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

C. Team Member Qualifications

Services provided by a quasi-governmental or private Community Mental Health Center (CMHC) must be rendered by an individual meeting the minimum qualifications as outlined in the current Mississippi Department of Mental Health (DHM) Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Use Disorders Community Service Providers and working within their scope of practice, licensure, and/or certification.

D. Rehabilitative Services

Services medically necessary for the treatment of illnesses, conditions, or injuries are provided to all eligible individuals. Services provided by a quasi-governmental or private Community Mental Health Center must be rendered by an individual meeting the minimum qualifications as outlined in the current Mississippi Department of Mental Health Operational Standards for Mental Health, Intellectual/Developmental Disabilities, And Substance Use Disorders Community Service Providers (DMH Operational Standards) and working within their scope of practice, licensure, and/or certification.

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 and treatment plan approval must meet the regulations outlined in the current DMH Operational Standards.
e. Treatment plan development and review is limited to four (4) services per state fiscal year.

2. Medication Management

a. Medication management refers to the provision of services to individuals with behavioral health needs by psychiatrists, physicians, psychiatric mental health nurse practitioners, or physician assistants in order to assess and treat their health needs by the evaluation, administration and monitoring of psychotropic medications.
b. 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. Psychosocial assessments must be completed by team members who meet the regulations outlined in the current DMH Operational Standards.
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 team members who meet the regulations outlined in the current DMH Operational Standards.
d. Psychological evaluations are limited to four (4) hours per state fiscal year.

5. Nursing Assessment

a. Nursing assessment refers to the provision of services to individuals with behavioral health needs by a registered nurse (RN) in order to assess and treat their health needs through appropriate nursing care.
b. 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 provided by and included in a treatment plan approved by the appropriate clinical team members as outlined in the current DMH Operational Standards.
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.
c. Family therapy services must be provided by and included in a treatment plan approved by the appropriate clinical team members as outlined in the current DMH Operational Standards.
d. 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.
e. Group therapy/multi-family group therapy services must be provided by and included in a treatment plan approved by the appropriate clinical team members as outlined in the current DMH Operational Standards as amended
f. 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.

d. Psychosocial rehabilitation services must be provided by and included in a treatment plan approved by the appropriate clinical team members as outlined in the current DMH Operational Standards.

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

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

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

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

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 provided by and included in a treatment plan approved by the appropriate clinical team members as outlined in the current DMH Operational Standards.

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 provided by and included in a treatment plan approved by the appropriate clinical team members as outlined in the current DMH Operational Standards.

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 purposes of crisis response services are 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.

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.

f. Crisis response services must be provided by and included in a treatment plan approved by the appropriate clinical team members as outlined in the current DMH Operational Standards.

g. 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.

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

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 of the team members must meet the regulations in the current DMH Operational Standards.

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 from 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. Peer support services must be provided by and included in a treatment plan approved by the appropriate clinical team members as outlined in the current DMH Operational Standards.
e. 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.

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

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 increases 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. Community support services must be provided by and included in a treatment plan approved by the appropriate clinical team members as outlined in the current DMH Operational Standards.
e. 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. Wraparound services must be provided by and included in a treatment plan approved by the appropriate clinical team members as outlined in the current DMH Operational Standards.

e. 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.

f. 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 psychiatric services must be provided by and included in a treatment plan approved by the appropriate clinical team members as outlined in the current DMH Operational Standards.

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.

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

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) Community support.
   8) Peer support.

d. PACT services must be provided and included in a treatment plan approved by the appropriate clinical team members as outlined in the current DMH Operational Standards.

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

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

g. 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.

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

19. Autism Spectrum Disorder (ASD) Services

Refer to Attachment 3.1-A, Exhibit 4b, Page 6.

13. Other Diagnostic, Screening, Preventive, and Rehabilitative Services: Mental Health Services described in Attachment 3.1-A, Exhibit 13.d are reimbursed as follows:

Covered services billed using Current Procedural Terminology (CPT) codes for psychiatric therapeutic procedures are reimbursed based on ninety percent (90%) of the most recent final Medicare fee schedule published by the Centers for Medicare and Medicaid Services (CMS) as of April 1 each year and effective July 1 and updated annually.

Covered services billed using Healthcare Common Procedure Coding System (HCPCS) are reimbursed according to a statewide uniform fixed fee schedule. In establishing the fee schedule, the Division of Medicaid (DOM) engaged an actuarial firm to establish fees. DOM provided service descriptions and other information for the existing mental health services offered and the proposed new services. The relationships between comparable services for Medicaid programs in other states were examined to develop factors to apply to existing Mississippi fees to calculate the new service group fees with the fees for the existing mental health services. Consideration was given to the service descriptions, required provider credentials and current costs associated with services. Preliminary fees were modified to better reflect the expected provider cost relative to other mental health services. The agency's state developed fee schedule rate is set as of July 1, 2012, and is effective for services provided on or after that date.

Covered Autism Spectrum Disorder (ASD) services are reimbursed as described in Attachment 4.19-B, Page 4b(2).

Except as otherwise noted in the plan, state-developed uniform fixed fee schedule rates are the same for both governmental and private providers of mental health rehabilitative services as described in Attachment 3.1-A, Exhibit 13.d. All rates are published on the agency's website at http://www.medicaid.ms.gov/FeeScheduleLists.aspx.

Notwithstanding any other provision of this section, the Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers for any service by five percent (5%) of the allowed amount for that service. The five percent (5%) reduction in reimbursement is made after the published rate is applied. This provision is not applicable to Indian Health Services or for services provided by the University of Mississippi Medical Center or a state agency, a state facility or a public agency that either provides its own state match through intergovernmental transfer or certification of funds to the division, or a service for which the federal government sets the reimbursement methodology and rate.

C. Team Member Qualifications

Services provided by a quasi-governmental or private Community Mental Health Center (CMHC) must be rendered by an individual meeting the minimum qualifications as outlined in the current Mississippi Department of Mental Health (DHM) Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Use Disorders Community Service Providers and working within their scope of practice, licensure, and/or certification.

~~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.~~

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

~~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

Services medically necessary for the treatment of illnesses, conditions, or injuries are provided to all eligible individuals. ~~as follows:~~ Services provided by a quasi-governmental or private Community Mental Health Center must be rendered by an individual meeting the minimum qualifications as outlined in the current Mississippi Department of Mental Health Operational Standards for Mental Health, Intellectual/Developmental Disabilities, And Substance Use Disorders Community Service Providers (DMH Operational Standards) and working within their scope of practice, licensure, and/or certification.

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 and treatment plan approval must meet the regulations outlined in the current DMH Operational Standards. ~~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~~e. Treatment plan development and review is limited to four (4) services per state fiscal year.

2. Medication Management

a. Medication management refers to the provision of services to individuals with behavioral health needs by psychiatrists, physicians, psychiatric mental health nurse practitioners, or physician assistants in order to assess and treat their health needs by the evaluation, administration and monitoring of psychotropic medications.

~~b. Medication management 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~~b. 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.~~ Psychosocial a~~A~~ssessments must be completed by team members who meet the regulations outlined in the current DMH Operational Standards.

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~~ by team members who meet the regulations outlined in the current DMH Operational Standards.

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.~~ refers to the provision of services to individuals with behavioral health needs by a registered nurse (RN) in order to assess and treat their health needs through appropriate nursing care.

~~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.~~b. 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 provided by and included in a treatment plan approved by the appropriate clinical team members as outlined in the current DMH Operational Standards. ~~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~~c. Family therapy services must be provided by and included in a treatment plan approved by the appropriate clinical team members as outlined in the current DMH Operational Standards. ~~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.~~
~~e~~d. 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.

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

~~f~~e. Group therapy/multi-family group therapy services must be provided by and included in a treatment plan approved by the appropriate clinical team members as outlined in the current DMH Operational Standards as amended ~~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~~f. 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~~d. Psychosocial rehabilitation services must be provided by and included in a treatment plan approved by the appropriate clinical team members as outlined in the current DMH Operational Standards. ~~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~~e. 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~~f. Psychosocial rehabilitation is limited to five (5) hours per day, five (5) days a week.

~~f~~g. 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 provided by and included in a treatment plan approved by the appropriate clinical team members as outlined in the current DMH Operational Standards. ~~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 provided by and included in a treatment plan approved by the appropriate clinical team members as outlined in the current DMH Operational Standards. ~~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 purposes of crisis response services are 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 r~~R~~esponse s~~S~~ervices must be available by phone with a mobile crisis response team twenty-four (24) hours a day, seven (7) days a week.

~~h~~f. Crisis response services must be provided by and included in a treatment plan approved by the appropriate clinical team members as outlined in the current DMH Operational Standards. ~~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~~g. Crisis r~~R~~esponse 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 of the team members must ~~include one of the following: a psychiatrist, physician, psychologist, LCSW, LMSW, LPC, LMFT, PMHNP, PA, RN, CMHT, CIDDT, and CAT.~~ meet the regulations in the current DMH Operational Standards.

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

g. Crisis r~~R~~esidential service is limited to sixty (60) days per state fiscal year.

h. Service does not include room and board (payment).

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

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 from 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~~d. Peer support services must be provided by and included in a treatment plan approved by the appropriate clinical team members as outlined in the current DMH Operational Standards. ~~one of the following team members: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP or PA.~~

~~f~~e. 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.

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

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 increases 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.~~d. Community support services must be provided by and included in a treatment plan approved by the appropriate clinical team members as outlined in the current DMH Operational Standards. ~~one of the following team members: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP or PA.~~

~~f.~~e. 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.~~d. Wraparound services must be provided by and included in a treatment plan approved by the appropriate clinical team members as outlined in the current DMH Operational Standards. ~~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.~~e. 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.~~f. 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 t~~T~~reatment.
   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 psychiatric services must be provided by and included in a treatment plan ~~and~~ approved by the appropriate clinical team members as outlined in the current DMH Operational Standards. ~~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~~)7) ~~—~~Community support.
   ~~9~~8) 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~~d. PACT services must be provided and included in a treatment plan approved by the appropriate clinical team members as outlined in the current DMH Operational Standards. ~~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~~e. Services must be prior authorized as medically necessary by the UM/QIO.

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

~~h~~g. 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.

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

19. Autism Spectrum Disorder (ASD) Services

Refer to Attachment 3.1-A, Exhibit 4b, Page 6.

13. Other Diagnostic, Screening, Preventive, and Rehabilitative Services: Mental Health Services described in Attachment 3.1-A, Exhibit 13.d are reimbursed as follows:

Covered services billed using Current Procedural Terminology (CPT) codes for psychiatric therapeutic procedures are reimbursed based on ninety percent (90%) of the most recent final Medicare fee schedule published by the Centers for Medicare and Medicaid Services (CMS) as of April 1 each year and effective July 1 and updated annually.

Covered services billed using Healthcare Common Procedure Coding System (HCPCS) are reimbursed according to a statewide uniform fixed fee schedule. In establishing the fee schedule, the Division of Medicaid (DOM) engaged an actuarial firm to establish fees. DOM provided service descriptions and other information for the existing mental health services offered and the proposed new services. The relationships between comparable services for Medicaid programs in other states were examined to develop factors to apply to existing Mississippi fees to calculate the new service group fees with the fees for the existing mental health services. Consideration was given to the service descriptions, required provider credentials and current costs associated with services. Preliminary fees were modified to better reflect the expected provider cost relative to other mental health services. The agency's state developed fee schedule rate is set as of July 1, 2012, and is effective for services provided on or after that date.

Covered Autism Spectrum Disorder (ASD) services are reimbursed as described in Attachment 4.19-B, Page 4b(2).

Except as otherwise noted in the plan, state-developed uniform fixed fee schedule rates are the same for both governmental and private providers of mental health rehabilitative services as described in Attachment 3.1-A, Exhibit 13.d. All rates are published on the agency's website at http://www.medicaid.ms.gov/FeeScheduleLists.aspx.

Notwithstanding any other provision of this section, the Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers for any service by five percent (5%) of the allowed amount for that service. The five percent (5%) reduction in reimbursement is made after the published rate is applied. This provision is not applicable to Indian Health Services or for services provided by the University of Mississippi Medical Center or a state agency, a state facility or a public agency that either provides its own state match through intergovernmental transfer or certification of funds to the division, or a service for which the federal government sets the reimbursement methodology and rate.