State of Mississippi

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

TARGETED CASE MANAGEMENT FOR CHRONICALLY MENTALLY ILL COMMUNITY BASED RECIPIENTS.

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

_X_ Target group includes individuals transitioning to a community setting. Case- management services will be made available for up to thirty (30) consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions.

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

_X_ Entire State;

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

C. Comparability of Services:

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

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

D. Definition of Services:

Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
  - Assessments are conducted within one week of referral or at least forty-eight (48) hours prior to discharge from an inpatient facility.
  - Reassessments are conducted at least annually and more often if medically necessary.

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

  - Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
    - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- ❖ Monitoring and follow-up activities:
    - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
      - services are being furnished in accordance with the individual's care plan;
      - services in the care plan are adequate; and
      - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
    - Case managers have monthly contact with the beneficiary via telephone and quarterly face-to-face visits.

_X_ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

E. Qualifications of Providers:

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

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

F. Freedom of Choice Exception:

_X____Target group consists of eligible individuals with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with chronic mental illness receive needed services:

Targeted case management services are provided by case managers employed by Community Mental Health Centers (CMHCs) or Private Mental Health Centers (PMHCs). Targeted case management services provided by CMHCs and PMHCs are certified by the Mississippi Department of Mental Health.

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

H. Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

I. Limitations:

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

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

~~**State of Mississippi**~~

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

~~19a Targeted case management services to chronic:ally mentally ill community based recipients.~~

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

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

State of Mississippi

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

TARGETED CASE MANAGEMENT FOR CHRONICALLY MENTALLY ILL COMMUNITY BASED RECIPIENTS.

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

 X Target group includes individuals transitioning to a community setting. Case- management services will be made available for up to thirty (30) consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions.

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

 X Entire State;

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

C. Comparability of Services:

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

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

D. Definition of Services:

~~Case management is the provision and coordination of services which are an integral part of aiding eligible recipients to gain access to needed medical, social, educational and otb.er services in order to attain their highest level of independent functioning. Case management services provide to the maximum extent possible that the person served has access to all available resources and receives available services necessary to reach and maintain an optimal level of functioning. Activities include client identification, assessment, reassessments, service planning, linkage to needed services, monitoring service delivery, supportive counseling and outreach services designed to seek out persons who have been screened and refer-red for case management and to make every effort to engage such persons in the receipt of case management services.~~
Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
  - Assessments are conducted within one week of referral or at least forty-eight (48) hours prior to discharge from an inpatient facility.
  - Reassessments are conducted at least annually and more often if medically necessary.

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

  - Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
    - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- ❖ Monitoring and follow-up activities:
    - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
      - services are being furnished in accordance with the individual's care plan;
      - services in the care plan are adequate; and
      - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
    - Case managers have monthly contact with the beneficiary via telephone and quarterly face-to-face visits.

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

E. Qualifications of Providers:

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

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

F. Freedom of Choice Exception:

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

1. ~~Case management services will be available at the option of the eligible recipient .~~
2. ~~An eligible recipient who wishes to receive case management services will have free choice to receive case management services from any qualified provider of these services .~~
3. ~~Eligible recipients will have free choice of the providers of other medical care as covered elsewhere in this Plan.~~

_X_ Target group consists of eligible individuals with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with chronic mental illness receive needed services:

Targeted case management services are provided by case managers employed by Community Mental Health Centers (CMHCs) or Private Mental Health Centers (PMHCs). Targeted case management services provided by CMHCs and PMHCs are certified by the Mississippi Department of Mental Health.

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

H. Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

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

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))