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

Telehealth Service

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

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

3) Telehealth service must be delivered in a real-time communication method that is Health Insurance Portability and Accountability Act (HIPAA) compliant and is:
    a. Live;
    b. Interactive; and
    c. Audiovisual.

4) The originating or spoke site is defined as the physical location of the beneficiary at the time the telehealth service is provided via telecommunications system. Telehealth services are covered in the following originating sites:
    a. Office of a physician or practitioner;
    b. Outpatient Hospital (including a Critical Access Hospital (CAH));
    c. Rural Health Clinic (RHC);
    d. Federally Qualified Health Center (FQHC);
    e. Community Mental Health/Private Mental Health Centers;
    f. Mississippi State Department of Health (MSDH) clinics,
    g. Therapeutic Group Homes;
    h. Indian Health Service Clinic;
    i. School-based clinic,
    j. School which employs a school nurse licensed as a Mississippi Registered Nurse,
    k. Inpatient hospital, and
    l. Beneficiary home.

5) The distant or hub site is defined as the physical location of the provider delivering the telehealth service via telecommunications system. The following provider types are allowed to render telehealth services as a distant site:
    a. Physicians,
    b. Physicians Assistants,
    c. Nurse Practitioners,
    d. Psychologists,
    e. Licensed Clinical Social Workers (LCSWs),
    f. Professional Counselors (LPCs),
    g. Licensed Marriage and Family Therapists (LMFTs),
    h. Board Certified Behavior Analysts (BCBAs) or Board Certified Behavior Analyst-Doctorals (BCBA-Ds),
    i. Community Mental Health Centers (CMHCs),
    j. Private Mental Health Centers,
    k. Federally Qualified Health Centers (FQHCs),
    l. Rural Health Centers (RHCs),
    m. Therapists: Speech, Occupational and Physical, and
    n. Mississippi State Department of Health (MSDH) clinics.

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

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

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

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

   Provided: ☐ No Limitations ☒ With Limitations

2. a. Outpatient hospital services.

   Provided: ☐ No Limitations ☒ With Limitations

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

   Provided: ☐ No Limitations ☒ With Limitations

   ☐ Not Provided

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

   Provided: ☐ No Limitations ☒ With Limitations

3. Other laboratory and x-ray services.

   Provided: ☐ No Limitations ☒ With Limitations

State/Territory: MISSISSIPPI

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

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

Provided: No limitations X With limitations

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

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

Provided: No limitations X With limitations*

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

Provided: No limitations X With limitations*

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

Provided: No limitations X With limitations*

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

Provided: No limitations X With limitations*

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

a. Podiatrists' services.

Provided: No limitations X With limitations *

Not provided ___

* Description provided on attachment.

State of Mississippi

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

b. Optometrists' services.

___ Provided: ___ No limitations ___ With limitations*

_X_ Not Provided

c. Chiropractor's services.

_X_ Provided: ___ No limitations ___ With limitations

___ Not provided.

d. Other practitioners' services.

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

___ Not provided.

7. Home health services.

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

Provided: ___ No limitations _X_ With limitations*

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

Provided: ___ No limitations _X_ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place, other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities except when the facility is not required to provide the home health service, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Provided: ___ No limitations _X_ With limitations*

*Description provided on attachment.

State of Mississippi

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

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

__Provided: __ No limitations __ With limitations*

_X_ Not provided.

8. Private duty nursing services.

__ Provided: __ No limitations __ With limitations*

__X__Not provided.

*Description provided on attachment.

State Mississippi

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

9. Clinic services.

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

[ ] Not provided.

10. Dental services.

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

[ ] Not provided.

11. Physical therapy and related services.

a. Physical therapy.

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

[ ] Not provided.

b. Occupational therapy.

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

[ ] Not provided.

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

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

[ ] Not provided.

*Description provided on attachment.

State Mississippi

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

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

a. Prescribed drugs.

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

[ ] Not provided.

b. Dentures.

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

[x] Not provided.

c. Prosthetic devices.

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

[ ] Not provided.

d. Eyeglasses.

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

[ ] Not provided.

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

a. Diagnostic services.

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

[ ] Not provided.

*Description provided on attachment.

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

b. Screening services.

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

/_/ Not provided.

c. Preventive services.

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

/_/ Not provided.

d. Rehabilitative services.

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

/_/ Not provided.

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

a. Inpatient hospital services.

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

/X/ Not provided.

b. Nursing facility services.

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

/X/ Not provided.

*Description provided on attachment.

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

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

Provided: ☐ No Limitations ☒ With Limitations*

☐ Not Provided

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

Provided: ☐ No Limitations ☒ With Limitations*

☐ Not Provided

17. Nurse-midwife services.

Provided: ☐ No Limitations ☒ With Limitations*

☐ Not Provided

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

Provided: ☐ No Limitations ☒ With Limitations*

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

☐ Not Provided

*Description provided on attachment

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

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

19. Case management services and Tuberculosis related services

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

X Provided: X With limitations

___ Not provided.

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

___ Provided: ___ With limitations*

X Not provided.

20. Extended services for pregnant women

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

X Additional coverage ++

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

___ Additional coverage ++

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

*Description provided on attachment.

State/Territory: Mississippi

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

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

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

/X/ Not provided.

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

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

/X/ Not provided.

23. Certified Pediatric or family nurse practitioners' services.

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

*Description provided on attachment.

State/ Territory: Mississippi

AMOUNT, DURATION, AND SCOPE OF MEDICAL

AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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

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

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

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

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

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

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

*Description provided on attachment.

State: Mississippi

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

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

_____ provided __X__ not provided

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State _____Mississippi_____

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

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

Provided: ____ No limitations ____With limitations __X__None licensed or approved

Please describe any limitations:

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

Provided: ___No limitations ___With limitations (please describe below)

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

Please describe any limitations:

Please check all that apply:

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

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

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

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

State/Territory: MS

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

CATEGORICALLY NEEDY GROUP(S)

30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

*The state needs to check each assurance below.

Provided: ___X___

I. General Assurances:

Routine Patient Cost – Section 1905(gg)(1)

_X_ Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

_X_ A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

_X_ A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

Inpatient Hospital Services

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

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

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 3.1-A
Exhibit 1a

STATE Mississippi

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

1a. Inpatient Hospital Services - Swing Bed:

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

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

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

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

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

TN # 93-08

Supersedes TN # NEW

Date Received
Date Approved APR 11 1995
Date Effective JUL 01 1993

State of Mississippi

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

2a. Outpatient Hospital Services

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

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

Emergency room services are allowed for all beneficiaries without limitations.

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

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

2b. Rural Health Clinic Services:

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

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

Scope of Services

A. Staffing Requirements

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

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

B. Direct Services

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

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

State of Mississippi

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

C. Encounter

1. An encounter is also referred to as a visit. An encounter at an RHC is a face-to-face visit between a clinic beneficiary and any health professional whose services are reimbursed as one (1) of the following under the State Plan.

   a. A medical encounter is a face-to-face visit between a beneficiary and a physician, physician assistant, nurse practitioner, or nurse midwife for the provision of medical services.

   b. A mental health encounter is a face-to-face visit between a beneficiary and a physician, nurse practitioner, physician assistant, clinical psychologist, licensed clinical social worker (LCSW), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT) or board certified behavior analyst for the provision of mental health services.

   c. A dental encounter is a face-to-face visit between a beneficiary and a dentist for the provision of dental services.

   d. A vision encounter is a face-to-face visit between a beneficiary and an ophthalmologist, optometrist, physician, nurse practitioner or physician assistant for the provision of vision services.

2. Encounters with more than one health professional for the same type of service or more than one encounter with the same health professional, which take place on the same day and at a single location constitute a single encounter, except when one of the following circumstances occur:

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

   b. The beneficiary has a combination of a medical encounter, mental health encounter, dental encounter, and/or vision encounter that are each a separate identifiable service. or

   c. The beneficiary has an initial preventative physical exam encounter and a separate medical, mental health, dental or vision encounter on the same day. .

3. Home Encounters

   A home encounter is covered as a face-to-face visit when performed within a rural area in the county or an adjacent county where the RHC is located.

State of Mississippi

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

4. RHC Mobile Unit Encounters are covered when the mobile unit meets the following criteria:

   a. Must be surveyed by the Mississippi Department of Health (MSDH) and receive an approval letter from the Centers for Medicare and Medicaid Services (CMS) prior to providing services.

   b. Must meet all federal and state requirements for RHC mobile units.

   c. Must have a fixed set of locations where the mobile unit is scheduled to provide services at specified dates and times.

      1) Locations for RHC mobile unit services must meet the rural and shortage area requirements at the time of survey.

      2) The schedule of times and locations must be posted on the mobile unit and publicized by other means so that beneficiaries will know the mobile unit's schedule in advance.

   d. Must operate:

      1) Within rural areas in the county or an adjacent county where the affiliated RHC has a permanent structure.

      2) If the RHC has no permanent structure, within rural areas in the county or adjacent county of the initial CMS approved locations.

      3) Mobile units must have a separate Mississippi Medicaid provider number from the affiliated RHC.

State of Mississippi

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

E. Telehealth services – refer to Attachment 3.1-A Introductory Pages

F. Non-Covered Services

1. RHC services are not covered when performed in a:

   a. Hospital (inpatient or outpatient).

   b. Nursing facility.

2. A physician employed by an RHC and rendering services to beneficiaries in a hospital must bill under the physician's individual provider number.

3. A school setting for the purpose of providing EPSDT well-child screenings.

4. Group therapy.

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

2c. Federally Qualified Health Centers Services:

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

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

Scope of Services

A. Staffing Requirements

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

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

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

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

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

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

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

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

B. Direct Services

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

C. Encounter

1. An encounter is also referred to as a visit. An encounter at a FQHC is a face-to-face visit between a beneficiary and any health professional whose services are reimbursed as one (1) of the following under the State Plan.

   a. A medical encounter is a face-to-face visit between a beneficiary and a physician, physician assistant, nurse practitioner, or nurse midwife for the provision of medical services.

   b. A mental health encounter is a face-to-face visit between a beneficiary and a physician, psychiatrist, psychiatric mental health nurse practitioner, nurse practitioner, physician assistant, clinical psychologist, licensed clinical social worker (LCSW), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), or board certified behavior analyst for the provision of mental health services.

   c. A dental encounter is a face-to-face visit between a beneficiary and a dentist for the provision of dental services.

   d. A vision encounter is a face-to-face visit between a beneficiary and an ophthalmologist, optometrist, physician, nurse practitioner or physician assistant for the provision of vision services.

2. Encounters with more than one health professional for the same type of service or more than one encounter with the same health professional, which take place on the same day and at a single location constitute a single encounter, except when one of the following circumstances occur:

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

b. The beneficiary has a combination medical encounter, mental health encounter, dental encounter, and/or vision encounter that are each a separate identifiable service.

c. The beneficiary has an initial preventative physical exam encounter and a separate medical, mental health, dental or vision encounter on the same day.

3. Home Encounters

A home encounter is covered as a face-to-face visit when performed within a rural area in the county or an adjacent county where the FQHC is located.

4. FQHC Mobile Unit Encounters are covered when the mobile unit meets the following criteria:

a. Must be surveyed by the Mississippi Department of Health (MSDH) and receive an approval letter from the Centers for Medicare and Medicaid Services (CMS) prior to providing services.

b. Must meet all federal and state requirements for FQHC mobile units.

c. Must have a fixed set of locations where the mobile unit is scheduled to provide services at specified dates and times.

1) Locations for FQHC mobile unit services must meet the rural and shortage area requirements at the time of survey.

2) The schedule of times and locations must be posted on the mobile unit and publicized by other means so that beneficiaries will know the mobile unit's schedule in advance.

d. Must operate:

1) Within rural areas in the county or an adjacent county where the affiliated FQHC has a permanent structure.

2) If the FQHC has no permanent structure, within rural areas in the county or an adjacent county of the initial CMS approved locations.

3) Mobile units must have a separate Mississippi Medicaid provider number from the affiliated FQHC.

E. Non-Covered Services

1. FQHC services are not covered when performed in a:

   a. Hospital (inpatient or outpatient).

   b. Nursing Facility.

2. A physician employed by an FQHC and rendering services to clinic patients in a hospital must bill under the physician's individual provider number.

3. A school setting for the purpose of providing EPSDT well-child screenings.

4. Group therapy.

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

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

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

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4a. Nursing Facility Services:

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

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

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

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

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

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

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

EPSDT Screenings:

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

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

EPSDT screenings must be provided by currently enrolled Mississippi Medicaid providers who have signed an EPSDT specific provider agreement and must adhere to the periodicity schedule of the American Academy of Pediatrics (AAP) Bright Futures. EPSDT screening providers include, but are not limited to:

1. The Mississippi State Department of Health (MSDH),
2. Public schools and/or public school districts certified by the Mississippi Department of Education,
3. Physicians,
4. Physician Assistants,
5. Nurse Practitioners,
6. Federally Qualified Health Centers (FQHC),
7. Rural Health Clinics (RHC), and
8. Comprehensive health clinics.

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

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

I. **Medical Risk Assessment**

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

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

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

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

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

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

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

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

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

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III. Medical Necessity

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

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

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

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IV. Rehabilitative Services

42 CFR 441.57

42 CFR 440.130 (d)

Medically necessary rehabilitative services recommended by a physician or licensed practitioner of the healing arts include a range of coordinated services provided to EPSDT-eligible beneficiaries to correct, reduce or prevent further deterioration of identified deficits in the EPSDT-eligible beneficiary's mental health and are intended to restore an EPSDT-eligible beneficiary to their maximum functioning. Medically necessary services are those that have been ordered by a physician or other licensed practitioner.

A. Rehabilitative services include the services listed in Attachment 3.1-A, Exhibit 13d without regard to limitations and services to correct deficits that are identified through comprehensive screening, assessment and evaluations by enrolled qualified providers and must:

1. Be provided by an enrolled Mississippi Division of Medicaid provider that is operating within the scope of their license and/or certification.

2. Be face-to-face with the beneficiary except for treatment plan development and review,

3. Be medically necessary,

4. Address identified problems allowing the beneficiary to attain the highest level of functioning, and

5. Be provided in a community-based setting.

B. Rehabilitative services listed below are covered when ordered by an enrolled physician or other licensed practitioner operating within their scope of practice and prior authorized as medically necessary by the UM/QIO. These include but are not limited to:

1. Day Treatment Services are covered for EPSDT-eligible beneficiaries when the service and provider meet the following requirements:

a. Day treatment is defined a behavioral intervention and strengths-based program using counseling, retraining and modeling while provided in the context of a therapeutic milieu, to treat serious emotional disturbances or autism/Asperger's syndrome.

b. The clinical purpose of day treatment is to improve emotional, behavioral, and social 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 of day treatment include:
   1) Treatment plan development and review.
   2) Skill building groups such as social skills training, self-esteem building, anger control, conflict resolution and daily living skills.

d. Day treatment programs must be certified to operate by the Mississippi Department of Mental Health.

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

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

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

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

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

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

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Autism Spectrum Disorder (ASD) Services

A. Pursuant to 42 C.F.R. § 440.60 Other Licensed Practitioners (OLP), the following licensed qualified health care practitioners (QCHP), working within their scope of practice and licensure, may provide Autism Spectrum Disorder (ASD) services:
   a) Licensed Physician,
   b) Licensed Psychologist,
   c) Mental Health Nurse Practitioner,
   d) Licensed Clinical Social Worker (LCSW),
   e) Licensed Professional Counselor (LPC), or
   f) Board Certified Behavior Analyst (BCBA).

B. The following unlicensed practitioners may provide ASD services under the supervision of a QHCP:
   a) A Board Certified assistant Behavior Analyst (BCaBA) who has a current and active certification from the Behavior Analyst Certification Board and is licensed by the Mississippi Board of Autism to practice under the supervision of a MS licensed BCBA, or

   b) A Registered Behavior Technician (RBT) who has a current and active certification from the Behavior Analyst Certification Board and who is under the direct supervision and direction of a BCBA or BCaBA.

C. The state assures that:
   a) Supervision is included in the state's scope of practice act for the licensed practitioners,
   b) Licensed practitioners assume professional responsibility for the services provided by the unlicensed practitioners,
   c) Licensed practitioners are able to furnish the services being provided, and
   d) Licensed practitioners bill for the services provided by the unlicensed practitioners.

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Prescribed Pediatric Extended Care (PPEC) Services

The Division of Medicaid covers pediatric extended care services prescribed by a child's attending physician when medically necessary, prior authorized by the Division of Medicaid's Utilization Management/Quality Improvement Organization (UM/QIO) or a contracted Coordinated Care Organization's (CCO's) UM/QIO when the child:

1. Is medically dependent or technologically dependent, and

2. Has complex medical conditions that require continual care.

Prescribed Pediatric Extended Care (PPEC) Service is defined as an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) expanded benefit for EPSDT-eligible beneficiaries diagnosed with a medically-complex, medically fragile condition and who are medically dependent and/or technology dependent requiring continual care as prescribed by the beneficiary's attending physician.

PPEC services include at a minimum: development, implementation and monitoring of a comprehensive protocol of care, developed in conjunction with the parent or guardian, which specifies the medical, nursing, psychosocial and developmental therapies required by the medically dependent or technologically dependent child served as well as the caregiver training needs of the child's legal guardian.

PPEC services must be provided by MS Medicaid enrolled PPEC Centers, licensed by the Mississippi State Department of Health (MSDH), and adhere to the MSDH Minimum Standards of Operation of PPEC Centers.

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Private Duty Nursing (PDN) Services

The Division of Medicaid covers medically necessary private duty nursing (PDN) services for Early and Periodic Screening, Diagnosis and Treatment (EPSDT)-eligible beneficiaries when ordered by the beneficiary's primary physician or appropriate physician specialist and prior authorized by the Division of Medicaid's Utilization Review/Quality Improvement Organization (UM/QIO) or a contracted Coordinated Care Organization's (CCO's) UM/QIO.

PDN services are defined as skilled nursing care services for EPSDT-eligible beneficiaries who require more individualized and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility.

PDN services must be provided by a Mississippi Medicaid enrolled PDN provider and comply with the provider requirements specified by the Division of Medicaid.

Personal Care Services (PCS)

The Division of Medicaid covers medically necessary personal care services (PCS) for Early and Periodic Screening, Diagnosis and Treatment (EPSDT)-eligible beneficiaries when ordered by the beneficiary's primary physician and prior authorized by the Division of Medicaid's Utilization Review/Quality Improvement Organization (UM/QIO) or a contracted Coordinated Care Organization's (CCO's) UM/QIO.

PCS are medically necessary personal care services for EPSDT-eligible beneficiaries who require assistance in order to safely perform the activities of daily living (ADLs) due to a diagnosed condition, disability, or injury. The delivery and receipt of these services must be medically necessary for the treatment of the beneficiary's condition, disability, or injury and exceed the level of care available through the home health benefit.

PCS services must be provided by a Mississippi Medicaid enrolled PDN provider and comply with the provider requirements specified by the Division of Medicaid.

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The Division of Medicaid covers medically necessary Mississippi Youth Programs Around the Clock (MYPAC) Therapeutic Services

a. MYPAC Therapeutic services are defined as treatment provided in the home or community to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible beneficiaries that require the level of care provided in a psychiatric residential treatment facility (PRTF) for family stabilization to empower the beneficiary to achieve the highest level of functioning. These are a group of therapeutic interventions designed to diffuse the current crisis, evaluate its cause, and intervene to reduce the likelihood of a recurrence.
b. The clinical purpose of MYPAC therapeutic 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 MYPAC therapeutic services, based on an all- inclusive model that covers all mental health services the individual may need, includes:
    1) Treatment plan development and review which is defined as the development and review of an overall plan that directs the treatment and support of the person receiving services by qualified providers.
    2) Medication management which includes the evaluation and monitoring of psychotropic medications.
    3) Intensive individual therapy defined as one-on-one therapy for the purpose of treating a mental disorder and family therapy defined as therapy for the family which is exclusively directed at the beneficiary's needs and treatment provided in the home. Family therapy involves participation of non-Medicaid eligible for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.
    4) Group therapy defined as face-to-face therapy addressing the needs of several beneficiaries within a group.
    5) Peer support services defined as non-clinical activities with a rehabilitation and resiliency/recovery focus that allow a person receiving of mental health services and substance use disorders services and their family members the opportunity to build skills for coping with and managing psychiatric symptoms, substance use issues and challenges associated with various disabilities while directing their own recovery.
    6) Skill building groups such as social skills training, self-esteem building, anger control, conflict resolution and daily living skills.
d. MYPAC therapeutic services must be included in a treatment plan and approved by one of the following team members: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, or PA. Team members who may provide day treatment include: a LMSW, CMHT, CIDDT, or CAT.
e. Services must be prior authorized as medically necessary by the UM/QIO.
f. MYPAC therapeutic services must be provided by a Mississippi Department of Mental Health certified provider within the scope of their license and/or certification. Qualifications for providers of each service component is described in Attachment 3.1-A, Exhibit 13d.

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

(i) By or under supervision of a physician;

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

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

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

Provided: □ No limitations* □X With limitations**

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

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

Please describe any limitations:

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

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5. The Division of Medicaid covers Physicians' Services, including those that an optometrist is legally authorized to perform within their scope of practice, with the following limitations:

   Hospital physician visits are limited to one (1) per day, except hospital physician visits to beneficiaries in Intensive or Coronary Care Units (ICU or CCU) are limited to two (2) per day. The Division of Medicaid covers additional medically necessary inpatient hospital physician visits with prior authorization from the Division of Medicaid or designee.

   Hospital emergency department (ED) physician visits are not limited.

   Nursing facility physician visits are limited to thirty-six (36) per state fiscal year (SFY).

   Physician office visits and hospital outpatient department physician visits are limited to:

   - For non-psychiatric physician visits a combined total of sixteen (16) visits per SFY.
   - For psychiatric physician visits a combined total of sixteen (16) visits per SFY.

   Physician services for EPSDT beneficiaries, if medically necessary, which exceed the limitations of the State Plan are covered with prior authorization from the Division of Medicaid or designee.

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5b Medical and surgical services by a dentist

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

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

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

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6d. Other Practitioners' Services:

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

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

Psychologist, Licensed Certified Social Workers (LCSW), Licensed Professional Counselors (LPC) Services and Licensed Marriage and Family Therapists (LMFT) are those provided by Psychologists, LCSWs, LPCs, and LMFTs who are certified by the appropriate Board and practicing within the scope of their license.

Licensed Pharmacist Services: Licensed pharmacist, employed by a Mississippi Medicaid pharmacy provider, within their scope of practice under state law are limited to:

1) Vaccine administration.

   Effective December 11, 2020, qualified pharmacy technicians and pharmacy interns/externs, acting under the supervision of a qualified pharmacist, as authorized by the Mississippi State Board of Pharmacy to administer FDA-authorized or FDA-licensed COVID-19 vaccines.

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

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

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

The primary components of this service are as follows:

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

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

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

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

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

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Home Health Services

The Division of Medicaid covers the following home health services:

1. Skilled Nursing Visit for intermittent or part-time nursing services provided by a registered nurse employed by a home health agency in accordance with Mississippi State Department of Health, Division of Health Facilities Licensure and Certification standards or a registered nurse when no home health agency exists in the area. The registered nurse must be a graduate of an approved school of professional nursing, who is licensed as a registered nurse by the State in which they practice.

2. Home Health Aide Visit for personal care services provided directly by an aide employed by a home health agency and in accordance with Mississippi State Department of Health, Division of Health Facilities Licensure and Certification standards. The home health aide must be an individual who has successfully completed a state-established or other home health aide training program approved by the State. Home Health aide services may be provided without a requirement for skilled nursing services and must be supervised by a registered nurse.

Home Health visits are limited to a combined total of thirty-six (36) visits per state fiscal year.

Home health services must be provided to a beneficiary at the beneficiary's place of residence defined as any setting in which normal life activities take place, other than:

1. A hospital,

2. Nursing facility,

3. Intermediate care facility for individuals with intellectual disabilities except when the facility is not required to provide the home health service; or

4. Any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Home health services must be provided in accordance with the beneficiary's physician's orders as part of a written plan of care, which must be reviewed every sixty (60) days. The beneficiary's attending physician must document that a face-to-face encounter occurred no more than ninety (90) days before or thirty (30) days after the start of home health services. The face-to-face encounter must be related to the primary reason the beneficiary requires the home health service.

The home health agency providing home health services must be certified to participate as a home health agency under Title XVIII (Medicare) of the Social Security Act, and comply with all

applicable state and federal laws and requirements.

The Division of Medicaid covers medical supplies, equipment, and appliances prescribed by a physician and prior authorized as specified by the Division of Medicaid. Medical supplies, equipment, and appliances may be provided regardless of whether a beneficiary is receiving services from a home health agency.

For the initial ordering of certain medical equipment the prescribing physician or allowed non-physician practitioner must document that a face-to-face encounter occurred no more than six (6) months prior to the start of services. The face-to-face encounter must be related to the primary reason the beneficiary requires the medical equipment. An allowed non-physician practitioner that performs the face-to-face encounter must communicate the clinical findings of the face-to-face encounter to the ordering physician. Those clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record.

Medical supplies, equipment, and appliances are covered if they:

1. Are relevant to the beneficiary's plan of care,
2. Are medically necessary,
3. Primarily serve a medical purpose,
4. Have therapeutic or diagnostic characteristics enabling a beneficiary to effectively carry out a physician's prescribed treatment for illness, injury, or disease, and
5. Are appropriate for use in the non-institutional setting where the beneficiary's normal life activities take place, other than a hospital; nursing facility; intermediate care facility for individuals with intellectual disabilities (ICF/IID) unless the ICF/IID is not required to provide the home health service; or any setting in which payment is or could be made under Medicaid for inpatient service that include room and board.

The beneficiary's need for medical supplies, equipment and appliances must be reviewed by the beneficiary's physician annually.

Medical equipment and appliances must be provided through qualified DME providers. Medical supplies may be provided through a qualified home health agency or DME provider.

The Division of Medicaid covers all medically necessary services for Early, Periodic Screening, Diagnosis and Treatment (EPSDT)-eligible beneficiaries without regard to service limitation and with prior authorization.

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

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

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

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

   Only medically necessary services are covered under the Medicaid program.

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

9a. Ambulatory Surgical Center

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

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

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

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

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

Only medically necessary services are covered under the Medicaid program.

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

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

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

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

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

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

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

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

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

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

10. Dental Services

The Division of Medicaid requires prior authorization for certain medically necessary dental services in an office setting and all dental services provided in an outpatient hospital setting by the Division of Medicaid's Utilization Review/Quality Improvement Organization (UM/QIO) or a contracted Coordinated Care Organization's (CCO's) UM/QIO for all beneficiaries except for emergencies.

The Division of Medicaid covers medically necessary dental services for non-Early and Period Screening, Diagnostic and Treatment (EPSDT)-eligible beneficiaries that:

a) Are an adjunct to treatment of an acute medical or surgical condition,

b) Include services of oral surgeons and dentists in connection with surgery related to the jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone, and

c) Include emergency dental extractions and treatment.

The Division of Medicaid covers medically necessary dental services for EPSDT-eligible beneficiaries including:

a) Diagnostic,

b) Preventive,

c) Therapeutic,

d) Emergency, and

e) Orthodontic.

Dental Benefit Limits:
For dates of service beginning July l, 2007, dental services (except orthodontia) are limited to $2,500 per beneficiary per fiscal year. Additional dental services in excess of the $2,500 annual limit may be provided with prior authorization from the Division of Medicaid's UM/QIO or a contracted CCO's UM/QIO.

Orthodontic Services:
Orthodontic services are covered when medically necessary and prior authorized by the Division of Medicaid or designated entity for EPSDT-eligible beneficiaries. Orthodontia-related services are limited to $4,200 per beneficiary per lifetime. Additional dental services in excess of the $4,200 lifetime limit may be provided with prior authorization from the Division of Medicaid's UM/QIO or a contracted CCO's UM/QIO.

Dentures:
Dentures are covered when medically necessary and prior authorized by the Division of Medicaid's UM/QIO or a contracted CCO's UM/QIO for EPSDT-eligible beneficiaries.

State: Mississippi

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

State of Mississippi

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

12a. **Prescribed Drugs**:

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

(2) All Medicaid non-Early and Period Screening, Diagnostic and Treatment (EPSDT)-eligible beneficiaries are limited to six (6) prescriptions, which includes legend and prescribed OTC drugs, per month with no more than two (2) brand name (single source or innovator multiple source) drugs per month.

1. Preferred brand drugs listed on the Universal Preferred Drug List (PDL) do not count toward the two (2) brand limit, and

2. Over-the-counter (OTC) drugs prescribed by a physician listed on the Division of Medicaid's OTC PDL do not count toward the two (2) brand limit.

(3) Prescription limits are not applicable for Medicaid beneficiaries receiving institutional long-term care services.

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

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

☒ Select obesity drugs will be covered as listed on the state's website.

☐ Agents when used to promote fertility;

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

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

☐ (f) Nonparticipating rebate manufacturers;

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

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

☒ (i) Select nonprescription (OTC) drugs:
Are defined by the Division of Medicaid, updated annually and located on the Division of Medicaid's website at https://medicaid.ms.gov/providers/ pharmacy /pharmacy-resources/

State of Mississippi

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

Supplemental Drug Rebate Agreements:

The Division of Medicaid, or the Division of Medicaid in consultation with the Sovereign States Drug Consortium, may negotiate supplemental drug rebate agreements (SDRAs) that would reclassify any drug not designated as preferred in the baseline listing for as long as the agreement is in effect. A SDRA between the Division of Medicaid and a drug manufacturer for drugs provided to the Medicaid program, submitted to the Centers for Medicare & Medicaid Services (CMS) on December 27, 2005 and entitled, "State of Mississippi Supplemental Rebate Agreement", was authorized by CMS. CMS authorized the State of Mississippi to enter into the "Sovereign States Drug Consortium (SSDC)" multi-state purchasing pool. The SDRA submitted to CMS on September 7, 2012, entitled, "State of Mississippi Supplemental Rebate Agreement", was authorized by CMS. CMS authorized the revised multi-state SSDC agreement submitted on March 17, 2014, for the Division of Medicaid population to cover supplemental drug rebates for fee-for-service and coordinated care Medicaid programs, effective July 1, 2014. CMS authorized the revised multi-state SSDC agreement submitted on November 3, 2017 to be effective January 1, 2018, with changes in references to various federal laws, to include the Covered Outpatient Drug Rule and to standardize the terms of the SDRA with that of the other states in the consortium.

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

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

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

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

Preferred Drug List:

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

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

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

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

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

State of Mississippi

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

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

The Division of Medicaid defines Physician Administered Drugs and Implantable Drug System Devices as any covered diagnostic or therapeutic radiopharmaceutical, contrast imaging agent, drug, biological or implantable drug system device that is administered in a clinically appropriate manner to a beneficiary by a Mississippi Medicaid provider other than a pharmacy provider. Physician Administered Drugs and Implantable Drug System Devices are not counted toward the beneficiary's monthly prescription limit.

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: MISSISSIPPI

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

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

Attachment 3.1-A

Exhibit 12d

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: MISSISSIPPI

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

12d. Eyeglasses:

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

TN # 2002-05

Superseded TN # 2000-08

Date Approved JUN 25 2002

Date Effective MAY 01 2002

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 3.1-A
Exhibit 13

State: Mississippi

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 3.1-A

State: Mississippi

Exhibit 13a

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 3.1-A
Exhibit 13b

State: Mississippi

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

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

State of Mississippi

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

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

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

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

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

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

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

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

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

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

13.d. Rehabilitative Services: Rehabilitative services, except as otherwise provided under this Plan, include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice and/or license under State law for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level (42 CFR 440.130 (d)). The Division of Medicaid covers medically necessary rehabilitative services for beneficiaries with mental health and/or substance use disorders.

A. Assurances

1. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services:
   The Division of Medicaid covers all medically necessary services for EPSDT-eligible beneficiaries ages birth to twenty-one (21) in accordance with 1905 (a) of the Act, without regard to service limitations and with prior authorization.
2. Adequacy of Service Provisions:
   The Community Mental Health Centers (CMHC) providers are responsible for ensuring that each beneficiary's mental health needs are met throughout the course of treatment.
3. Freedom of Choice:
   Participants have freedom of choice of qualified enrolled providers, agencies and staff within agencies.
4. The state has a system in place to identify Medicaid beneficiaries.

B. Provider Requirements

1. Rehabilitative services may be provided by the following licensed and enrolled providers acting within their scope of practice:

   a. Board-certified or board-eligible psychiatrists licensed by the Mississippi Board of Medical Licensure.

   b. Physicians licensed by the Mississippi Board of Medical Licensure.

   c. 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.

   d. 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.

   e. Psychologists must hold a Ph.D. degree in psychology and be licensed by the Mississippi Board of Psychology.

   f. 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.

g. 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. Provisionally Licensed Professional Counselors (P-LPC) may provide services within the scope of their provisional license.
h. 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. Provisionally Licensed LMFTs may provide services within the scope of their provisional license.

2. Rehabilitative services may be provided by Quasi-governmental or Private Community Mental Health Center (CMHC/PMHC) agencies certified by the Mississippi Department of Mental Health (DMH), in accordance with state law. Quasi-governmental CMHCs are defined as entities operated under the supervision of regional commissions appointed by county boards of supervisors comprising their respective catchment areas.

a. DMH issues a four (4) year certification for the agency.
b. DMH must certify each type of rehabilitation service individually.
c. DMH certification is based on the following:
   1) Adherence to DMH standards, DMH grant requirement guidelines, contracts, memoranda of understandings, and memoranda of agreements;
   2) Compliance with DMH fiscal management standards and practices outlined in the DMH Operational Standards based on a risk-based audit system;
   3) Evidence of fiscal compliance with external funding sources;
   4) Compliance with ethical practices and codes of conduct of professional licensing entities related to provision of services and management of the organization; and
   5) Evidence of solid business and management practices.
d. Required staff qualifications:
   1) Qualifications for practitioners listed in B.1. above,
   2) All CMHC/PMHC staff must operate within the scope of their practice.

Licensed Master Social Workers (LMSW) must hold a Master's degree, and be licensed by the Mississippi State Board of Examiners for Social Workers and Marriage and Family Therapists.

   2) Professional Art Therapists (ATR-BC) must hold a Master's degree in art therapy and be licensed by the Mississippi Department of Health (MSDH).
   3) 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.
   4) 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.
   5) DMH certified staff:
      (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.

(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 twenty-four (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 staff listed in B.1) and B.2)a) through e).

(c) Peer Support Specialist Professionals must hold a minimum of a high school diploma or GED equivalent, be certified by DMH as a Certified Peer Support Specialist and must be under the supervision of a psychiatrist, physician, PMHNP, PA, LCSW, LMSW, 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.

(d) Peer Support Specialist supervisors must hold a minimum of a master's degree in addictions, mental health, intellectual/developmental disabilities, or human or behavioral services field and either a 1) professional license or 2) a DMH credential as a Mental Health Therapist, Intellectual/Developmental Disability Therapist, or Addictions therapist prior to or immediately upon acceptance of a Peer Support Specialist Supervisory position. They must also receive training specifically developed for Peer Support Specialist supervisors by DMH.

C. Rehabilitative Services are medically necessary for the treatment of the beneficiary's illness, condition, or injury and include the following.

1. Treatment Plan Development and Review

a. Treatment plan development and review is defined as the development and review of an overall plan that directs the treatment and support of the person receiving services by qualified providers.
b. The clinical purpose of treatment plan development and review is to meet the needs of the beneficiary and support independence and community participation by addressing behaviors and making recommendations for treatment.
c. This process may also be called a beneficiary's service plan or plan of care.
d. The composition of the staff must include appropriate professionals acting within their scope of practice.
e. The treatment plan must be approved by one of the following: a psychiatrist, physician, psychologist, PMHNP, PA, LCSW, LPC, LMSW, LMFT.
f. Treatment plan development and review is limited to four (4) services per state fiscal year.

2. Crisis Response Services

a. Crisis Response Services are defined as an intensive therapeutic service, available twenty-four (24) hours per day, seven (7) days per week, which allows for the assessment of and intervention in a mental health crisis. Crisis Response Services are limited to less than 24 hours per episode. These services must be available throughout the provider's catchment area and must include:
   1) A toll-free telephone number,
   2) Mobile Crisis Response personnel,
   3) Walk-in availability at all DMH certified service locations.
b. The clinical purpose of crisis response services is to assist the beneficiary cope with immediate stressors, identify and use available resources and the beneficiary's strengths, and develop treatment options to avoid unnecessary hospitalization and return to the beneficiary's prior level of functioning.
c. The service components for crisis response services include and can be provided by any of the team members listed in C.2.d.:
   1) Assessment,
   2) De-escalation which includes verbal and non-verbal techniques to reduce the emotional, mental, and/or physical stress level of a beneficiary, and
   3) Service coordination and facilitation which includes determining what additional services are needed and assisting the beneficiary in obtaining those services.
d. Team members must include:
   1) A Certified Peer Support Professional with specific roles and responsibilities,
   2) A licensed and/or credentialed master's level therapist with experience and training in crisis response services,
   3) A Community Support Specialist with experience and training in crisis response

services,

4) A Crisis Response Coordinator for the agency provider's catchment area who is a licensed and/or credentialed master's level therapist with a minimum of two (2) years' experience and training in crisis response services, and
5) At least one (1) employee with experience and training in crisis response services to each population served by the agency provider.

e. Crisis Response Services must be available by phone twenty-four (24) hours a day, seven (7) days a week and must meet the DMH standards of operation.
f. Crisis Response Services are not limited.

3. Crisis Residential Services

a. Crisis Residential Services are defined as time-limited residential treatment services provided in a Crisis Residential Unit which provides psychiatric care, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to beneficiaries who are experiencing a period of acute psychiatric distress which severely impairs their ability to cope with normal life circumstances. The unit 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. Crisis Residential Services must be 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 that is certified by the DMH to provide Crisis Residential Services.
c. The clinical purpose of Crisis Residential Services is to provide treatment to an beneficiary 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.
d. The service components for Crisis Residential Services include:
    1. Treatment plan development and review by any of the staff listed in C.3.e.
    2. Medication management provided by a psychiatrist or PMHNP.
    3. Nursing assessment provided by a PMHNP or RN.
    4. Individual therapy provided by master's level staff.
    5. Family therapy provided by master's level staff. Family therapy involves participation of non-Medicaid eligible for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.
    6. Group therapy provided by master's level staff. Group therapy involves participation of non-Medicaid eligible individuals for the benefit of the beneficiary but does not include services directed at the non-Medicaid individuals. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but

remains the focus of the service.

7. Skill building groups such as social skills re-training, self-esteem building, anger control, conflict resolution and daily living skills provided master's level staff or other direct service staff under the direction of the Master's level staff.

e. Crisis Residential Services must be medically necessary and ordered by a psychiatrist, physician, psychologist, PMHNP or PA.
f. The Crisis Residential Services Provider, under the direction of a Facility Director, must have the following staff in the ratios required by DMH:
   1. An immediately available psychiatrist, PMHNP, or psychologist,
   2. A full-time RN, and
   3. Other Master's level staff.
g. Crisis Residential Services must be prior authorized as medically necessary by the Utilization Management/Quality Improvement Organization (UM/QIO) or designee.
h. Crisis Residential Services are limited to sixty (60) days per state fiscal year.
i. Crisis Residential Services do not include room and board.

4. Community Support Services

a. Community Support Services are defined as services provided by a mobile community-based Community Support Specialist who focuses on the mental health needs of the beneficiary while attempting to restore the beneficiary's ability to succeed in the community
b. The clinical purpose of Community Support Services is to assist the beneficiary in achieving and maintaining rehabilitation, resiliency, and recovery goals.
c. The service components for Community Support Services include:
   1) Identification of strengths which will aid the beneficiary in their recovery and the barriers that will challenge the development of skills necessary for independent functioning in the community.
   2) Individual therapeutic interventions with a beneficiary that directly increase the restoration of skills needed to accomplish the goals set forth in the Individual Service Plan.
   3) Monitoring and evaluating the effectiveness of interventions that focus on restoring, retraining, and reorienting, as evidenced by symptom reduction and progress toward goals.
   4) Psychoeducation to retrain the identification and self-management of prescribed medication regimen and communication with the prescribing provider.
   5) Direct interventions in de-escalating situations to prevent crisis.
   6) Retraining a beneficiary on accessing needed services such as medical, social, educational, transportation, housing, substance abuse, personal care, and other services that may be identified in the Recovery Support Plan as components of Health, Home, Purpose and Community.
   7) Reorienting a beneficiary on relapse prevention.
   8) Facilitation of the Individual Service Plan and/or Recovery Support Plan which includes the active involvement of the beneficiary and the people identified as

important in the person's life.

d. Community Support Services are provided by a Community Support Specialist Professional.
e. Community Support Services must be included in a treatment plan approved by one of the following: a psychiatrist, physician, psychologist, PMHNP, PA, LCSW, LPC, or LMSW, LMFT.
f. Community Support Services are limited to four hundred (400) fifteen (15) minute units per state fiscal year.

5. Medication Evaluation and Management

a. Medication management includes the evaluation and monitoring of psychotropic medications.
b. Medication evaluation is performed by a psychiatrist, physician PMHNP or PA. The clinical purpose is to assess a beneficiary's mental health needs and to evaluate if psychopharmacological treatment of a mental disorder is necessary.
c. 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 illness.
d. The clinical purpose of medication monitoring is to ensure the beneficiary receives the proper dosage and adjustment of medications resulting in the appropriate therapeutic effects of the medication.
e. Monitoring is performed by a psychiatrist, physician, PMHNP or PA.
f. Only a psychiatrist, physician, PMHNP and PA can prescribe psychotropic medications.
g. Medication evaluation and management visits are not limited when performed by a CMHC or PMHC.

6. Medication Administration

a. Medication administration is defined as the administering of a prescribed medication.
b. Only a psychiatrist, physician, PMHNP, PA, RN or LPN can administer medications.
c. Medication administration is not limited.

7. Psychiatric Diagnostic Evaluation

a. A Psychiatric Diagnostic Evaluation is defined as an integrated biopsychosocial assessment, including history, mental status, and recommendations.
b. The clinical purpose of a Psychiatric Diagnostic Evaluation is to diagnose emotional, behavioral, or developmental disorders.
c. A Psychiatric Diagnostic Evaluation must be provided by physician or other licensed practitioner operating within their scope of license and practice.
d. Psychiatric Diagnostic Evaluations are limited to four (4) units per state fiscal year.

8. Psychological Diagnostic Evaluation

a. A Psychological Diagnostic Evaluation is defined as an evaluation assessing the beneficiary's cognitive, emotional, behavioral and social functioning using

standardized tests, interviews and behavioral observations.

b. The clinical purpose of a Psychological Diagnostic 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 Diagnostic Evaluations must be completed by a licensed psychologist.
d. Psychological Diagnostic Evaluations are limited to eight (8) units per state fiscal year.

9. Mental Health Assessment by a Non-Physician

a. A Mental Health Assessment is defined as the documentation of information from the beneficiary and/or collaterals describing the beneficiary'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 beneficiary'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 Mental Health Assessment is to create a comprehensive picture of the beneficiary in order to develop treatment goals.
c. A Mental Health Assessment must be provided by one of the following: PMHNP, PA, LCSW, LMSW, LPC, LMFT, CMHT, CIDDT, and CAT.
d. Mental Health Assessments are limited to four (4) units per state fiscal year.

10. Brief Emotional/Behavioral Health Assessment

a. A Brief Emotional/Behavioral Health Assessment is defined as a brief screening used to assess a beneficiary's emotional and/or behavioral health and covers a variety of standardized assessments.
b. The clinical purposed of a Brief Emotional/Behavioral Assessment is to identify the need for more in-depth evaluation for a number of mental/behavioral conditions.
c. A Brief Emotional/Behavioral Health Assessment must be provided by one of the following: a psychiatrist, physician, psychologist, PMHNP, PA, LCSW, LPC, LMSW, LMFT, CMHT, CIDDT, and CAT.
d. Brief Emotional/Behavioral Health Assessment are limited to twelve (12) per state fiscal year.

11. Nursing Assessment

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

12. Individual Psychotherapy

a. Individual Psychotherapy is defined as one-on-one therapy for the purpose of treating a mental disorder.
b. The clinical purpose of Individual Psychotherapy is to assess, prevent, and relieve distress or dysfunction and to increase the beneficiary's sense of well-being and personal development.
c. Individual Psychotherapy services must be included in a treatment plan approved by one of the practitioners listed in B.1.
d. Individual Psychotherapy must be provided by the practitioners list in B.1. or in CMHC/PMHC by one (1) of the following staff in addition to the practitioners listed in B.1.: LMSW, CMHT, CIDDT, and CAT.
e. Individual Psychotherapy is limited to thirty-six (36) sessions per state fiscal year when provided without an evaluation and management visit. Interactive complexity is covered with an individual psychotherapy session when medically necessary.

13. Family Psychotherapy

a. Family Psychotherapy is defined as therapy for the family which is exclusively directed at the beneficiary's needs and treatment. Family psychotherapy is covered both with and without the beneficiary present. Family therapy involves participation of non-Medicaid eligible individuals for the benefit of the beneficiary but does not include services directed at the non-Medicaid individuals. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.
b. The clinical purpose of Family Psychotherapy is to identify and treat family problems that cause dysfunction.
c. Family Psychotherapy services must be included in a treatment plan approved by a psychiatrist, physician, psychologist, PMHNP, PA, LCSW, LPC, or LMFT.
d. Family Psychotherapy must be provided by the practitioners listed in B.1. or in a CMHC/PMHC by one (1) of the following staff in addition to the practitioners listed in B.1.: LMSW, CMHT, CIDDT, and CAT.
e. Family Psychotherapy is limited to twenty-four (24) sessions per state fiscal year.

14. Group Therapy/Multi-Family Group Therapy

a. Group Therapy is defined as face-to-face therapy addressing the needs of several beneficiaries 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 practitioner listed in B.1. or CMHC/PMHC licensed staff and family members of at least two (2) different beneficiaries in a group setting. It combines the power of a group process with the systems focus of Family Therapy. Group therapy involves participation of non-Medicaid eligible individuals for the benefit of the beneficiary but does not include services directed at the non-Medicaid individuals. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

d. The clinical purpose of Multi-Family Group Therapy is to give beneficiaries and/or the family a safe and comfortable place to work out problems and emotional disorders, gain insight into their own thoughts and behavior, and offer suggestions and support to others.

f. Group Therapy/Multi-Family Group Therapy services must be included in a treatment plan approved by a psychiatrist, physician, psychologist, PMHNP, PA, LCSW, LPC, or LMSW, LMFT.

g. Group Therapy/Multi-Family Group Therapy services must be provided by the practitioners listed in B.1. or in a CMHC/PMHC by one (1) of the following staff in addition to the practitioners listed in B.1.: LMSW, CMHT, CIDDT, and CAT.

h. Group Therapy/Multi-Family Group Therapy is limited to forty (40) sessions per state fiscal year. Interactive complexity is covered when medically necessary.

15. Acute Partial Hospitalization Services

a. Acute Partial Hospitalization Services are defined as a non-residential treatment program for beneficiaries who are experiencing a period of such acute distress that their ability to cope with normal life circumstances is severely impaired. These beneficiaries 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 Services are to provide an alternative to hospitalization for beneficiaries not requiring twenty-four (24) hour supervision but still requiring a high degree of therapeutic support to return to normal daily activities in the home, school, work, and community.

c. The service components for Acute Partial Hospitalization Services include:
   1) Treatment plan development and review by any of the staff listed in C.3.f.
   2) Medication management provided by a psychiatrist, physician, PA or PMHNP.
   3) Nursing assessment provided by a PMHNP or RN.
   4) Individual therapy provided by master's level staff.
   5) Family therapy provided by master's level staff. Family therapy involves participation of non-Medicaid eligible for the benefit of the beneficiary.
   6) Group therapy provided by master's level staff.

d. Acute Partial Hospitalization Services must be provided by licensed/certified entities including, but not limited to, a CMHC/PMHC, an outpatient department of a hospital or free-standing psychiatric unit, or a private psychiatric clinic.

e. Acute Partial Hospitalization Services must be prior authorized as medically necessary by the UM/QIO or designee.

f. Acute Partial Hospitalization Services must be included in a treatment plan approved by a psychiatrist, physician, psychologist, PMHNP, PA, LCSW, LPC, or LMFT.

g. Acute Partial Hospitalization Services are limited to one hundred (100) days per state fiscal year. Services must be provided for a minimum of four (4) hours in one (1) day for at least three (3) days per week.

16. Psychosocial Rehabilitation Services

a. Psychosocial Rehabilitation Services are defined as a network of services designed to treat a serious and persistent mental illness. Psychosocial Rehabilitation Services must meet the standards of the Mississippi Department of Mental Health.

b. The clinical purpose of Psychosocial Rehabilitation Services is to assist beneficiaries to restore them to their highest level of functioning in their community.

c. Psychosocial Rehabilitation Services are provided in a DMH approved Psychosocial Rehabilitation Program by bachelor's level staff that provide active treatment through evidence-based curriculum, such as Illness Management and Recovery, which includes psycho educational groups that are defined as groups to retrain and refocus on coping skills.

d Psychosocial Rehabilitation Services must be included in a treatment plan approved by a psychiatrist, physician, psychologist, PMHNP, PA, LCSW, LPC, LMSW or LMFT.

e. The Psychosocial Rehabilitation Program must comply with the Operational Standards published by DMH.

f. Psychosocial Rehabilitation Services must be prior authorized as medically necessary by the Division of Medicaid's UM/QIO or designee.

g. Psychosocial Rehabilitation Services are limited to five (5) hours per day, five (5) days a week.

17. Program of Assertive Community Treatment (PACT) Services

a. Program of Assertive Community Treatment (PACT) Services are defined as a person-centered, recovery-oriented mental health service delivery model for facilitating community living, psychosocial rehabilitation and recovery from symptoms of severe and persistent mental illness, severe symptoms and impairments who have not benefited from traditional outpatient programs. PACT Services are 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 beneficiaries to different mental health providers, programs, and other agencies.

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

c. The components of PACT Services are based on an all-inclusive evidence-based model that may include, but are not limited to, one (1) or more of the following:
   1) Treatment plan review and development provided by any of the staff listed in C.17.e.
   2) Medication management provided by a psychiatrist, physician, PA or PMHNP.
   3) Individual therapy provided by master's level staff.
   4) Family therapy provided by master's level staff. Family therapy involves participation of non-Medicaid eligible individuals for the benefit of the beneficiary.
   5) Group therapy provided by master's level staff.
   6) Crisis response provided by a team member operating within their scope of practice.
   7) Community support provided by a community support specialist.
   8) Peer support provided by a peer support specialist.

d. The composition of the PACT team members must meet the requirements of the DMH and must include, but are not limited to:
   1) A team leader with a Master's degree in nursing, social work, psychiatric rehabilitation or psychology, or is a psychiatrist. The team leader must be professionally licensed or have a DMH credentials as a Certified Mental Health Therapist,
   2) A Psychiatrist or PMHNP,
   3) Registered nurse (RN),
   4) Master's level mental health professional,
   5) Substance use disorder specialist,
   6) Employment specialist,
   7) Certified Peer Support Specialist Professional (CPSSP), and
   8) Other clinical personnel as determined by DMH.

e. PACT Services must be included in a treatment plan, approved by the team leader, and provided by a psychiatrist, physician, psychologist, PMHNP, PA, LCSW, LMSW, LPC, LMFT, CMHT, CIDDT, CAT, RN, CPSSP, or employment specialist.

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

designee.

g. PACT is limited to sixteen hundred (1600) fifteen (15) minute units per state fiscal year.

18. 18. Intensive Community Outreach and Recovery Team (ICORT) Services

a. Intensive Community Outreach and Recovery Team (ICORT) Services are defined as a recovery and resiliency oriented, intensive, community-based rehabilitation and assertive community treatment service for symptoms of severe and persistent mental illness. It is a team-oriented approach to mental health rehabilitation intervention and supports necessary to assist people in achieving and maintaining rehabilitative, resiliency and recovery goals.

b. The clinical purpose of ICORT Services is to assist in keeping the people receiving the service in the community in which they live avoiding placement in state operated behavioral health service locations.

c. The components of ICORT include:
   1) Treatment plan development and review provided by any of the staff listed in C.18.d.
   2) Medication management provided by a psychiatrist, physician, PA or PMHNP.
   3) Individual therapy and family therapy provided in the home provided by master's level staff.
   4) Group therapy provided by master's level staff.
   5) Peer support services provided by a peer support specialist.
   6) Psychoeducation provided by an ICORT team member.

d. ICORT Services must be included in a treatment plan and approved by a psychiatrist, physician, psychologist, PMHNP, PA, LCSW, LPC, or LMFT.

e . ICORT Services providers must have the following staff:
   1) A Team Leader who is a full-time Master's Level CMHT,
   2) A full-time registered nurse,
   3) A full-time equivalent Certified Peer Support Specialist Professional, and
   4) If deemed necessary by DMH, a part-time Community Support Specialist can be added to the Intensive Community Outreach and Recovery Team.

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

g. ICORT Services are limited to sixteen hundred (1600) fifteen minute units per state fiscal year.

19. Peer Support Services

a. Peer support Services are defined as non-clinical activities with a rehabilitation and resiliency/recovery focus that allow a person receiving of mental health services and substance use disorders services and their family members the opportunity to build skills for coping with and managing psychiatric symptoms, substance use issues and challenges associated with various disabilities while directing their own recovery.

b. The clinical purpose of Peer Support Services is to provide peer-to-peer support assisting a beneficiary with recovery from mental illness or substance abuse.

c. The service components of Peer Support Services include:
   1) Development of a recovery support plan, and
   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 certified Peer Support Specialist Professional.

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

f. Peer support is limited to two hundred (200) fifteen (15) minute units per state fiscal year.

17. Intensive Outpatient Psychiatric Services

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

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

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

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

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

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

18. PACT

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

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

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

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

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

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

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

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

State of Mississippi

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

15. Intermediate Care Facilities for Individuals with Intellectual Disabilities

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

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

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

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16. Inpatient Psychiatric Services:

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

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

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

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

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

State of Mississippi

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

18. Hospice Benefit

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

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

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

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

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

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

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

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

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

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

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

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

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

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

State of Mississippi

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

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

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

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

State of Mississippi

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

Extended Services for Pregnant and Post-Partum Women up to sixty (60) days post-partum

1. Medical Risk Screening performed by a physician, nurse practitioner, physician assistant or certified nurse-midwife per pregnancy as medically necessary,
2. Screening, Brief Intervention, and Referral to Treatment (SBIRT) performed by a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist, license clinical social worker (LCSW), licensed professional counselor (LPC), or licensed marriage and family therapist (LMFT).

Extended services for pregnant 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 as determined by the Medical Risk Screening.

1. Initial nursing assessment and evaluation performed by a registered nurse (RN) per pregnancy unless medically necessary,
2. Nursing Services, per fifteen (15) minutes, to include health education, performed by a registered nurse,
3. Home visit for postnatal assessment and follow-up performed by a registered nurse per pregnancy unless medically necessary,
4. Nutritional assessment and counseling performed by a registered dietician or licensed nutritionist per pregnancy unless medically necessary,
5. Nutritional counseling and dietician visit per 15 minutes performed by a registered dietician or licensed nutritionist,
6. Mental health assessment performed by a non-physician practitioner per pregnancy unless medically necessary,
7. Behavioral health prevention education services performed by a mental health professional.

STATE Mississippi

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

23. Certified Pediatric or Family Nurse Practitioners' Services

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

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

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

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

App. 11/2/87 Eff. 4/1/87

State of Mississippi

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

24a. Transportation - The Division of Medicaid covers transportation through the following methods:

1) Emergency Ground Ambulance services which meet the following criteria:

- The transport requires a basic life support (BLS), advanced life support (ALS) or specialty care transport certified emergency ground ambulance, equipment and staff in order to transport a beneficiary to the nearest appropriate facility where the beneficiary will be accepted for treatment,

- The use of other means of transportation is medically contraindicated because it would endanger or be detrimental to the beneficiary's health, and

- The beneficiary's condition is of such severity that the absence of immediate medical care could reasonably result in permanently placing the beneficiary's health in jeopardy, and/or serious impairment of bodily functions, and/or serious and permanent dysfunction of any body organ or part, or other serious medical consequence.

2) Emergency Air Ambulance services provided in a rotary wing aircraft which meet the following criteria:

- The transport requires a BLS or ALS certified emergency rotary-wing air ambulance, equipment, and staff in order to transport a beneficiary to the nearest appropriate facility where the beneficiary will be accepted for treatment,

- The use of other means of transportation is medically contraindicated because it would endanger or be detrimental to the beneficiary's health, and

- The beneficiary's condition is of such severity that the absence of immediate medical care could reasonably result in permanently placing the beneficiary's health in jeopardy, and/or serious impairment of bodily functions, and/or serious and permanent dysfunction of any body organ or part, or other serious medical consequences.

State of Mississippi

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

3) Emergency and Urgent Air Ambulance services provided in a fixed wing aircraft which meet all the following criteria:

   - The transport requires an emergency or urgent fixed-wing air ambulance equipped and staffed to provide medical care appropriate for the beneficiary's needs and transportation to the nearest appropriate facility,

   - The use of other means of transportation is medically contraindicated because it would endanger or be detrimental to the beneficiary's health, and

   - The beneficiary 's condition is of such severity that the absence of fixed-wing air ambulance transport to the nearest appropriate facility for treatment could reasonably result in permanently placing the beneficiary's health in jeopardy, and/or serious impairment of bodily functions, and/or serious and permanent dysfunction of any body organ or part, or other serious medical consequence.

4) Non-emergency transportation (NET) services for eligible Medicaid beneficiaries are arranged and coordinated through the NET Broker as described in Attachment 3.1-D.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 3.1-A
Exhibit 24c

State Mississippi

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

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

TN No. 94-13
Supersedes TN No. New

Date Received 7-11-94
Date Approved 8-15-94
Date Effective 7-01-94

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

24d

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Mississippi

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

25. Licensed Physician Assistants

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

State of Mississippi

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

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

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

State of Mississippi

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

1905(a)(29) Medication-Assisted Treatment (MAT)

i. General Assurance

MAT is covered under the Medicaid state plan for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020, and ending September 30, 2025.

ii. Assurances

a. The state assures coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

b. The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

c. The state assures coverage for all formulations of MAT drugs and biologicals for OUD that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355 and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

iii. Service Package

The state covers the following counseling services and behavioral health therapies as part of MAT.

a) Please set forth each service and components of each service (if applicable), along with a description of each service and component service. From October 1, 2020, through September 30, 2025, the state assures that MAT to treat OUD as defined at section 1905(ee)(1) of the Social Security Act (the Act) is covered exclusively under section 1905(a)(29) of the Act.

Service components for MAT:

1) Assessments related to the beneficiary's opioid use disorder.

2) Drug screenings.

3) Medication Evaluation and Management is the intentional face-to-face interaction between a physician or a nurse practitioner and a beneficiary for the purpose of assessing the need for psychotropic medication, prescribing

medications, and, regular periodic monitoring of the medications prescribed for therapeutic effect and medical safety

4) Medication administration including the provision of Food and Drug Administration (FDA) approved drugs for the treatment of opioid use disorder (OUD).

5) Individual therapy,

6) Group therapy,

7) Family therapy. This service actively involves the beneficiary and is tailored to the beneficiary's individual needs. The beneficiary remains the focus of the treatment service. Family therapy that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

The State assures there will be no duplication of services through the MAT benefit and other services covered by the State Plan.

b) Please include each practitioner and provider entity that furnishes each service and component service.

1) Opioid Treatment Programs (OTPs) certified by the Mississippi Department of Mental Health that provide methadone treatment.

2) Physicians and non-physician practitioners:

a) Assessments related to the beneficiary's opioid use disorder provided by physician, nurse practitioner or physician assistant.

b) Medication management and drug screenings provided by a physician, nurse practitioner or physician assistant.

c) Medication Evaluation and Management provided by physician, nurse practitioner or physician assistant.

d) Medication administration including the provision of Food and Drug Administration (FDA) approved drugs for the treatment of opioid use disorder (OUD) provided by physician, nurse practitioner, or physician assistant.

e) Individual therapy provided by physician, nurse practitioner, physician assistant, psychologist, licensed professional counselor (LPC), licensed clinical social worker (LCSW), or licensed marriage and family therapist (LMFT).

f) Group therapy provided by physician, nurse practitioner, physician assistant, psychologist, licensed professional counselor (LPC), licensed clinical social worker (LCSW), or licensed marriage and family therapist (LMFT).

g) Family therapy provided by physician, nurse practitioner, physician assistant, psychologist, licensed professional counselor (LPC), licensed clinical social worker (LCSW), or licensed marriage and family therapist (LMFT).

c) Please include a brief summary of the qualifications for each practitioner or provider entity that the state requires. Include any licensure, certification, registration, education, experience, training and supervisory arrangements that the state requires.

1) OTPs are limited to those that prescribe and dispense methadone and must be certified by the Mississippi Department of Mental Health.

2) Physician, nurse practitioner, physician assistant, psychologist, LPC, LCSW, or LMFT, must be licensed by the state of Mississippi. A physician, nurse practitioner and physician assistant must be a buprenorphine waivered practitioner in order to prescribe, administer, or dispense buprenorphine. These providers are not eligible to enroll as OTPs.

iv. Utilization Controls

__X__ The state has drug utilization controls in place. (Check each of the following that apply)

_____ Generic first policy
__X__ Preferred drug lists
__X__ Clinical criteria
__X__ Quantity limits

_____ The state does not have drug utilization controls in place.

v. Limitations

Describe the state's limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.

MAT drugs and services provided through OTPs are not limited.

Services provided outside of an OTP are limited as listed below:

1) Individual therapy is limited to thirty-six (36) sessions per state fiscal year (SFY),

2) Group therapy is limited to forty (40) sessions per SFY,

3) Family therapy is limited to twenty-four (24) sessions per SFY.

Effective April 1, 2021, prior authorization is required for non-preferred drugs provided as physician administered drugs and OTP services.

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section 1006(b) of the SUPPORT for Patients and Communities Act (P.L. 115-271) enacted on October 24, 2018. Section 1006(b) requires state Medicaid plans to provide coverage of Medication-Assisted Treatment (MAT) for all Medicaid enrollees as a mandatory Medicaid state plan benefit for the period beginning October 1, 2020, and ending September 30, 2025. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 60). Public burden for all of the collection of information requirements under this control number is estimated to take about 80 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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.

X 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):
X 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.
X 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 Comprehensive 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 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 careplan. 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:

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

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

State of Mississippi

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

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

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)): Infants under the age of one who whose medical status during their first year of life causes them to be at risk of morbidity or mortality as determined by a medical risk screening.

X 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):
X 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.
X 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 Comprehensive 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

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

- 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) tohelp 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 toaddress 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 implementedand adequately addresses the eligible individual's needs, and which may be withthe 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 careplan. 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 infants under the age of one 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 register nurses to provide TCM with the following qualifications:
   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 case management 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 case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

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

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))

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

F. Freedom of Choice

The State assures that the provision of High-Risk Case Management Services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act;

1. Eligible recipients will have free choice of the providers of EPSDT High-Risk Case Management.

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

G. Payment for High-Risk Case Management Services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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.

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

- ❖ 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:

Targeted case management services are provided by case managers employed by Community Mental Health Centers (CMHCs) or Private Mental Health Centers (PMHCs) certified by the Mississippi Department of Mental Health. Targeted Case Management for people with serious mental illness or serious emotional disturbance must be provided by one of the following:

1. A licensed social worker (LSW) with two (2) years of experience in mental health,

2. A registered nurse with two (2) years of experience in mental health, or
3. An employee that holds at least a Master's degree in an addictions, mental health, intellectual/developmental disabilities, or human services/behavioral health-related field and has either (1) a professional license or (2) a DMH credential as a Mental Health Therapist, Intellectual and Developmental Disabilities Therapist, or Addictions Therapist as appropriate to the service and population being served.

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPEOF 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. Case managers must hold qualifications specific to the target population as described in Qualifications of Providers as detailed above.

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:

Targeted Case Management for the Chronically Mentally Ill is limited to two-hundred sixty (260), fifteen (15) minute units per state fiscal year. The Division of Medicaid covers all medically necessary services for EPSDT eligible beneficiaries ages birth to twenty-one (21) in accordance with 1905(a) of the Act, without regard to services limitations and with prior authorizations.

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

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

A. Target Group:

The target group is defined as beneficiaries with a confirmed diagnosis of Intellectual and/or Developmental Disabilities (IDD) and Autism Spectrum Disorders as defined by 42 C.F.R. § 483.102 and 45 C.F.R. § 1385.3, and is likely to continue indefinitely resulting in substantial functional limitations with two (2) or more life activities which include receptive and expressive language, learning, self-care, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

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

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

_X_ Entire State,

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

C. Comparability of Services:

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

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

D. Definition of Services:

Targeted Case Management services are defined as the coordination of services to assist beneficiaries, eligible under the State Plan within the target group, in gaining access to needed medical, social, educational and other services. Targeted Case Management is responsible for identifying individual problems, needs, strengths, resources and coordinating and monitoring appropriate services to meet those needs. Targeted Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the beneficiary access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the beneficiary's needs (42 CFR § 440.169(e)). Targeted Case Management ensures the changing needs of the beneficiary within the target group are addressed on an ongoing basis, that appropriate choices are provided from the widest array of options for meeting those needs, and includes the following services:

State of Mississippi

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

1. A Comprehensive Assessment

   A comprehensive assessment is completed annually to determine a beneficiary's needs for services and supports including identification of any medical, educational, social, or other service needs. The assessment must include obtaining a beneficiary's history, identifying and documenting the needs of the beneficiary, and gathering information from sources such as family members, medical providers, social workers, and educators, as appropriate. Reassessments are conducted when there is a significant change in the beneficiary's circumstances that may affect his/her level of functioning and needs.

2. Plan of Services and Supports

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

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

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

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

3. Referral and Related Activities

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

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

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

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

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

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

5. Case Records

   Targeted Case Management providers maintain case records that document for all individuals receiving targeted case management as follows:

   (a) The name of the individual,

   (b) The dates of the case management service,

   (c) The name of the provider agency and the person providing the case management service,

   (d) The nature, content, units of the case management service received and whether goals specified in the care plan have been achieved,

   (e) Whether the individual has declined services in the care plan,

   (f) The need for, and occurrences of, coordination with other case managers,

   (g) A timeline for obtaining needed services, and

   (h) A timeline for reevaluation of the plan.

E. Qualifications of Providers:

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

1. Targeted Case Managers must:

   a) Have a minimum of a Bachelor's degree in a human services field with no experience required or a Bachelor's degree in a non-related field and at least one-year relevant experience, or

   b) Be a Registered nurse with at least one-year relevant experience.

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

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

   a) Capacity to provide Targeted Case Management services,

   b) At least one (1) year of experience with coordination of services for individuals within the target group, and

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

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

Medicaid program.

F. Freedom of Choice:

The state assures that the provision of Targeted Case Management services to the target group will not restrict an individual's freedom of choice of providers in violation of Section 1902(a)(23) of the Act.

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

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

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

G. Access to Services:

1. Targeted case management services will not be used to restrict an individual's access to other services under the state plan,

2. Individuals will not be compelled to receive targeted case management services, condition receipt of targeted case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of targeted case management services, and

3. Providers of targeted case management services do not have the authority to authorize or deny the provision of other services under the state plan.

H. Targeted Case Management services are not provided to beneficiaries who are in institutions except for individuals transitioning to a community setting. Case management services will be made available for up to one-hundred eighty (180) consecutive days of a covered stay in a medical institution.

I. Limitations:

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

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

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

State Mississippi

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

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

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

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

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

X Entire State

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

C. Comparability Services:

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

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

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

State Mississippi

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

These activities include:

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

State Mississippi

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

E. Qualifications of Providers:

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

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

   a) assessment;

   b) care/services plan development;

   c) linking/coordination of services; and

   d) reassessment/follow-up.

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

3. Demonstrated experience with the target population;

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

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

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

1. Have a bachelor's or master's degree in child development, early childhood education, special education, social work, early intervention, or be a registered nurse (RN), and have two (2) years related professional experience in the administration of programs or provision of direct services to children with special healthcare needs, developmental delays, or handicapping conditions and their families, or

2. Have a degree in a related field with course credits addressing child development, disabilities and family systems and have two (2) years of relevant professional experience.

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

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

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

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

State of Mississippi

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Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)): EPSDT-eligible beneficiaries with a serious emotional disturbance (SED) that meet the level of care provided in a psychiatric residential treatment facility (PRTF).

X 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):
X 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.
X 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;

  Assessments must be completed 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 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;

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

- 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 careplan. 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 weekly and more often if 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)):
Targeted Case Management services for EPSDT-eligible beneficiaries with SED must be provided by a community mental health center or private community mental health center which complies with the requirements to enroll as a Mississippi Medicaid Provider and be certified by the Mississippi Department of Mental Health to provide Targeted Case Management, also referred to as, "wraparound facilitation," by the Mississippi Department of Mental Health and hold a certification to provide wraparound facilitation.
Case managers must meet the following:

1. Hold a minimum of a Bachelor's degree in a mental health, intellectual/developmental disabilities, or human services/behavioral health related field,
2. Hold a Community Support Specialist credential,
3. Complete trainings as required by the Mississippi Department of Mental Health.
4. Be under the supervision of a Supervisor as defined by the Mississippi Department of Mental Health.

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.

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

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)):
X Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services: Providers must be certified by the Mississippi Department of Mental Health to provide targeted case management, also referred to as "wraparound facilitation" by the Mississippi Department of Mental Health. These providers receive training specific to the target population as described in the Qualifications of Providers detailed above.

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 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))