

State of Mississippi

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

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)): Pregnant women and post-partum women up to sixty (60) days post-partum who are at risk of morbidity or mortality from unstable medical and/or mental health conditions.

Target group includes individuals transitioning to a community setting. Case- management services will be made available for up to 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). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):

- Entire State
 Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

- Services are provided in accordance with §1902(a)(10)(B) of the Act.
 Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- ❖ 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;

The Initial Health Risk Assessment must be completed within fifteen (15) calendar days after the referral is received for TCM. Case managers must make contact with the beneficiary at least monthly to ensure the beneficiary's needs are being addressed.

- ❖ 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 healthcare decision maker) and others to develop those goals; and

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- 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.

Monitoring and follow up activities must be completed at least monthly, and more often as necessary.

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

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Provider agency or entity of targeted case management services for pregnant and postpartum women, up to sixty (60) days post-partum, must comply with the requirements to enroll as a Mississippi Medicaid Provider and meet the following qualifications:

1. Have a minimum of two (2) years' experience providing comprehensive case management services to the target population,
2. Have an established system to coordinate services for Medicaid beneficiaries,
3. Have demonstrated programmatic and administrative experience in providing comprehensive case management services,
4. Have established referral systems, demonstrated linkages, and referral ability with essential social and health services agencies,
5. Employ registered nurses to provide TCM with the following qualifications:

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- a. Be licensed by the Mississippi Board of Nursing and in good standing,
- b. Have one (1) year documented experience working with the target population,
- c. Have documented experience, skills or training in crisis intervention, effective communication and culture diversity and competency,
- d. Have access to multi-disciplinary staff when needed, and
- e. Possess knowledge of resources for the service community.

Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

_____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of casemanagement services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):

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

Case Records (42 CFR 441.18(a)(7)):

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

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case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

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: MISSISSIPPI

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Targeted Case Management

Targeted Case Management for High-Risk Pregnant Women is paid a monthly rate from a statewide uniform fee schedule. Services listed on the beneficiary's plan of care are reimbursed according to the payment methodology for that service. Effective July 1, 2021, the fees will remain the same as those effective as of July 1, 2021.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of targeted case management. All rates are published on the agency's website at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#.

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- d. Have access to multi-disciplinary staff when needed, and
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- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

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

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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: MISSISSIPPI

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Targeted Case Management

~~1. Targeted Case Management for High-Risk Pregnant Women—The case management fee is a negotiated rate of payment. Potential providers indicated participation was contingent upon establishing a fee that allowed them to recover the cost of providing the services recognizing the additional effort required to initialize each case. The rate will be evaluated annually. is paid a monthly rate from a statewide uniform fee schedule. Services listed on the beneficiary’s plan of care are reimbursed according to the payment methodology for that service. Effective July 1, 2021, the fees will remain the same as those effective as of July 1, 2021.~~

~~2. Targeted Case Management for High Risk Infants—The case management fee is based upon the current negotiated fee of:~~

~~\$12.00 for open and ongoing EPSDT case management contracts~~

~~\$6.00 for closure of EPSDT case management~~

~~3. All services—In the case of a public agency, reimbursement determined to be in excess of cost will be recouped by means of a rate adjustment for the next year.~~

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of targeted case management. All rates are published on the agency’s website at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#.

~~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.~~