychotherapy	295
96101	Psych Test Per Hr Phys	214
96118	Neuropsych Tst By Psych/Phys	10
96372	Ther, Proph, Diag Inj Subq Or Iv	167
99201	Office Or Other Outpatient Vis	11
99202	Office Or Other Outpatient Vis	24
99203	Office Or Other Outpatient Vis	89
99204	Office Or Other Outpatient Vis	44
99205	Office Or Other Outpatient Vis	37
99211	Office Or Other Outpatient Vis	21
99212	Office Or Other Outpatient Vis	436
99213	Office Or Other Outpatient Vis	1,466
99214	Office Or Other Outpatient Vis	538
99215	Office Or Other Outpatient Vis	172
99217	Observation Care Discharge Day	4
99220	Initial Observation Care, Per	6
99221	Initial Hospital Care, Per Day	73
99222	Initial Hospital Care, Per Day	12
99223	Initial Hospital Care, Per Day	3
99231	Subsequent Hospital Care, Per	25
99232	Subsequent Hospital Care, Per	34
99233	Subsequent Hospital Care	6
99234	Observ/Hosp Same Date	1
99235	Observ/Hosp Same Date	3
99236	Observ/Hosp Same Date	1
99238	Hospital Discharge Day Managem	25
99239	Hospital Discharge Day	1
99241	Office Consultation For A New	1
99242	Office Consultation For A New	4

99243	Office Consultation For A New	7
99244	Office Consultation For A New	43
99245	Office Consultation For A New	15
99252	Inpatient Consult New Or Est Patient, Ex	3
99253	Inpatient Consult New Or Est Patient, De	4
99254	Inpatient Consult New Or Est Patient, Co	3
99255	Inpatient Consult New Or Est Patient, Co	3
99282	Emergency Department Visit For	3
99283	Emergency Department Visit For	9
99284	Emergency Department Visit For	8
99285	Emergency Dept Visit	5
99291	Critical Care, First Hour	5
99305	Nursing Facility Care, Init	1
99307	Nursing Fac Care, Subseq	2
99308	Nursing Fac Care, Subseq	9
99309	Nursing Fac Care, Subseq	1
99354	Prolong E&M/Psyctx Serv O/P	2
99394	Periodic Reevaluation And Mana	1
99401	Counseling And/Or Risk Factor	1
H0031	Mh Health Assess By Non-Md	714
H0032	Mh Svc Plan Dev By Non-Md	703
H0036	Comm Psy Face-Face Per 15min	1,255
H0038	Self-Help/Peer Svc Per 15min	34
H2011	Crisis Interven Serv 15 Min	133
H2012	Behav Hlth Days Treat, Per Hr	341
H2020	Ther Behav Svc, Per Diem	17
H2021	Com Wrap-Around Sv, 15 Min	44
H2022	Com Wrap-Around Sv, Per Diem	272
H2030	Mh Clubhouse Svc, Per 15 Min	37
J0401	Aripiprazole Extended Release Inj 1 Mg	2
T1002	Rn Services Up To 15 Minutes	853
T1017	Targeted Case Management	708
T1027	Family Training & Counseling	14
T2015	Habil Prevoc Waiver Per Hr	2
T2022	Case Management; Per Month	17
T2048	Bh Ltc Res R&B, Per Diem	13
	Total Unduplicated Beneficiaries	***3,813***

The table above represents the number of beneficiaries out of the 14,722 beneficiaries enrolled in DOM's FFS delivery system who met the criteria for the AMRP who received a metal health service during the reporting period (8/1/2015 – 6/30/2016).

Rendering Mental Health Providers



Red = High concentration of Mental Health Providers rendering services to beneficiaries who met the criteria for the AMRP and received a mental health service during the reporting period (8/1/2015 – 6/30/2016).

Yellow = Medium concentration of Mental Health Providers rendering services to beneficiaries who met the criteria for the AMRP and received a mental health service during the reporting period (8/1/2015 – 6/30/2016).

Blue = Low concentration of Mental Health Providers rendering services to beneficiaries who met the criteria for the AMRP and received a mental health service during the reporting period (8/1/2015 – 6/30/2016).

Prenatal and Postnatal Obstetric Services

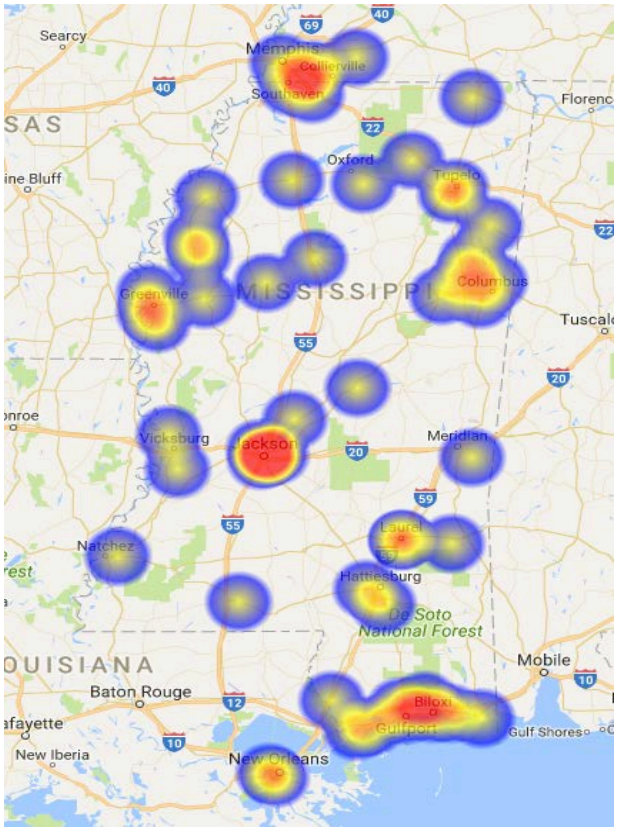
In Mississippi, the population receiving services for prenatal and postnatal obstetrics, including labor and delivery would only be enrolled in FFS for one (1) month prior to being

enrolled into MississippiCAN. There were only 602 Medicaid FFS beneficiaries who received a maternity service during the reporting period. Therefore, the data analysis confirms most prenatal and postnatal obstetric services are being provided through MississippiCAN except during the one (1) month period prior to being enrolled into MississippiCAN.

Provider Type	Provider Count	Unduplicated Beneficiary Count
Ob-Gyn	532	602
Certified Nurse Midwife	1	

The table above represents the number of beneficiaries out of the 14,722 beneficiaries enrolled in DOM's FFS delivery system who met the criteria for the AMRP who received a prenatal and postnatal obstetric service during the reporting period (8/1/2015 – 6/30/2016). No particular access to care issue stood out in review of prenatal and postnatal obstetric service data.

Rendering Prenatal and Postnatal Obstetric Providers



Red = High concentration of Prenatal and Postnatal Obstetric Providers rendering services to beneficiaries who met the criteria for the AMRP and received a prenatal and postnatal obstetric service during the reporting period (8/1/2015 – 6/30/2016).

Yellow = Medium concentration of Prenatal and Postnatal Obstetric Providers rendering services to beneficiaries who met the criteria for the AMRP and received a prenatal and postnatal obstetric service during the reporting period (8/1/2015 – 6/30/2016).

Blue = Low concentration of Prenatal and Postnatal Obstetric Providers rendering services to beneficiaries who met the criteria for the AMRP and received a prenatal and postnatal obstetric service during the reporting period (8/1/2015 – 6/30/2016).

Home Health Services

DOM covers home health services for beneficiaries who are essentially homebound, under the care of a physician, and in need of home health services on an intermittent basis. The beneficiary's residence cannot include a hospital, skilled nursing facility, or a mental or criminal institution. The Division of Medicaid covers 25 home health visits per state fiscal year, July 1 – June 30. The visits may be a combination of a skilled nurse and/or home health aide, or home health aide visits will be allowed without the requirement for skilled care by a nurse.

DOM covers the cost of medical supplies reported in the medical supplies cost center of the Medicare cost report, which are directly identifiable supplies furnished to individual patients and for which a separate charge is made, in the payment for the visit. Physical therapy and speech therapy visits are not covered through the home health program for non-EPSDT beneficiaries. DOM does not cover Durable Medical Equipment (DME), orthotics, or prosthetics supplied through a home health agency. DOM pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with DOM policy, without regard to service limitations and with prior authorization.

In February 2016, CMS promulgated Face-to-Face Requirements for Home Health Services, policy changes and clarifications related to Home Health (CMS-2348-F) Final Rule (42 CFR Part 440). DOM intends to be fully compliant with the final rule effective July 1, 2017.

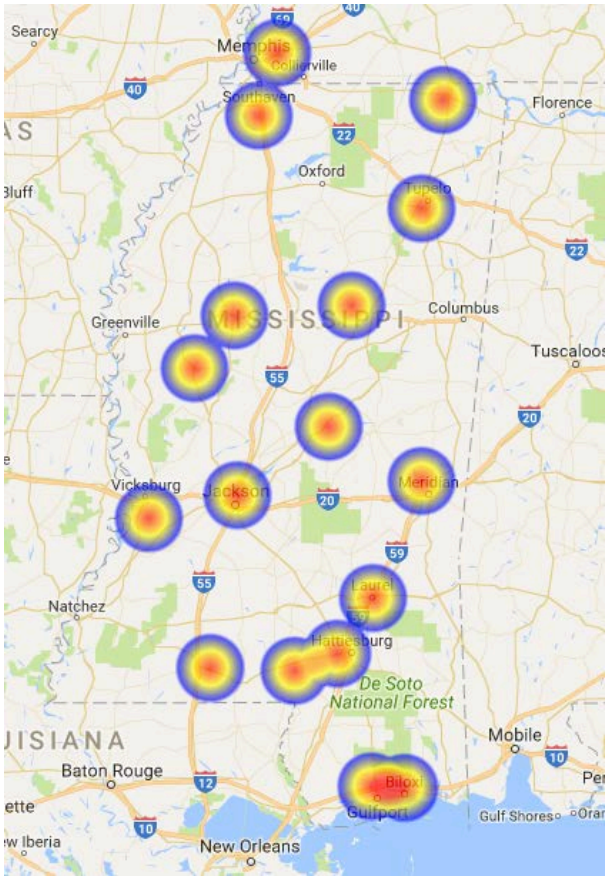
Data- Home Health Services

Revenue Code	Beneficiary Count
0270 – Medical/Surgical Supplies and Devices	20
0421 – Physical Therapy	7
0441 – Speech-Language Pathology	3
0551- Skilled Nursing	52

0571 – Home Health Aide	1
Total Unduplicated Beneficiaries	***58***

The table above represents the number of beneficiaries out of the 14,722 beneficiaries enrolled in DOM's FFS delivery system who met the criteria for the AMRP who received home health services during the reporting period (8/1/2015 – 6/30/2016). No particular access to care issue stood out in review of the home health services data.

Rendering Home Health Providers



Red = High concentration of Home Health Providers rendering services to beneficiaries who met the criteria for the AMRP and received home health services during the reporting period (8/1/2015 – 6/30/2016).

Yellow = Medium concentration of Home Health Providers rendering services to beneficiaries who met the criteria for the AMRP and received home health services during the reporting period (8/1/2015 – 6/30/2016).

Blue = Low concentration of Home Health Providers rendering services to beneficiaries who met the criteria for the AMRP and received home health services during the reporting period (8/1/2015 – 6/30/2016).

Data Sources

Data for the DOM AMRP was collected through administrative claims, beneficiary enrollment information and provider enrollment information from the Medicaid Management Information System (MMIS), and stored in the Decision Support System (DSS) data warehouse.

Provider and Beneficiary Input

DOM strives to reasonably accommodate all audiences through our communications tools, including the external website at https://medicaid.ms.gov/. The DOM website was developed with a variety of audiences in mind and includes tools to address issues for individuals who are non-English speaking, aged, disabled and/or impaired such as font size buttons, a Google language translator tool, prominent search features, a site map and it is built on a response website frame within a content management system. DOM also routinely performs Web Content Accessibility Guidelines checks to ensure adherence to web standard guidelines, as well as HTML validation to be in line with World Wide Web Consortium (W3C) standards.

Providers and beneficiaries may contact DOM by calling the main call center or submitting a form online. The main call center will route the call to the appropriate area. The DOM website contains other ways for providers and beneficiaries to contact DOM, that include: submitting a general inquiry form online, reporting fraud and abuse, submitting an official Request for Information, reporting a change in eligibility requirements, and reporting third party insurance. The DOM website also contains a list of Divisions/Topics of Interest that include: Appeals; Communications; Coordinated Care; Eligibility; Financial and Performance Audit; Human Resources; Information Technology; Legal; Long Term Care; Medical Services; Mental Health; Pharmacy; Policy and Compliance; Policy, Planning and Development; Procurement; Program Integrity; Provider Beneficiary Relations; Reimbursement; Requests for Information; and Third Party Recovery.

DOM Communications

The Office of Provider Beneficiary Relations serves as a liaison for Medicaid beneficiaries and providers for the purpose of providing assistance and education in accessing services,

providing services, and addressing claims issues. The Office of Provider Beneficiary Relations is divided into two (2) divisions: Provider Relations and Beneficiary Relations.

DOM communicates with beneficiaries, providers and employees in a variety of ways, which is illustrated in the chart below.

	Employees	Beneficiaries	Providers	Elected Officials	Mississippians
	Over 1,000	Over 780,000	Over 28,000 enrolled	52 Senators 122 Reps	Nearly 3 million
Email memos	X		X	X	
Medicaid Snapshot	X				
Medicaid Focus	X				
Media alert/news release	X	X	X	X	X
Medicaid call center		X	X	X	X
Workshops and events		X	X	X	X
Provider Bulletin			X		
Fact sheets and brochures	X	X	X	X	X
Speaker requests		X	X	X	X
Fax blast			X		
Late breaking news			X		
Remittance advice banner message			X		
External website	X	X	X	X	X
Intranet website	X				
Disaster communications	X	X	X	X	X
Requests for information		X	X	X	X
Legislative inquiries				X	
Professional associations contacts			X		

Provider Communications

The Provider Relations Division is responsible for overseeing provider outreach and education of the Mississippi Medicaid programs and any other issues related to providers. This division is responsible for assisting providers with claim issues and any other problems or questions the provider may have about the Mississippi Medicaid program. This is handled through phone calls, written correspondence, and onsite office visits.

DOM publishes and sends a quarterly newsletter, the Provider Bulletin, to enrolled Mississippi Medicaid providers. The Provider Bulletin is mailed to providers by DOM's fiscal agent, Xerox and posted on both the Envision web portal and the DOM website.

The Provider Bulletin aims to inform providers of Medicaid news and policy changes, a way to connect with our executive director, provides contact information for provider field

representatives listed by county, and more. It is published four (4) times per year, and as needed to communicate extremely important information.

All providers are held accountable for knowing of and abiding by information contained in the Provider Bulletins in accordance with DOM's Administrative Code.

In addition to the quarterly newsletter, DOM releases Late Breaking News and News and Notices for the provider community. Late Breaking News articles are posted on the Envision web portal. News and Notices are posted on the DOM website.

During calendar year 2015, Provider Relations Division handled 9,323 calls, with an average abandonment rate of 5.26% for the year. This division received 17 web inquiries and conducted a total of 40 outreach events in 2015. During the timeframe of January 2016 – July 2016, Provider Relations handled 3,528 calls, with an average abandonment rate of 3.56% for this timeframe in 2016. This division handled 25 web inquiries and conducted 6 outreach events.

Administrative Hearings for Providers

According to the provisions of Section 43-13-121 of the Mississippi Code of 1972, as amended, and the applicable federal statutes and regulations, administrative hearings shall be available to providers of services participating in the Mississippi Medicaid Program. These hearings are for providers who are dissatisfied with a decision of the Division of Medicaid relating to disallowances, withholding of funds, refusals in the renewal of a provider agreement, terminations of provider agreements, suspensions of provider participation, or matters relating to payment rates or reimbursement if not previously considered by the Division of Medicaid under Public Notice or Public Hearing Procedures. Administrative hearings are also available for providers who are terminated or denied enrollment for any of the reasons set forth in 42 C.F.R. § 455.416. *(Appendix B)*

Beneficiary Communications

DOM's Beneficiary Relations Division is responsible for conducting outreach as well as educating Medicaid beneficiaries about all Medicaid services and programs. This division travels the entire state conducting and attending various seminars, health fairs and meetings in different arenas, reaching many Medicaid beneficiaries face-to-face to reinforce understanding of the programs. These efforts are conducted in conjunction with community-based organizations, local social services agencies and other government agencies. The Beneficiary Relations Division is responsible for the provider's compliance with Title VI Civil Rights and Section 504 Rehabilitation Act

During calendar year 2015, Beneficiary Relations Division handled 61,350 calls, with an average abandonment rate of 5.50% for the year. This division handled 304 web inquiries and conducted a total of 205 outreach events in 2015 for beneficiaries. During the timeframe of January 2016 – July 2016, Beneficiary Relations handled 33,472 calls, with an average abandonment rate of 3.99% for this timeframe in 2016. This division received 302 web inquiries and conducted 149 outreach events for beneficiaries for this timeframe in 2016.

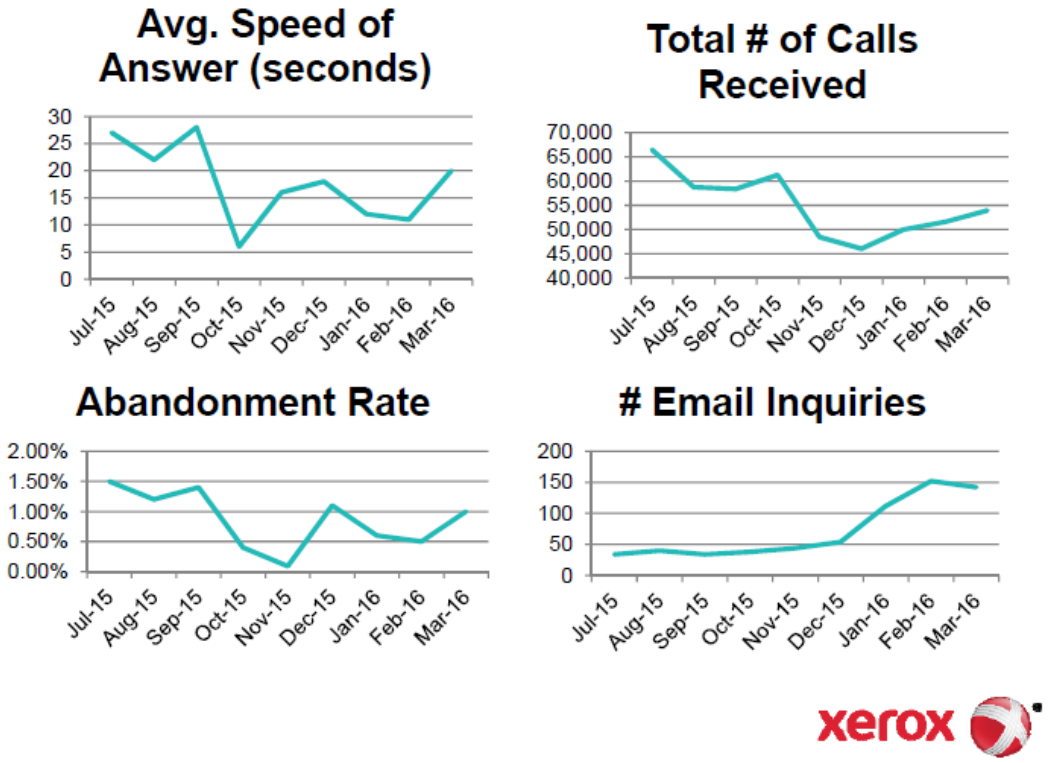
Administrative Hearings for Beneficiaries

In accordance with Section 43-13-116 of the Mississippi Code of 1972, as amended, and 42 CFR 431.200, *et seq*., DOM provides beneficiaries the opportunity to request a fair hearing in order to appeal decisions relating to denials, terminations, suspensions or reductions of Medicaid covered services. *(Appendix B)*

Xerox Call Center Provider Services Statistics

DOM's fiscal agent, Xerox, maintains a Mississippi based call center to assist providers and beneficiaries with questions related to billing, eligibility, and general operations of the MS Medicaid program.

- Total number of calls received Calendar Year 2014: 796,859
- Total number of calls received Calendar Year 2015: 731,434
- Total number of calls received January-March 2016: 155,538



Conclusion

In summary, the information contained in DOM's AMRP includes service utilization and access information regarding the 14,722 beneficiaries enrolled in DOM's FFS delivery system who met the criteria for the AMRP during the reporting period (8/1/2015 – 6/30/2016). The FFS beneficiary count was obtained, with applicable exclusions considered in the participant population, as stated in the requirements of the Final Rule. DOM also took into consideration the estimated 330,000 DOM beneficiaries that transitioned to MSCAN from May 1, 2015 to July 31, 2015. DOM intends to use the data reported in the AMRP as baseline for the reported population.

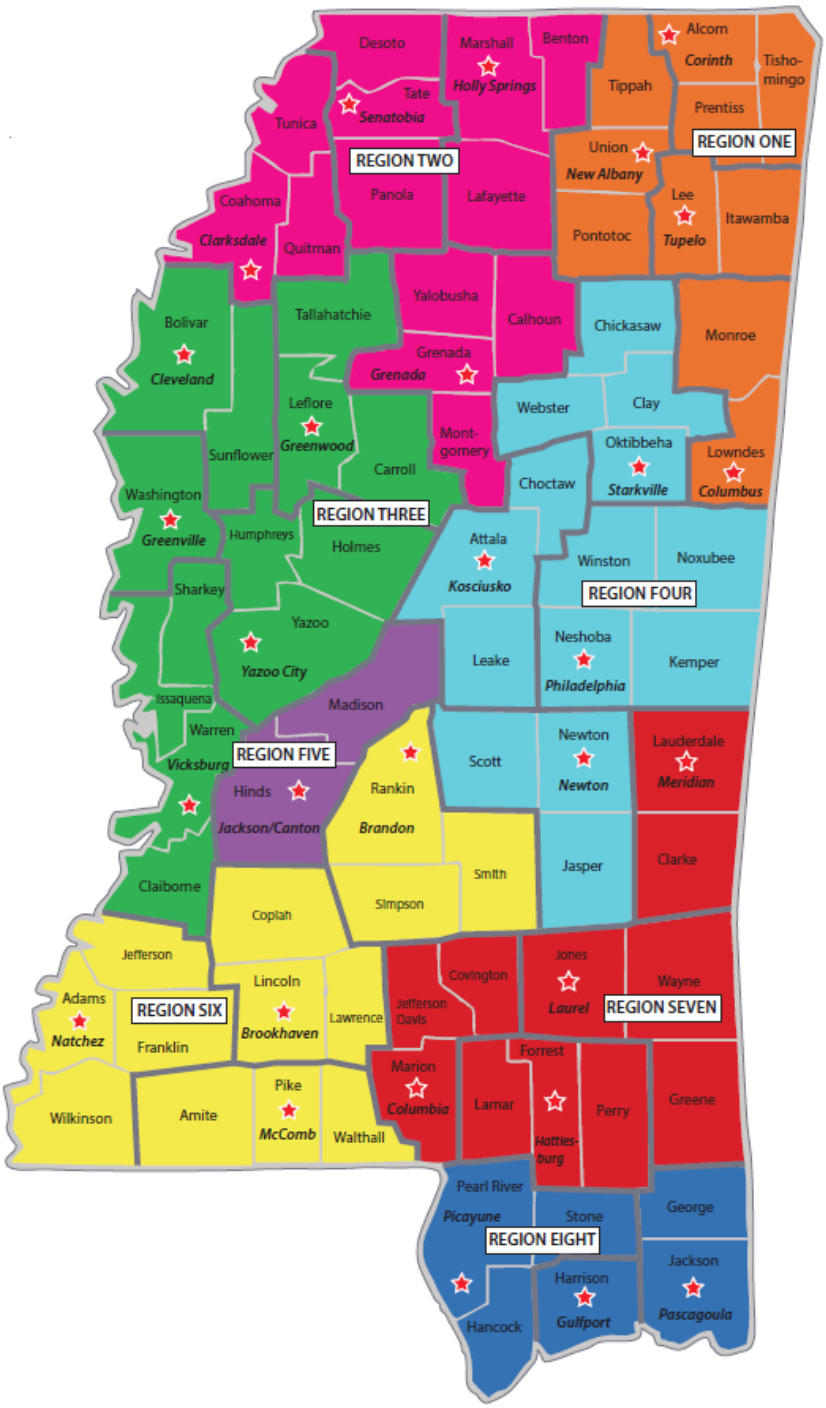
Although this report has focused on only a small subset of Mississippi Medicaid enrolled participants, utilization of services and access to services are evidenced by the data submitted in this plan. DOM has a robust system for monitoring provider payment rates which assures that payments to providers are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available.

DOM will continue to monitor utilization of services and access for the population identified in the AMRP as well as the DOM enrolled population in its entirety. As needed, DOM will develop action plans to address any identified access to care issues. DOM will

conduct in-depth analysis of the identified issue, conduct policy research, seek input from beneficiaries and collaborate with community stakeholders. After an in-depth analysis, DOM will correct the access to care issue through state plan and/or Administrative Code revisions, rate adjustments and continued provider outreach. DOM will conduct analysis of the access to care issue over a three-year period following the implementation of any State Plan Amendment.

Appendix A

MISSISSIPPI DIVISION OF MEDICAID REGIONAL OFFICES



Appendix B

RESOURCES AND LINKS

DOM Administrative Code Title 23

Mental Health
https://medicaid.ms.gov/wp-content/uploads/2014/10/AdminCode-Part_206.pdf

Appeals
https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-300.pdf

Fee Schedules and Billing Guidelines for Mental Health Services

Billing Guidelines for Psychiatry and Psychiatric Nurse Practitioners for Mental Health/Psychiatry Services
https://medicaid.ms.gov/wp-content/uploads/2014/03/MentalHealthPsychiatry.pdf

Billing Guidelines for Therapeutic and Evaluative Mental Health Services for Expanded EPSDT (T&E)
https://medicaid.ms.gov/wp-content/uploads/2015/11/TherapeuticEvaluativeMentalHealth_ExpandedEPSDT.pdf

Billing Guidelines for Community/Private Mental Health Centers (CMHC/PMHC)
https://medicaid.ms.gov/wp-content/uploads/2014/03/CommunityMentalHealthCenter.pdf

CMS Guidelines for Rural Health Clinics

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf

CMS Guidelines for Federally Qualified Health Centers

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf