TEMPLATE FOR CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: Mississippi
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))

/s/ June 27, 2025

(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

| | |
|---|---|
| Name: Cindy Bradshaw | Position/Title: Executive Director, MS Div. of Medicaid |
| Name: Brian Whitmire | Position/Title: Deputy Administrator, Office of Eligibility |
| Name: Jennifer Wentworth | Position/Title: Chief of Staff |
| Name: Vacant | Position/Title: Senior Director of Legislative and External Affairs |

**Disclosure Statement** This information is being collected to pursuant to 42 U.S.C. 1397aa, which requires states to submit a State Child Health Plan in order to receive federal funding. This mandatory information collection will be used to demonstrate compliance with all requirements of Title XXI of the Act and implementing regulations at 42 CFR part 457. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #34). Public burden for all of the collection of information requirements under this control number is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 457 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Name of Project Officer
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid and CHIP Services
Mail Stop - S2-01-16

## Section 1. General Description and Purpose of the Children's Health Insurance Plans and the Requirements

**1.1.** The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101)(a)( 1)); (42 CFR § 457.70):

**1.1.1** ☒ Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

**1.1.2.** ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

**1.1.3.** ☐ A combination of both of the above. (Section 2101(a)(2))

**1.1-DS** ☐ The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

**1.2** ☒ Check to provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR § 457.40(d))

**1.3** ☒ Check to provide an assurance that the State complies with all applicable civil rights requirements, including Title VI of the Civil Rights Act of 1964, Title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42 CFR § 457.130)

**1.4** Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR § 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan: Effective Date: July 1, 1998

Implementation Date: July 1, 1998

**Amendment #1** submitted: August 1, 1998 Implemented January 1, 2000
**Amendment #2** submitted: September 22, 1999 Implemented January 1, 2000
**Amendment #3** submitted: July 6, 2000 Implemented October 1, 2000
**Amendment #4** submitted: July 3, 2001 Implemented July 1, 2001
**Amendment #5** submitted: September 30, 2002 Implemented January 1, 2005
**Amendment #6** submitted: December 29, 2005 Implemented January 1, 2005
**Amendment #7** submitted: December 6, 2010 Implemented January 1, 2010
Mental health parity requirements.

**Amendment #8** submitted: September 25, 2013 Implemented July 1, 2013

Insurance Program Reauthorization Act of 2009 (CHIPRA); clarification of enrollee coverage provided in an emergency department.

**Amendment #9** submitted: February 9, 2015 Implemented January 1, 2015 To reflect the change in operation of the separate CHIP health plan to two (2) contracted MCOs.

**Amendment #10** submitted: January 9, 2018 Implemented: October 1, 2019 To include a Health Services Initiative offering expanded vision services to low-income children throughout the state.

**Amendment #11** submitted: May 7, 2019 Implemented: July 1, 2018 To demonstrate compliance with the Mental Health Parity and Addiction Equality Act (MHPAEA) final rule.

**Amendment #12:** MS SPA 19-0012-CHIP Effective Date: July 1, 2018 To include managed care requirements.

**Amendment #13:** MS SPA 20-0013-CHIP Submitted: January 31, 2020 To change the benchmark from the Mississippi Effective: November 1, 2019 State and School Employee's Health Insurance Plan to a Medicaid "like" State Plan

**Amendment #14:** MS SPA 20-0014-CHIP Disaster Relief Submitted: June 29, 2020 To implement temporary adjustments to enrollment and redetermination during Governor or federally-declared disasters and waive certain cost-sharing during the COVID-19 emergency Effective: March 18, 2020

**Amendment # 15:** MS SPA 20-0015-CHIP Behavioral Health: The purpose of this SPA is to comply with section 5022 of the SUPPORT Act in areas related to coverage of behavioral health screening, prevention and treatment services, strategies to facilitate use of appropriate screening and assessment tools and the requirement that these services be provided in a culturally and linguistically appropriate manner.

Effective: August 30, 2021

**Amendment # 15:** MS SPA 23-0015-CHIP American Rescue Plan Submitted: The purpose of this SPA is to demonstrate compliance with the American Rescue Plan Act provisions that require states to cover treatment (including treatment of a condition that may seriously complicate COVID-19 treatment), testing, and vaccinations for COVID-19 without cost sharing in CHIP.

Effective: March 11, 2021

**Amendment # 16:** MS SPA 23-0016-CHIP Postpartum
The purpose of this SPA is to provide continuous 12-month postpartum coverage for pregnant women in CHIP. Effective April 1, 2023.

**Amendment # 17:** MS SPA 23-0017-CHIP Vaccine Attestation
The purpose of this SPA is to comply with the Inflation Reduction Act (IRA) requirement to attest to the coverage of all Advisory Committee on Immunization Practices (ACIP) recommended vaccines and their administration in the CHIP program
Effective October 1, 2023

**Amendment # 18:** MS SPA 25-0018-CHIP Incarcerated Youth
The purpose of this SPA is to comply with Section 2102(d)(1) requiring coverage for incarcerated youth of screening, diagnostic, and case management services otherwise available under CHIP.
Effective January 1, 2025

**Amendment # 19:** MS SPA 25-0019-CHIP Benefit Limits
The purpose of this SPA is to comply with the Medicaid & CHIP Eligibility and Enrollment final rule amending 42 C.F.R § 457.480(a) which prohibits annual and lifetime limits on benefits in CHIP.
Effective June 1, 2025

**6.1.4.6.** ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done)

**6.1.4.7** ☒ Other (Describe) Medicaid "like" excluding non-emergency transportation (NET), EPSDT, Mississippi Youth Programs Around the Clock (MYPAC) and Community Support Programs (CSP).

The benefit period is one (1) calendar year commencing January 1.

**6.2. The State elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42 CFR § 457.490)**

The state assures that no annual, lifetime or other aggregate dollar limitations are imposed on any medical or dental services covered under the CHIP State plan consistent with 42 CFR 457.480(a).

**6.2.1.** ☒ Inpatient services (Section 2110(a)(1))

Must be pre-certified as medically necessary and includes the following:

(1) Hospital room and board (including dietary and general nursing services).
(2) Use of operating or treatment rooms.
(3) Anesthetics and their administration.
(4) Intravenous injections and solutions.
(5) Physical therapy.
(6) Radiation therapy.
(7) Oxygen services and inhalation therapy
(8) Diagnostic services, such as x-rays, clinical laboratory examination, electrocardiograms, and electroencephalograms.
(9) Drugs and medicines, sera, biological and pharmaceutical preparations used during hospitalization which are listed in the hospital's formulary at the time of hospitalization, including charges for "take home" drugs.
(10) Dressings and Supplies, sterile trays, casts, and orthopedic splints.
(11) Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment and Supplies.
(12) Psychological testing when ordered by the physician and performed by a full-time employee of the hospital subject to limitations.
(13) Intensive, Coronary, and Burn Care Unit services.
(14) Occupational therapy.
(15) Speech therapy.

**6.2.2.** ☒ Outpatient services (Section 2110(a)(2))

See Physician Services and Surgical Services.

**6.2.3.** ☒ Physician services (Section 2110(a)(3)) Include the following:

In-hospital medical care.

(1) Benefits for Covered Medical Expenses are paid for medically necessary inpatient psychiatric treatment of an enrollee.
(2) Certification of medical necessity by the UM/QIO or designee is required for admissions to a hospital.

**6.2.11.** ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)

Benefits for Covered Medical Expenses for treatment of mental, behavioral and neurodevelopmental disorders on an outpatient basis.

State-operated mental hospitals do not offer community-based outpatient services.

**6.2.12.** ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))

Rental of Durable Medical Equipment is covered for temporary therapeutic use; provided, however, when prior authorized by the UM/QIO or designee, the purchase price of such equipment may be allowed. To be Durable Medical Equipment, an item must be (1) made to withstand repeated use; (2) primarily used to serve a medical purpose; (3) generally not useful to a person in the absence of illness, injury or disease; and (4) appropriate for use in the enrollee's home.

Prosthetic or Orthotic Devices necessary for the alleviation or correction of conditions arising from accidental injury, illness, or congenital abnormalities are covered services. Benefits are available for the initial placement, fitting, and purchase of Prosthetic or Orthotic devices that require a prescription by a physician and for the repair or replacement when medically necessary. Shoes are not covered except for the following:
(1) a surgical boot which is part of an upright brace, (2) one pair of mismatched shoes annually in instances where a foot size disparity is greater than two sizes, and (3) a custom fabricated shoe in the case of a significant foot deformity.

Eyeglasses and hearing aids are covered services.

**6.2.13.** ☒ Disposable medical supplies (Section 2110(a)(13))

Supplies provided under the Plan, which are medically necessary disposable items, primarily serving a medical purpose, having therapeutic or diagnostic characteristics essential in enabling an enrollee to effectively carry out a practitioner's prescribed treatment for illness, injury, or disease.

**6.2.14.** ☒ Home and community-based health care services (See instructions) (Section 2110(a)(14))

Services and supplies required for the administration of Home Infusion Therapy regimen must be (1) medically necessary for the treatment of the disease; (2) ordered by a

practitioner; (3) as determined by the UM/QIO or designee capable of safe administration in the home; (4) provided by a licensed Home Infusion Therapy provider coordinated and pre-certified by the UM/QIO or designee; (5) ordinarily in lieu of inpatient hospital therapy; and (6) more cost effective than inpatient therapy.

Benefits for home health nursing services must be approved by the UM/QIO or designee in lieu of hospitalization.

**6.2.15.** ☒ Nursing care services (Section 2110(a)(15))

Benefits include nursing services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) when ordered and supervised by a practitioner and when the services rendered require the technical skills of an RN or LPN.

Benefits are provided for covered medical expense when performed by a nurse practitioner practicing within the scope of his or her license at the time and place service is rendered.

Benefits for private duty nursing services are provided for an illness or injury that the Insurer's Utilization Review Program determines to be of such a nature and complexity that the skilled nursing services could not be provided by the hospital's nursing staff. A shift of eight (8) continuous hours or more is required for private duty nursing services. Benefits are also provided for nursing services in the home for illness or injury that the Insurer's Utilization Review Program determines to require the skills of an RN or LPN. Benefits for nursing services provided in an enrollee's home must be approved by the UM/QIO or designee in lieu of hospitalization. No nursing benefits are provided for:

(1) Services of a nurse who ordinarily lives in the child's home or is a member of the child's family;
(2) Services of an aide, orderly or sitter; or
(3) Nursing services provided in a long-term care facility or inpatient hospital.

**6.2.16.** ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)

Benefits are allowed for elective abortion only when documented to be medically necessary within the limits of federal and state law.

**6.2.17.** ☒ Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)

(1) Benefits are provided for preventive and diagnostic dental care as recommended by the American Academy of Pediatric Dentistry (AAPD).

(2) Benefits are provided for restorative, endodontic, periodontic, and surgical dental services, as indicated below:

a. Amalgam, Silicate, Sedative and Composite Resin Fillings including the replacement of an existing restoration;
b. Stainless steel crowns to posterior and anterior teeth;
c. Porcelain crowns to anterior teeth only;
d. Simple extraction;
e. Extraction of an impacted tooth;
f. Pulpotomy, pulpectomy, and root canal; and
g. Gingivectomy, gingivoplasty and gingival curettage.

Other Dental Services:

(1) Benefits are provided for dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) effected solely through external means occurring while the enrolled child is covered under the Program. Injury to teeth as a result of chewing or biting is not considered an accidental injury.
(2) Benefits are provided for anesthesia and for associated facility charges when the mental or physical condition of the enrolled child requires dental treatment to be rendered under physician-supervised general anesthesia in a hospital setting, surgical center or dental office. These services must be pre-certified.
(3) No benefits will be provided for orthodontics, dentures, occlusion reconstruction, or for inlays unless such services are provided pursuant to an accidental injury as described above or when such services are recommended by a physician or dentist for the treatment of severe craniofacial anomalies or full cusp Class III malocclusions. Diagnosis and surgical treatment for temporomandibular joint (TMJ) disorder or syndrome and craniomandibular disorder, whether such treatment is rendered by a practitioner or dentist, is covered regardless of whether the temporomandibular/craniomandibular joint disorder was caused by an accidental injury or was congenital in nature.

**6.2.18.** ☒ Inpatient substance use disorder treatment services and residential substance use disorder

treatment services (Section 2110(a)(18))

Benefits for covered medical expenses are provided for the treatment of substance use disorder , whether for alcohol abuse, drug abuse, or a combination of alcohol and drug abuse, as follows:

(1) Benefits for covered medical expenses are provided for medically necessary inpatient stabilization and residential substance use disorder treatment.
(2) Certification of medical necessity by the UM/QIO or designee is required for admissions to a hospital or residential treatment center.
(3) Benefits for substance use disorder do not include services for treatment of mental, behavioral and neurodevelopmental disorders.

**6.2.19.** ☒ Outpatient substance use disorder (SUD) treatment services (Section 2110(a)(19))

(1) Benefits are provided for covered medical expenses for medically necessary outpatient SUD treatment services in a hospital, a primary residential substance abuse and rehabilitation center, or community mental health center or private community mental health center.
(2) Benefits are provided for covered medical expenses for substance use disorder treatment while not confined as a hospital inpatient.
(3) Benefits for substance use disorder do not include services for treatment of mental, behavioral and neurodevelopmental disorders.

**6.2.20.** ☐ Case management services (Section 2110(a)(20))

**6.2.21.** ☒ Care coordination services (Section 2110(a)(21))

Care coordination is available to members through the CCOs.

**6.2.22.** ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))

Benefits are provided for physical therapy services specified in a plan of treatment prescribed by the enrollee's practitioner and provided by a licensed physical therapist. Not covered for maintenance physical therapy.

Benefits are provided for medically necessary occupational therapy services prescribed by the enrollee's practitioner and specified in a treatment plan. Occupational therapy services must be provided by a licensed occupational therapist. Not covered for maintenance occupational therapy.

Benefits are provided for medically necessary speech therapy services prescribed by the enrollee's practitioner and specified in a treatment plan. Speech therapy is not covered for maintenance speech or articulation disorders.

Benefits are provided for an annual hearing examination, if indicated by the results of a hearing screening.

**6.2.23.** ☒ Hospice care (Section 2110(a)(23))

Benefits are provided for inpatient and home hospice services, subject to utilization management requirements.

**6.2.24.** ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))

Benefits are provided for general anesthesia service when requested by the attending physician and performed by an anesthesiologist or a certified registered nurse anesthetist practicing within the scope of his or her license at the time and place service is rendered.

Transplant Benefits:

(1) Any human solid organ or bone marrow/stem cell transplant is covered, provided the following applies:

(i) The enrollee or provider obtains prior approval from the Insurer's Utilization Management Program; and
(ii) The condition is life-threatening; and
(iii) Such transplant for that condition is the subject of an ongoing phase III clinical trial; and
(iv) Such transplant for that condition follows a written protocol that has been reviewed and approved by an institutional review board, federal agency or other such organization recognized by medical specialists who have appropriate expertise; and
(v) The enrollee is a suitable candidate for the transplant under the medical protocols used by the Insurer's Utilization Management Program.

(2) In addition to regular benefits, benefits are provided for surgical, storage, and transportation expenses incurred and directly related to the donation of an organ or tissue used in a covered organ transplant procedure.
(3) Benefits are provided for transportation costs of recipient and two other individuals to and from the site of the transplant surgery and reasonable and necessary expenses for meals and lodging of two individuals at the site of transplant surgery. Reasonable and necessary expenses for transportation, meals, and lodging of two other individuals are provided. Only those expenses which are incurred at the time of the transplant surgery are eligible for reimbursement. Travel expenses incurred as a result of pre-operative and post-operative services are not eligible for reimbursement. Only actual travel expenses supported by receipts are reimbursed. In any event, the total benefits for transportation, meals, and lodging are limited to ten thousand dollars and zero cents ($10,000.00).
(4) If a covered solid organ or tissue transplant is provided from a living donor to a human transplant recipient:
(i) The following expenses are covered:
1) A search for matching tissue, bone marrow or organ
2) Donor's transportation
3) Charges for removal, withdrawal and preservation, and

4) Donor's hospitalization.

(ii) When only the recipient is enrolled in the Program, the donor is entitled to donor coverage benefits. The donor benefits are limited to only those not available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program. Benefits provided to the donor will be paid under the recipient's contract.

(iii) When both the recipient and the donor are enrolled in the Program.

(iv) When only the donor is a CHIP participant, the donor is not entitled to donor coverage benefits. No benefits are provided to the non-member transplant recipient.

(v) If any organ or tissue is sold rather than donated to the enrollee, no benefits are payable for the purchase price of such organ or tissue.

Manipulative therapy is a covered medical expense.

Benefits are provided for medically necessary services and supplies required for the treatment of injury or disease of the eye which fall within the legal scope of practice of a licensed optometrist. Benefits are provided for annual routine eye examinations, eyeglasses, and the fitting of eyeglasses.

Benefits are provided for diabetes self-management training and education, including medical nutrition therapy, for the treatment of diabetes.

**6.2.25.** ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))

**6.2.26.** ☒ Medical transportation (Section 2110(a)(26))

Professional ambulance services to the nearest hospital, which is equipped to handle the enrollee's condition in connection with covered hospital inpatient, care; or when related to and within seventy-two (72) hours after accidental bodily injury or medical emergency whether or not inpatient care is required.

**6.2.27.** ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))

**6.2.28.** ☒ Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))

Limitations and Exclusions:

a. For convalescent, custodial, or domiciliary care or rest cures, including room and board, with or without routine nursing care, training in personal hygiene and other forms of self-care or supervisory care by a physician for an enrollee who is mentally or physically disabled as a result of retarded development or body infirmity, or who is not under specific medical, surgical or psychiatric treatment to reduce his disability to the extent necessary to enable him to live outside an institution providing care; neither

**6.2-BH Behavioral Health Coverage** Section 2103(c)(5) requires that states provide coverage to prevent, diagnose, and treat a broad range of mental health and substance use disorders in a culturally and linguistically appropriate manner for all CHIP enrollees, including pregnant women and unborn children.

Guidance: Please attach a copy of the state's periodicity schedule. For pregnancy-related coverage, please describe the recommendations being followed for those services.

**6.2.1- BH Periodicity Schedule** The state has adopted the following periodicity schedule for behavioral health screenings and assessments. Please specify any differences between any covered CHIP populations:

- ☐ State-developed schedule
- ☒ American Academy of Pediatrics/ Bright Futures
- ☒ Other Nationally recognized periodicity schedule (please specify: U.S. Preventive Service Task Force.)
- ☐ Other (please describe: )

**6.3- BH Covered Benefits** Please check off the behavioral health services that are provided to the state's CHIP populations, and provide a description of the amount, duration, and scope of each benefit. For each benefit, please also indicate whether the benefit is available for mental health and/or substance use disorders. If there are differences in benefits based on the population or type of condition being treated, please specify those differences.

If EPSDT is provided, as described at Section 6.2.22 and 6.2.22.1, the state should only check off the applicable benefits. It does not have to provide additional information regarding the amount, duration, and scope of each covered behavioral health benefit.

All benefits may exceed limits if deemed medically necessary.

Guidance: Please include a description of the services provided in addition to the behavioral health screenings and assessments described in the assurance below at 6.3.1.1-BH.

**6.3.1- BH** ☒ Behavioral health screenings and assessments. (Section 2103(c)(6)(A))

In addition to the required screenings covered as part of the assurance at section 6.3.1.1-BH, the state covers the following:

UHC and Molina only require Prior Authorization for out-of-network providers.

UHC covers:
Psychiatric Diagnostic Evaluations.

Psychological Diagnostic Evaluations.

Mental Health Assessments.

Brief Emotional/Behavioral Health Assessments.

Nursing Assessments.

Molina covers:
Psychosocial assessments. Psychological evaluations.

Psychiatric Diagnostic Evaluations and Office Visits.

Mental Health Assessments.

Brief Emotional/Behavioral Health Assessments.

Nursing Assessments.

Office Visits.

**6.3.1.1- BH** ☒ The state assures that all developmental and behavioral health recommendations outlined in the AAP Bright Futures periodicity schedule and United States Public Preventive Services Task Force (USPSTF) recommendations graded as A and B are covered as a part of the CHIP benefit package, as appropriate for the covered populations.

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools in primary care practice, providing education, training, and technical resources, and covering the costs of administering or purchasing the tools.

**6.3.1.2- BH** ☒ The state assures that it will implement a strategy to facilitate the use of age-appropriate validated behavioral health screening tools in primary care settings. Please describe how the state will facilitate the use of validated screening tools.

Providers are required to perform behavior health screening according to age-

appropriate and validated screening -tools. Specifically, SPA 20-0013-CHIP requires UHC and Molina the use of USPSFT recommendations graded as A and B and under SPA 20-0015-CHIP also requires the use of the AAP Bright Futures for all developmental and behavioral health screenings specified in the March 2, 2020 SHO #20-001 letter. The CCOs are currently using the screening tool. This requirement will also be added to the CCO's contracts with the next planned Amendment. The CCOs must conduct provider education and training on screening tools, disseminate information on validated screening tools, and provide updates which are shared with providers as the updates are implemented by the appropriate entity. The CCOs will disseminate this information via provider manuals, provider newsletters and/or global updates.

**6.3.2- BH** ☒ Outpatient services (Sections 2110(a)(11) and 2110(a)(19))

Guidance: Psychosocial treatment includes services such as psychotherapy, group therapy, family therapy and other types of counseling services.

**6.3.2.1- BH** ☒ Psychosocial treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC and Molina cover within the CMHC:
Individual Psychotherapy provided without an evaluation and management visit. Interactive complexity is covered with an individual psychotherapy session when medically necessary.

Family Psychotherapy.

Group Therapy/Multi-Family Group Therapy. Interactive complexity is covered with group therapy sessions when medically necessary.

UHC and Molina cover outside of the CMHC:
Individual/Family/Group Therapy outside of CMHC, no prior authorization is required for participating providers.

**Psychosocial Treatment**
Outpatient Psychotherapeutic Services [Psychosocial Treatment] include initial assessment, and individual, family, group, and multi-family group therapies. Outpatient Psychotherapeutic Services are defined as intentional, face-to-face interactions (conversations or non-verbal encounters, such as play therapy) between a Mental Health Therapist, IDD Therapist or A/D Therapist (as appropriate to the population being served) and a person, family or group where a therapeutic relationship is established to help resolve symptoms of a mental and/or emotional disturbance.

**6.3.2.2- BH** ☒ Tobacco cessation

Provided for: ☒ Substance Use Disorder

UHC and Molina follow DOM's PDL with no further restrictions. All FDA approved medications are available.

UHC and Molina do not have any limits on tobacco cessation benefits including counseling and also refer to the Mississippi Tobacco Quitline for beneficiaries age 18 and older as a statewide initiative. For beneficiaries under age 18, referral is made to individual practitioners for tobacco cessation services, RAT program, and the SmokeFreeTeen program. Beneficiaries are also enrolled in CM as appropriate for tobacco cessation.

**Tobacco cessation services**
The Mississippi Tobacco Quitline is an evidence-based, tobacco cessation treatment program that has services available to residents of the state of Mississippi who are motivated to quit using tobacco products and 18 years of age and older. The program is available by the telephone and also in a web-based format to deliver counseling and nicotine replacement therapy (the patch and gum) at no cost to participants. All staff are Master's Level counselors who deliver effective behavior modification therapy. For beneficiaries under age 18, referral is made to individual practitioners for tobacco cessation services in addition to the following: Reject All Tobacco (RAT) program for kindergarten to 6$^{th}$ grade, and for teens (ages 13-17) the SmokeFreeTeen program (SmokeFree.gov).

Guidance: In order to provide a benefit package consistent with section 2103(c)(5) of the Act, MAT benefits are required for the treatment of opioid use disorders. However, if the state provides MAT for other SUD conditions, please include a description of those benefits below at section 6.3.2.3- BH.

**6.3.2.3- BH** ☒ Medication Assisted Treatment
Provided for: ☒ Substance Use Disorder

UHC and Molina cover with no limitations on outpatient psychotherapy/behavioral therapies available under MAT. Participation is not required in order to receive the medication component. All FDA approved medications are available. Limitations on buprenorphine are according to the PDL located at Universal Preferred Drug List | Mississippi Division of Medicaid (ms.gov).

**Medication Assisted Treatment/Opioid Treatment Services**
Opioid Treatment Services include medication assisted treatment, counseling, and recovery support for people with a diagnosis of opioid addiction. The clinical purpose of opioid treatment services is to support the person by utilizing methadone, and/or buprenorphine, including buprenorphine-naloxone formulations, naltrexone, and other medications approved by the federal Food and Drug Administration (FDA), while the person participates in a spectrum of counseling and other recovery support services that

are intended to assist the person with successful recovery from opioid addiction Service components include:
1) Assessments
2) Laboratory services
3) Physician services including Medication Evaluation and Management
4) Medication Administration
5) Therapy Services
6) Medical Services
7) Pharmacy Services

**6.3.2.3.1- BH** ☒ Opioid Use Disorder

**6.3.2.3.2- BH** ☒ Alcohol Use Disorder

**6.3.2.3.3- BH** ☐ Other

**6.3.2.4- BH** ☒ Peer Support
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC and Molina cover:
Peer support.

**Peer Support Services**
Peer Support Services are non-clinical activities with a rehabilitation and resiliency/recovery focus that allow a person receiving mental health services and substance use 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. Natural resources are utilized to enhance community living skills, community integration, rehabilitation, resiliency and recovery. Peer Support is a helping relationship between peers and/or family members that is directed toward the achievement of specific goals defined by the person. Peer Support Services are provided by Certified Peer Support Specialist Professionals. A Certified Peer Support Specialist Professional is a person with significant life-altering experience, also referred to as lived experience, who has successfully completed peer support competencies-based training and testing.

**6.3.2.5- BH** ☐ Caregiver Support
Provided for: ☐ Mental Health ☐ Substance Use Disorder

**6.3.2.6- BH** ☐ Respite Care
Provided for: ☐ Mental Health ☐ Substance Use Disorder

**6.3.2.7- BH** ☒ Intensive in-home services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC and Molina covers:
PACT services. Prior authorization required.

Program of Assertive Community Treatment (PACT) is an individual-centered, recovery-oriented mental health service delivery model for facilitating community living, psychological rehabilitation and recovery for persons who have the most severe and persistent mental illnesses, have severe symptoms and impairments, and have not benefited from traditional outpatient programs. The important characteristics of Programs of Assertive Community Treatment (PACT) are:

1. PACT serves individuals who may have gone without appropriate services. Consequently, the individual group is often over represented among the homeless and in jails and prisons, and has been unfairly thought to resist or avoid involvement in treatment.
2. PACT services are delivered by a group of multidisciplinary mental health staff who work as a team and provide the majority of the treatment, rehabilitation, and support services individuals need to achieve their goals. Many, if not all, staff share responsibility for addressing the needs of all individuals requiring frequent contact.
3. PACT services are individually tailored with each individual and address the preferences and identified goals of each individual. The approach with each individual emphasizes relationship building and active involvement in assisting individuals with severe and persistent mental illness to make improvements in functioning, to better manage symptoms, to achieve individual goals, and to maintain optimism.
4. The PACT team is mobile and delivers services in community locations to enable each individual to find and live in their own residence and find and maintain work in community jobs rather than expecting the individual to come to the program.
5. PACT services are delivered in an ongoing rather than time-limited framework to aid the process of recovery and ensure continuity of caregiver. Severe and persistent mental illnesses are episodic disorders and many individuals benefit from the availability of a longer-term treatment approach and continuity of care. This allows individuals opportunity to recompensate, consolidate gains, sometimes slip back, and then take the next steps forward until they achieve recovery.

PACT Admissions criteria includes:

PACT Teams serve individuals with severe and persistent mental illness as listed in the most current edition of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association that seriously impair their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability. Individuals with other psychiatric illnesses are eligible dependent on the level of the long-term disability. (Individuals with a primary diagnosis of a substance abuse disorder, intellectual disability or other Axis II disorders are not the intended individual group. Additionally, individuals with a chronically violent history may not be appropriate for this service.)

Individuals with significant functional impairments as demonstrated by at least one of the following conditions:

1. Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives.
2. Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities).
3. Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).

Individuals must have one or more of the following problems, which are indicators of continuous high-service needs (i.e., greater than eight hours per month):
1. High use of acute psychiatric hospitals (e.g., two [2] or more admissions per year) or psychiatric emergency services.
2. Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).
3. Coexisting substance abuse disorder of significant duration (e.g., greater than six [6] months).
4. High risk or recent history of criminal justice involvement (e.g., arrest, incarceration).
5. Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or in imminent risk of becoming homeless.
6. Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available.
7. Difficulty effectively utilizing traditional office-based outpatient services

**6.3.2.8- BH** ☒ Intensive outpatient
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC and Molina cover:
Intensive Community Outreach and Recovery Team (ICORT) (previously referred to as Intensive Outpatient Psychiatric (IOP)). Prior authorization required. ICORT is provided in the community setting.

ICORT is a recovery and resiliency oriented, intensive, community-based rehabilitation and outreach service for children and adults with a 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. ICORT services are provided primarily in natural settings and are delivered face-to-face with the person and their family/significant other as appropriate, to the primary well-being and benefit of the recipient. Intensive Community Outreach and Recovery assists in the setting and attaining of individually defined recovery/resiliency goals. ICORT primary treatment objective 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.

**6.3.2.9- BH** ☒ Psychosocial rehabilitation
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC covers:
Psychosocial Rehabilitation Services.

Molina covers:
Psychosocial Rehabilitation Services. Prior authorization required.

**Psychosocial Rehab**
Psychosocial Rehabilitative Services (PSR) consists of a network of services designed to support and restore community functioning and well-being of adults with a serious and persistent mental illness. The purpose of the service is to promote recovery, resiliency, and empowerment of the person in his/her community. Service activities aim to improve reality orientation, social skills and adaptation, coping skills, effective management of time and resources, task completion, community and family integration, vocational and academic skills, and activities to incorporate the personal into independent community living; as well as to alleviate psychiatric decompensation, confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth. PSR Psychosocial Rehabilitative Services must utilize systematic, curriculum-based interventions for recovery skills development for participants. The curriculum-

based interventions must be evidence-based or recognized best practices in the field of mental health as recognized by Substance Abuse and Mental Health Services Administration (SAMHSA).

Guidance: If the state considers day treatment and partial hospitalization to be the same benefit, please indicate that in the benefit description. If there are differences between these benefits, such as the staffing or intensity of the setting, please specify those in the description of the benefit's amount, duration, and scope.

**6.3.3- BH** ☒ Day Treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC and Molina covers:
Day Treatment Services. Prior authorization required.

**Day Treatment**
Day Treatment Services are the most intensive outpatient services available to children/youth with serious emotional disturbance. The services must provide an alternative to residential treatment or acute psychiatric hospitalization or serve as a transition from these services. Day Treatment Services are a behavioral intervention and strengths-based program, provided in the context of a therapeutic milieu, which provides primarily school-age children/adolescents with serious emotional disturbances the intensity of treatment necessary to enable them to live in the community. Day Treatment Services are based on behavior management principles and include, at a minimum, positive feedback, self-esteem building and social skills training. Additional components are determined by the needs of the participants at a particular service location and may include skills training in the areas of impulse control, anger management, problem solving, and/or conflict resolution.

**6.3.3.1- BH** ☒ Partial Hospitalization
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC covers and Molina covers with prior authorization:
Acute Partial Hospitalization Services.

Acute Partial Hospitalization Services provide medical supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to people who are experiencing a period of such acute distress that their ability to cope with normal life circumstances is severely impaired. Acute Partial Hospitalization Services are designed to provide an alternative to inpatient hospitalization for such people or to serve as a bridge from inpatient to outpatient treatment. Service content may vary based on need but must include close observation/supervision and intensive support with a focus on the reduction/elimination of acute symptoms. Acute Partial Hospitalization Services may be provided to children/youth with serious emotional disturbance or people with substance use disorders.

**6.3.4- BH** ☒ Inpatient services, including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Sections 2110(a)(10) and 2110(a)(18))

Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC and Molina cover:
No limitations, prior authorization required.

Guidance: If applicable, please clarify any differences within the residential treatment benefit (e.g. intensity of services, provider types, or settings in which the residential treatment services are provided).

**6.3.4.1- BH** ☒ Residential Treatment

Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC and Molina cover:
Psychiatric residential treatment facilities (PRTFs) are residential services for children under twenty-one (21). Prior authorization required.

**Psychiatric Residential Treatment Facility**
Psychiatric Residential Treatment Facility is defined as any non-hospital establishment with permanent facilities which provides a twenty-four (24) hour program of care by qualified therapists for children under the age of 21, with an average length of stay of 6 months. These services include, but are not limited to, duly licensed mental health professionals, psychiatric mental health nurse practitioners, psychiatrists, psychologists and licensed certified social workers, for emotionally disturbed children and adolescents referred to such facility by a court, local school district or by the Department of Human Service. These children are not in an acute phase of illness requiring the services of a psychiatric hospital, and are in need of such restorative treatment services. For purposes of this service, the term "serious emotionally disturbed" means a condition exhibiting one or more of the following characteristics over along period of time and to a marked degree, which adversely affects educational performance:
1. An inability to learn which cannot be explained by intellectual, sensory or health factors;
2. An inability to build or maintain satisfactory relationships with peers and teachers;
3. Inappropriate types of behavior or feelings under normal circumstances;
4. A general pervasive mood of unhappiness or depression; or
5. A tendency to develop physical symptoms or fears associated with personal or school problems.

**6.3.4.2- BH** ☒ Detoxification

Provided for: ☒ Substance Use Disorder

UHC and Molina cover:
No limitations. Prior authorization required. Ambulatory detox in the outpatient setting is provided if it does not require 24 hour medical observation but if so, it would be provided in an inpatient detox setting.

**Detox**
Detoxification is a set of interventions aimed at managing acute and intoxication and withdrawal. It denotes a clearing of toxins from the body of the patient who is acutely intoxicated and/or dependent on substances of abuse. Detoxification seeks to minimize the physical harm caused by the abuse of substances and is available in the acute, sub-acute and residential setting.

Guidance: Crisis intervention and stabilization could include services such as mobile crisis, or short term residential or other facility based services in order to avoid inpatient hospitalization.

**6.3.5- BH** ☒ Emergency services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC and Molina cover:
Emergency services are not limited and do not require prior authorization.

**Emergency/Crisis Response Services**
Emergency crisis services are available at all emergency rooms in the state for members on a walk in basis or if 911 and emergency transport is involved. Emergency/crisis response in the community mental health setting is defined as a time-limited intensive intervention, available twenty-four (24) hours a day, seven (7) days a week. Crisis response services allow for the assessment of the crisis and ability to activate a mobile crisis team. Trained crisis response staff provides crisis stabilization directed toward preventing hospitalization. Children or adults requiring crisis services are those who are experiencing a significant emotional/behavioral crisis. A crisis situation is defined as a situation in which an individual's mental health and/or behavioral health needs exceed the individual's resources, in the opinion of the mental health professional assessing the situation. Staff must be able to triage and make appropriate clinical decisions, including accessing the need for inpatient services or less restrictive alternatives. These services are available throughout the entire state and catchment areas.

**6.3.5.1- BH** ☒ Crisis Intervention and Stabilization
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC and Molina covers:
Crisis Response Services are not limited. No prior authorization required.
Crisis Residential Services. Prior authorization required.

Crisis Response is an intensive therapeutic service which allows for the assessment of and intervention in a mental health crisis. Crisis Response Services are provided to children/youth who are experiencing a significant emotional/behavioral crisis in which the person's mental health and/or behavioral health needs exceed the person's resources (in the opinion of the mental health professional assessing the situation.) Trained Crisis Response personnel provide crisis stabilization directed toward preventing hospitalization. Employees triage and make appropriate clinical decisions, including assessing the need for inpatient services or less restrictive alternatives. Crisis Response Services facilitate and verify formal initial assessment and therapy appointments, when the crisis situation subsides, with the mental health provider of the person's choice (if the person is able to remain in the community) utilizing the "warm handoff" method. A "warm handoff" is an approach to care transitions in which health care providers directly link people with typical service providers, using face-to-face or phone transfer.

Crisis Residential Services are time-limited residential treatment services provided in a Crisis Residential Unit which provides psychiatric supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to people who are experiencing a period of acute psychiatric distress which severely impairs their ability to cope with normal life circumstances. Crisis Residential Services prevent civil commitment and/or longer term inpatient psychiatric hospitalization by addressing acute symptoms, distress and further decomposition. Crisis Residential Services content may vary based on each person's needs but must include close observation/supervision and intensive support with a focus on the reduction/elimination of acute symptoms.

**6.3.6- BH** ☒ Continuing care services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC and Molina covers:
Wraparound. No prior authorization required.

**Wraparound**
Wraparound facilitation is the creation and facilitation of a child and family team for the purpose of developing a single plan of care to address the needs of youth with complex mental health challenges and their families.

Activities include:
1. Engaging the family;
2. Assembling the child and family team;
3. Facilitating a child and family team meeting at a minimum every thirty (30) days;
4. Facilitating the creation of a plan of care, which includes a plan for anticipating, preventing and managing crisis, within the child and family team meeting;
5. Working with the team in identifying agency providers of services and other community resources to meet family and youth needs;

6. Making necessary referrals for youth;
7. Documenting and maintaining all information regarding the plan of care, including revisions and child and family team meetings;
8. Presenting plan of care for approval by the family and team;
9. Providing copies of the plan of care to the entire team including the youth and family parent(s)/legal guardian(s);
10. Monitoring the implementation of the plan of care and revising if necessary to achieve outcomes;
11. Maintaining communication between all child and family team members;
12. Monitoring the progress toward needs met and whether or not the referral behaviors are decreasing;
13. Leading the team to discuss and ensure the supports and services the youth and family are receiving continue to meet the caregiver and youth's needs;
14. Educating new team members about the wraparound process; and,
15. Maintaining team cohesiveness.

**6.3.7- BH** ☒ Care Coordination
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC and Molina cover:
Community Support Services.

Community Support Services are directed towards children, adolescents and families and will vary with respect to hours, type and intensity of services, depending on the changing needs of each person. The purpose/intent is to provide specific, measurable, and individualized services to each person served focusing on the person's ability to succeed in the community; to identify and access needed services; and, to show improvement in school, work, family, and community participation.

Community Support Services should be person-centered and focus on the person's recovery and ability to succeed in the community; to identify and access needed services; and, to show improvement in home, health, purpose and community.

**6.3.7.1- BH** ☐ Intensive wraparound
Provided for: ☐ Mental Health ☐ Substance Use Disorder

MYPAC is not covered by either UHC or Molina.

**6.3.7.2- BH** ☒ Care transition services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC and Molina cover:
Transition of Care program for CHIP members discharging for institutional or inpatient

settings.

**Care Coordination/Transition of Care**
Individuals with mental health and substance abuse disorders frequently rely on multiple organizations and treatment professionals to provide their health care. Additionally, a significant number of people with serious medical conditions also have behavioral health conditions.

Effectively coordinating care between these treatment professionals can lead to improved health outcomes, result in reduced healthcare costs, and benefit practitioners by enhancing networking with other professionals.

UHC and Molina provide a full array of care coordination services as well as a full transition of care program to their members ensuring the members are appropriately transitioned from any inpatient setting to the community to re-engage in life and work. This process begins with any hospital or residential setting notification of admission and the staff began to engage in discharge planning creating a transitional plan of care with the hospital staff, member, family, and outpatient professionals to ensure that the there is a multi disciplinary team who is supporting the member.

**6.3.8- BH** ☒ Case Management
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC covers:
Targeted Case Management – no prior authorization but conducts outlier medical necessity review per member.

Molina covers:
Targeted Case Management.

**Targeted Case Management**

Targeted Case Management is defined as services that provide information/referral and resource coordination to the member and/or his/her collaterals. Case Management Services are directed towards helping the member maintain his/her highest possible level of independent functioning. Case managers monitor the treatment plan and ensure team members complete tasks that are assigned to them, that follow up and follow through occur and help identify when the treatment team may need to review the treatment plan for updates if the established plan is not working.

Targeted case management may be provided face-to- face or via telephone and is not designed to be a mobile service, but there is no prohibition on services being provided in a location other than the community mental health center. Targeted case management must be included in the individual's treatment plan and the frequency of case

management services will be determined by the complexity of the case and the need of the beneficiary, but shall not occur less than once monthly.

**6.3.9- BH** ☒ Other
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC covers and Molina covers with prior authorization:
Neonatal alcohol fetal syndrome treatment.

## 6.4- BH Assessment Tools

**6.4.1- BH** Please specify or describe all of the tool(s) required by the state and/or each managed care entity: United Healthcare utilizes all tools check except InterQual. Molina only utilizes InterQual. The Division of Medicaid does not require specific assessment tools to be used.

☒ ASAM Criteria (American Society Addiction Medicine)
☒ Mental Health ☐ Substance Use Disorders

☒ InterQual
☒ Mental Health ☒ Substance Use Disorders

Molina only utilizes this tool.

☐ MCG Care Guidelines
☐ Mental Health ☐ Substance Use Disorders

☒ CALOCUS/LOCUS (Child and Adolescent Level of Care Utilization System)
☒ Mental Health ☒ Substance Use Disorders

☒ CASII (Child and Adolescent Service Intensity Instrument)
☐ Mental Health ☐ Substance Use Disorders

☐ CANS (Child and Adolescent Needs and Strengths)
☐ Mental Health ☐ Substance Use Disorders

☐ State-specific criteria (e.g. state law or policies) (please describe)
☐ Mental Health ☐ Substance Use Disorders

☐ Plan-specific criteria (please describe)
☐ Mental Health ☐ Substance Use Disorders

☒ Other (please describe)
☒ Mental Health ☒ Substance Use Disorders

United Healthcare also utilized ESPII.

☐ No specific criteria or tools are required
☐ Mental Health ☐ Substance Use Disorders

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools to determine possible treatments or plans of care, providing education, training, and technical resources, and covering the costs of administering or purchasing the assessment tools.

**6.4.2- BH** ☒ Please describe the state's strategy to facilitate the use of validated assessment tools for the treatment of behavioral health conditions.

Providers are encouraged to use -validated assessment tools for the treatment of behavioral health conditions. The CCOs are responsible for conducting trainings and communications to providers to utilize - validated assessment tools. The CCOs are responsible for follow-up for compliance. The CCOs encourage use through education, bulletins and clinical reviews.

**6.2.5- BH Covered Benefits** The State assures the following related to the provision of behavioral health benefits in CHIP:

☒ All behavioral health benefits are provided in a culturally and linguistically appropriate manner consistent with the requirements of section 2103(c)(6), regardless of delivery system.

☒ The state will provide all behavioral health benefits consistent with 42 CFR 457.495 to ensure there are procedures in place to access covered services as well as appropriate and timely treatment and monitoring of children with chronic, complex or serious conditions.

TEMPLATE FOR CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: Mississippi
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))

Tate Reeves 6/27/2025
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: ~~Drew Snyder~~Cindy Bradshaw Position/Title: Executive Director, MS Div. of Medicaid
Name: ~~Cindy Bradshaw~~Brian Whitmire Position/Title: Deputy Administrator, Office of Eligibility Name: Jennifer Wentworth Position/Title: ~~Deputy Administrator, Office of Finance~~Chief of Staff
Name: ~~Trip Polles~~ Vacant Position/Title: Senior Director of Legislative and External Affairs

**Disclosure Statement** This information is being collected to pursuant to 42 U.S.C. 1397aa, which requires states to submit a State Child Health Plan in order to receive federal funding. This mandatory information collection will be used to demonstrate compliance with all requirements of ~~t~~Title XXI of the Act and implementing regulations at 42 CFR part 457. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #34). Public burden for all of the collection of information requirements under this control number is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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.

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 457 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Name of Project Officer
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid and CHIP Services
Mail Stop - S2-01-16

## Section 1. General Description and Purpose of the Children's Health Insurance Plans and the Requirements

**1.1.** The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101)(a)( 1)); (42 CFR § 457.70):

**1.1.1** ☒ Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

**1.1.2.** ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

**1.1.3.** ☐ A combination of both of the above. (Section 2101(a)(2))

**1.1-DS** ☐ The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

**1.2** ☒ Check to provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR § 457.40(d))

**1.3** ☒ Check to provide an assurance that the State complies with all applicable civil rights requirements, including ~~t~~Title VI of the Civil Rights Act of 1964, ~~t~~Title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42 CFR § 457.130)

**1.4** Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR § 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan: Effective Date: July 1, 1998

Implementation Date: July 1, 1998

| | |
|---|---|
| **Amendment #1** submitted: August 1, 1998 | Implemented January 1, 2000 |
| **Amendment #2** submitted: September 22, 1999 | Implemented January 1, 2000 |
| **Amendment #3** submitted: July 6, 2000 | Implemented October 1, 2000 |
| **Amendment #4** submitted: July 3, 2001 | Implemented July 1, 2001 |
| **Amendment #5** submitted: September 30, 2002 | Implemented January 1, 2005 |
| **Amendment #6** submitted: December 29, 2005 | Implemented January 1, 2005 |
| **Amendment #7** submitted: December 6, 2010 Mental health parity requirements. | Implemented January 1, 2010 |
| **Amendment #8** submitted: September 25, 2013 | Implemented July 1, 2013 |

Insurance Program Reauthorization Act of 2009 (CHIPRA); clarification of enrollee coverage provided in an emergency department.

**Amendment #9** submitted: February 9, 2015 Implemented January 1, 2015 To reflect the change in operation of the separate CHIP health plan to two (2) contracted MCOs.

**Amendment #10** submitted: January 9, 2018 Implemented: October 1, 2019 To include a Health Services Initiative offering expanded vision services to low-income children throughout the state.

**Amendment #11** submitted: May 7, 2019 Implemented: July 1, 2018 To demonstrate compliance with the Mental Health Parity and Addiction Equality Act (MHPAEA) final rule.

**Amendment #12:** MS SPA 19-0012-CHIP Effective Date: July 1, 2018 To include managed care requirements.

**Amendment #13:** MS SPA 20-0013-CHIP Submitted: January 31, 2020 To change the benchmark from the Mississippi Effective: November 1, 2019 State and School Employee's Health Insurance Plan to a Medicaid "like" State Plan

**Amendment #14:** MS SPA 20-0014-CHIP Disaster Relief Submitted: June 29, 2020 To implement temporary adjustments to enrollment and redetermination during Governor or federally-declared disasters and waive certain cost-sharing during the COVID-19 emergency Effective: March 18, 2020

**Amendment # 15:** MS SPA 20-0015-CHIP Behavioral Health: The purpose of this SPA is to comply with section 5022 of the SUPPORT Act in areas related to coverage of behavioral health screening, prevention and treatment services, strategies to facilitate use of appropriate screening and assessment tools and the requirement that these services be provided in a culturally and linguistically appropriate manner.

Effective: August 30, 2021

**Amendment # 15:** MS SPA 23-0015-CHIP American Rescue Plan Submitted: The purpose of this SPA is to demonstrate compliance with the American Rescue Plan Act provisions that require states to cover treatment (including treatment of a condition that may seriously complicate COVID-19 treatment), testing, and vaccinations for COVID-19 without cost sharing in CHIP.

Effective: March 11, 2021

**Amendment # 16:** MS SPA 23-0016-CHIP Postpartum
The purpose of this SPA is to provide continuous 12-month postpartum coverage for pregnant women in CHIP. Effective April 1, 2023.

**Amendment # 17:** MS SPA 23-0017-CHIP Vaccine Attestation
The purpose of this SPA is to comply with the Inflation Reduction Act (IRA) requirement to attest to the coverage of all Advisory Committee on Immunization Practices (ACIP) recommended vaccines and their administration in the CHIP program
Effective October 1, 2023

**Amendment # 18:** MS SPA 25-0018-CHIP Incarcerated Youth
The purpose of this SPA is to comply with Section 2102(d)(1) requiring coverage for incarcerated youth of screening, diagnostic, and case management services otherwise available under CHIP.
Effective January 1, 2025

**Amendment # 19:** MS SPA 25-0019-CHIP Benefit Limits
The purpose of this SPA is to comply with the Medicaid & CHIP Eligibility and Enrollment final rule amending 42 C.F.R § 457.480(a) which prohibits annual and lifetime limits on benefits in CHIP.
Effective June 1, 2025

**6.1.4.6.** ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done)

**6.1.4.7** ☒ Other (Describe) Medicaid "like" excluding non-emergency transportation (NET), EPSDT, Mississippi Youth Programs Around the Clock (MYPAC) and Community Support Programs (CSP).

The benefit period is one (1) calendar year commencing January 1.

**6.2. The State elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42 CFR § 457.490)**

The state assures that no annual, lifetime or other aggregate dollar limitations are imposed on any medical or dental services covered under the CHIP State plan consistent with 42 CFR 457.480(a).

**6.2.1.** ☒ Inpatient services (Section 2110(a)(1))

Must be pre-certified as medically necessary and includes the following:

(1) Hospital room and board (including dietary and general nursing services).
(2) Use of operating or treatment rooms.
(3) Anesthetics and their administration.
(4) Intravenous injections and solutions.
(5) Physical therapy.
(6) Radiation therapy.
(7) Oxygen services and inhalation therapy
(8) Diagnostic services, such as x-rays, clinical laboratory examination, electrocardiograms, and electroencephalograms.
(9) Drugs and medicines, sera, biological and pharmaceutical preparations used during hospitalization which are listed in the hospital's formulary at the time of hospitalization, including charges for "take home" drugs.
(10) Dressings and Supplies, sterile trays, casts, and orthopedic splints.
(11) Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment and Supplies.
(12) Psychological testing when ordered by the physician and performed by a full-time employee of the hospital subject to limitations.
(13) Intensive, Coronary, and Burn Care Unit services.
(14) Occupational therapy.
(15) Speech therapy.

**6.2.2.** ☒ Outpatient services (Section 2110(a)(2))

See Physician Services and Surgical Services.

**6.2.3.** ☒ Physician services (Section 2110(a)(3)) Include the following:

In-hospital medical care.

(1) Benefits for Covered Medical Expenses are paid for medically necessary inpatient psychiatric treatment of an enrollee.
(2) Certification of medical necessity by the UM/QIO or designee is required for admissions to a hospital.

**6.2.11.** ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)

Benefits for Covered Medical Expenses for treatment of mental, behavioral and neurodevelopmental disorders on an outpatient basis.

State-operated mental hospitals do not offer community-based outpatient services.

**6.2.12.** ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))

Rental of Durable Medical Equipment is covered for temporary therapeutic use; provided, however, when prior authorized by the UM/QIO or designee, the purchase price of such equipment may be allowed. To be Durable Medical Equipment, an item must be (1) made to withstand repeated use; (2) primarily used to serve a medical purpose; (3) generally not useful to a person in the absence of illness, injury or disease; and (4) appropriate for use in the enrollee's home.

Prosthetic or Orthotic Devices necessary for the alleviation or correction of conditions arising from accidental injury, illness, or congenital abnormalities are covered services. Benefits are available for the initial placement, fitting, and purchase of Prosthetic or Orthotic devices that require a prescription by a physician and for the repair or replacement when medically necessary. Shoes are not covered except for the following:
(1) a surgical boot which is part of an upright brace, (2) one pair of mismatched shoes annually in instances where a foot size disparity is greater than two sizes, and (3) a custom fabricated shoe in the case of a significant foot deformity.

Eyeglasses ~~(limited to one (1) per year)~~and hearing aids ~~(limited to one (1) every three years)~~ are covered services.

**6.2.13.** ☒ Disposable medical supplies (Section 2110(a)(13))

Supplies provided under the Plan, which are medically necessary disposable items, primarily serving a medical purpose, having therapeutic or diagnostic characteristics essential in enabling an enrollee to effectively carry out a practitioner's prescribed treatment for illness, injury, or disease~~,~~.

**6.2.14.** ☒ Home and community-based health care services (See instructions) (Section 2110(a)(14))

Services and supplies required for the administration of Home Infusion Therapy regimen

must be (1) medically necessary for the treatment of the disease; (2) ordered by a

practitioner; (3) as determined by the UM/QIO or designee capable of safe administration in the home; (4) provided by a licensed Home Infusion Therapy provider coordinated and pre-certified by the UM/QIO or designee; (5) ordinarily in lieu of inpatient hospital therapy; and (6) more cost effective than inpatient therapy.

Benefits for home health nursing services must be approved by the UM/QIO or designee in lieu of hospitalization. ~~Benefits for nursing services are limited to ten thousand dollars and zero cents ($10,000.00) annually.~~

**6.2.15.** ☒ Nursing care services (Section 2110(a)(15))

Benefits include nursing services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) when ordered and supervised by a practitioner and when the services rendered require the technical skills of an RN or LPN.

Benefits are provided for covered medical expense when performed by a nurse practitioner practicing within the scope of his or her license at the time and place service is rendered.

Benefits for private duty nursing services are provided for an illness or injury that the Insurer's Utilization Review Program determines to be of such a nature and complexity that the skilled nursing services could not be provided by the hospital's nursing staff. A shift of eight (8) continuous hours or more is required for private duty nursing services. Benefits are also provided for nursing services in the home for illness or injury that the Insurer's Utilization Review Program determines to require the skills of an RN or LPN. Benefits for nursing services provided in an enrollee's home must be approved by the UM/QIO or designee in lieu of hospitalization. ~~Benefits for nursing services are limited to ten thousand dollars and zero cents ($10,000.00) annually. (This limit does not apply to nurse practitioner services.)~~ No nursing benefits are provided for:

(1) Services of a nurse who ordinarily lives in the child's home or is a member of the child's family;
(2) Services of an aide, orderly or sitter; or
(3) Nursing services provided in a long-term care facility or inpatient hospital.

~~Benefits are provided for confinement in a skilled nursing facility for up to sixty (60) days per benefit period, January 1 to December, 31, subject to utilization management requirements.~~

**6.2.16.** ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)

Benefits are allowed for elective abortion only when documented to be medically

necessary within the limits of federal and state law.~~.~~

**6.2.17.** ☒ Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)

~~Covered dental services are limited to two thousand dollars and zero cents ($2,000.00)~~

~~each calendar year (CY).~~

(1) Benefits are provided for preventive and diagnostic dental care as recommended by the American Academy of Pediatric Dentistry (AAPD)~~, as indicated below:~~.

~~a. Bitewing X-rays - as needed, but no more frequently than once every six (6) months;~~
~~b. Complete Mouth X-ray and Panoramic X-ray - as needed, but no more frequently than once every twenty-four (24) months;~~
~~c. Prophylaxis - one every six (6) months; must be separated by six (6) full months;~~
~~d. Fluoride Treatment - limited to one each six (6) month period;~~
~~e. Space Maintainers - limited to permanent teeth through age 15 years; and~~
~~f. Sealants - covered up to age 14 years, every thirty-six (36) months.~~

(2) Benefits are provided for restorative, endodontic, periodontic, and surgical dental services, as indicated below:

a. Amalgam, Silicate, Sedative and Composite Resin Fillings including the replacement of an existing restoration;
b. Stainless steel crowns to posterior and anterior teeth;
c. Porcelain crowns to anterior teeth only;
d. Simple extraction;
e. Extraction of an impacted tooth;
f. Pulpotomy, pulpectomy, and root canal; and
g. Gingivectomy, gingivoplasty and gingival curettage.

Other Dental Services: ~~(The calendar year maximum does not apply to these services.)~~

(1) Benefits are provided for dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) effected solely through external means occurring while the enrolled child is covered under the Program. Injury to teeth as a result of chewing or biting is not considered an accidental injury.
(2) Benefits are provided for anesthesia and for associated facility charges when the mental or physical condition of the enrolled child requires dental treatment to be rendered under physician-supervised general anesthesia in a hospital setting, surgical center or dental office. These services must be pre-certified.
(3) No benefits will be provided for orthodontics, dentures, occlusion reconstruction, or for inlays unless such services are provided pursuant to an accidental injury as described above or when such services are recommended by a physician or dentist for the treatment of severe craniofacial anomalies or full cusp Class III malocclusions. Diagnosis and surgical treatment for temporomandibular joint (TMJ) disorder or syndrome and craniomandibular disorder, whether such treatment is rendered by a practitioner or dentist, is ~~subject to a lifetime maximum benefit of five thousand dollars and zero cents ($5,000.00) per member. This lifetime maximum will apply~~ covered regardless of whether the temporomandibular/craniomandibular joint disorder was caused by an accidental injury or was congenital in nature.

**6.2.18.** ☒ Inpatient substance use disorder treatment services and residential substance use disorder

treatment services (Section 2110(a)(18))

Benefits for covered medical expenses are provided for the treatment of substance use disorder , whether for alcohol abuse, drug abuse, or a combination of alcohol and drug abuse, as follows:

(1) Benefits for covered medical expenses are provided for medically necessary inpatient stabilization and residential substance use disorder treatment.
(2) Certification of medical necessity by the UM/QIO or designee is required for admissions to a hospital or residential treatment center.
(3) Benefits for substance use disorder do not include services for treatment of mental, behavioral and neurodevelopmental disorders.

**6.2.19.** ☒ Outpatient substance use disorder (SUD) treatment services (Section 2110(a)(19))

(1) Benefits are provided for covered medical expenses for medically necessary outpatient SUD treatment services in a hospital, a primary residential substance abuse and rehabilitation center, or community mental health center or private community mental health center.
(2) Benefits are provided for covered medical expenses for substance use disorder treatment while not confined as a hospital inpatient.
(3) Benefits for substance use disorder do not include services for treatment of mental, behavioral and neurodevelopmental disorders.

**6.2.20.** ☐ Case management services (Section 2110(a)(20))

**6.2.21.** ☒ Care coordination services (Section 2110(a)(21))

Care coordination is available to members through the CCOs.

**6.2.22.** ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))

Benefits are provided for physical therapy services specified in a plan of treatment prescribed by the enrollee's practitioner and provided by a licensed physical therapist. Not covered for maintenance physical therapy.

Benefits are provided for medically necessary occupational therapy services prescribed by the enrollee's practitioner and specified in a treatment plan. Occupational therapy services must be provided by a licensed occupational therapist. Not covered for maintenance occupational therapy.

Benefits are provided for medically necessary speech therapy services prescribed by the enrollee's practitioner and specified in a treatment plan. Speech therapy is not covered for maintenance speech or articulation disorders.

Benefits are provided for an annual hearing examination, if indicated by the results of a hearing screening.

**6.2.23.** ☒ Hospice care (Section 2110(a)(23))

Benefits are provided for inpatient and home hospice services, subject to utilization management requirements. ~~Benefits for hospice services are limited to an overall lifetime maximum of fifteen thousand dollars and zero cents ($15,000.00).~~

**6.2.24.** ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))

Benefits are provided for general anesthesia service when requested by the attending physician and performed by an anesthesiologist or a certified registered nurse anesthetist practicing within the scope of his or her license at the time and place service is rendered.

Transplant Benefits:

(1) Any human solid organ or bone marrow/stem cell transplant is covered, provided the following applies:

(i) The enrollee or provider obtains prior approval from the Insurer's Utilization Management Program; and
(ii) The condition is life-threatening; and
(iii) Such transplant for that condition is the subject of an ongoing phase III clinical trial; and
(iv) Such transplant for that condition follows a written protocol that has been reviewed and approved by an institutional review board, federal agency or other such organization recognized by medical specialists who have appropriate expertise; and
(v) The enrollee is a suitable candidate for the transplant under the medical protocols used by the Insurer's Utilization Management Program.

(2) In addition to regular benefits, benefits are provided for surgical, storage, and transportation expenses incurred and directly related to the donation of an organ or tissue used in a covered organ transplant procedure.
(3) Benefits are provided for transportation costs of recipient and two other individuals to and from the site of the transplant surgery and reasonable and necessary expenses for meals and lodging of two individuals at the site of transplant surgery. Reasonable and necessary expenses for transportation, meals, and lodging of two other individuals are provided. Only those expenses which are incurred at the time of the transplant surgery are eligible for reimbursement. Travel expenses incurred as a result of pre-operative and post-operative services are not eligible for reimbursement. Only actual travel expenses supported by receipts are reimbursed. In any event, the total benefits for transportation, meals, and lodging are limited to ten thousand dollars and zero cents ($10,000.00).
(4) If a covered solid organ or tissue transplant is provided from a living donor to a human transplant recipient:
(i) The following expenses are covered:
1) A search for matching tissue, bone marrow or organ
2) Donor's transportation
3) Charges for removal, withdrawal and preservation, and

4) Donor's hospitalization.

(ii) When only the recipient is enrolled in the Program, the donor is entitled to donor coverage benefits. The donor benefits are limited to only those not available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program. Benefits provided to the donor will be paid under the recipient's contract.

(iii) When both the recipient and the donor are enrolled in the Program.

(iv) When only the donor is a CHIP participant, the donor is not entitled to donor coverage benefits. No benefits are provided to the non-member transplant recipient.

(v) If any organ or tissue is sold rather than donated to the enrollee, no benefits are payable for the purchase price of such organ or tissue~~;~~.

Manipulative therapy is a covered medical expense ~~but benefits shall not exceed two thousand dollars and zero cents ($2,000.00) annually~~.

Benefits are provided for medically necessary services and supplies required for the treatment of injury or disease of the eye which fall within the legal scope of practice of a licensed optometrist. Benefits are provided for annual routine eye examinations, eyeglasses, and the fitting of eyeglasses.

Benefits are provided for diabetes self-management training and education, including medical nutrition therapy, for the treatment of diabetes~~, subject to a limitation of two hundred fifty dollars and zero cents ($250.00) per benefit period, January 1 to December 31~~.

**6.2.25.** ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))

**6.2.26.** ☒ Medical transportation (Section 2110(a)(26))

Professional ambulance services to the nearest hospital, which is equipped to handle the enrollee's condition in connection with covered hospital inpatient, care; or when related to and within seventy-two (72) hours after accidental bodily injury or medical emergency whether or not inpatient care is required.

**6.2.27.** ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))

**6.2.28.** ☒ Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))

Limitations and Exclusions:

a. For convalescent, custodial, or domiciliary care or rest cures, including room and board, with or without routine nursing care, training in personal hygiene and other forms of self-care or supervisory care by a physician for an enrollee who is mentally or physically disabled as a result of retarded development or body infirmity, or who is not under specific medical, surgical or psychiatric treatment to reduce his disability to the extent necessary to enable him to live outside an institution providing care; neither

**6.2-BH Behavioral Health Coverage** Section 2103(c)(5) requires that states provide coverage to prevent, diagnose, and treat a broad range of mental health and substance use disorders in a culturally and linguistically appropriate manner for all CHIP enrollees, including pregnant women and unborn children.

Guidance: Please attach a copy of the state's periodicity schedule. For pregnancy-related coverage, please describe the recommendations being followed for those services.

**6.2.1- BH Periodicity Schedule** The state has adopted the following periodicity schedule for behavioral health screenings and assessments. Please specify any differences between any covered CHIP populations:

- ☐ State-developed schedule
- ☒ American Academy of Pediatrics/ Bright Futures
- ☒ Other Nationally recognized periodicity schedule (please specify: U.S. Preventive Service Task Force.)
- ☐ Other (please describe: )

**6.3- BH Covered Benefits** Please check off the behavioral health services that are provided to the state's CHIP populations, and provide a description of the amount, duration, and scope of each benefit. For each benefit, please also indicate whether the benefit is available for mental health and/or substance use disorders. If there are differences in benefits based on the population or type of condition being treated, please specify those differences.

If EPSDT is provided, as described at Section 6.2.22 and 6.2.22.1, the state should only check off the applicable benefits. It does not have to provide additional information regarding the amount, duration, and scope of each covered behavioral health benefit.

All benefits may exceed limits if deemed medically necessary.

Guidance: Please include a description of the services provided in addition to the behavioral health screenings and assessments described in the assurance below at 6.3.1.1-BH.

**6.3.1- BH** ☒ Behavioral health screenings and assessments. (Section 2103(c)(6)(A))

In addition to the required screenings covered as part of the assurance at section 6.3.1.1-BH, the state covers the following:

UHC and Molina only require Prior Authorization for out-of-network providers.

UHC covers:
Psychiatric Diagnostic Evaluations ~~are limited to four (4) units per state fiscal year~~.

Psychological Diagnostic Evaluations ~~are limited to sixteen (16) hours state fiscal year~~.

Mental Health Assessments ~~are limited to four (4) units per state fiscal year~~.

Brief Emotional/Behavioral Health Assessments ~~are limited to sixteen (16) per state fiscal year~~.

~~A~~ Nursing Assessments ~~is limited to one hundred forty-four (144) fifteen (15) minute units per state fiscal year~~.

Molina covers:
Psychosocial assessments ~~is limited to four (4) assessments per calendar year~~.

Psychological evaluations ~~are limited to four (4) hours per calendar year~~.

Psychiatric Diagnostic Evaluations and Office Visits ~~, no limit~~.

Mental Health Assessments ~~are limited to four (4) units per state fiscal year~~.

Brief Emotional/Behavioral Health Assessments ~~are limited to sixteen (12) per state fiscal year~~.

~~A~~ Nursing Assessments ~~is limited to one hundred forty-four (144) fifteen (15) minute units per state fiscal year~~.

Office Visits ~~, no limit~~.

**6.3.1.1- BH** ☒ The state assures that all developmental and behavioral health recommendations outlined in the AAP Bright Futures periodicity schedule and United States Public Preventive Services Task Force (USPSTF) recommendations graded as A and B are covered as a part of the CHIP benefit package, as appropriate for the covered populations.

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools in primary care practice, providing education, training, and technical resources, and covering the costs of administering or purchasing the tools.

**6.3.1.2- BH** ☒ The state assures that it will implement a strategy to facilitate the use of age-appropriate validated behavioral health screening tools in primary care settings. Please describe how the state will facilitate the use of validated screening tools.

Providers are required to perform behavior health screening according to age-

appropriate and validated screening -tools. Specifically, SPA 20-0013-CHIP requires UHC and Molina the use of USPSFT recommendations graded as A and B and under SPA 20-0015-CHIP also requires the use of the AAP Bright Futures for all developmental and behavioral health screenings specified in the March 2, 2020 SHO #20-001 letter. The CCOs are currently using the screening tool. This requirement will also be added to the CCO's contracts with the next planned Amendment. The CCOs must conduct provider education and training on screening tools, disseminate information on validated screening tools, and provide updates which are shared with providers as the updates are implemented by the appropriate entity. The CCOs will disseminate this information via provider manuals, provider newsletters and/or global updates.

**6.3.2- BH** ☒ Outpatient services (Sections 2110(a)(11) and 2110(a)(19))

Guidance: Psychosocial treatment includes services such as psychotherapy, group therapy, family therapy and other types of counseling services.

**6.3.2.1- BH** ☒ Psychosocial treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC and Molina cover within the CMHC:
Individual Psychotherapy ~~is limited to fifty-two (52) sessions per calendar year when~~ provided without an evaluation and management visit. Interactive complexity is covered with an individual psychotherapy session when medically necessary.

Family Psychotherapy ~~is limited to twenty-four (24) sessions per calendar year~~.

Group Therapy/Multi-Family Group Therapy ~~is limited to forty (40) sessions per calendar year~~. Interactive complexity is covered with group therapy sessions when medically necessary.

UHC and Molina cover outside of the CMHC:
Individual/Family/Group Therapy ~~with no limit~~ outside of CMHC, no prior authorization is required for participating providers.

**Psychosocial Treatment**
Outpatient Psychotherapeutic Services [Psychosocial Treatment] include initial assessment, and individual, family, group, and multi-family group therapies. Outpatient Psychotherapeutic Services are defined as intentional, face-to-face interactions (conversations or non-verbal encounters, such as play therapy) between a Mental Health Therapist, IDD Therapist or A/D Therapist (as appropriate to the population being served) and a person, family or group where a therapeutic relationship is established to help resolve symptoms of a mental and/or emotional disturbance.

**6.3.2.2- BH** ☒ Tobacco cessation

Provided for: ☒ Substance Use Disorder

UHC and Molina follow DOM's PDL with no further restrictions. All FDA approved medications are available.

UHC and Molina do not have any limits on tobacco cessation benefits including counseling and also refer to the Mississippi Tobacco Quitline for beneficiaries age 18 and older as a statewide initiative. For beneficiaries under age 18, referral is made to individual practitioners for tobacco cessation services, RAT program, and the SmokeFreeTeen program. Beneficiaries are also enrolled in CM as appropriate for tobacco cessation.

**Tobacco cessation services**
The Mississippi Tobacco Quitline is an evidence-based, tobacco cessation treatment program that has services available to residents of the state of Mississippi who are motivated to quit using tobacco products and 18 years of age and older. The program is available by the telephone and also in a web-based format to deliver counseling and nicotine replacement therapy (the patch and gum) at no cost to participants. All staff are Master's Level counselors who deliver effective behavior modification therapy. For beneficiaries under age 18, referral is made to individual practitioners for tobacco cessation services in addition to the following: Reject All Tobacco (RAT) program for kindergarten to 6th grade, and for teens (age~~s~~ 13-17) the SmokeFreeTeen program (SmokeFree.gov).

Guidance: In order to provide a benefit package consistent with section 2103(c)(5) of the Act, MAT benefits are required for the treatment of opioid use disorders. However, if the state provides MAT for other SUD conditions, please include a description of those benefits below at section 6.3.2.3- BH.

**6.3.2.3- BH** ☒ Medication Assisted Treatment
Provided for: ☒ Substance Use Disorder

UHC and Molina cover with no limitations on outpatient psychotherapy/behavioral therapies available under MAT. Participation is not required in order to receive the medication component. All FDA approved medications are available. Limitations on buprenorphine are according to the PDL located at Universal Preferred Drug List | Mississippi Division of Medicaid (ms.gov).

**Medication Assisted Treatment/Opioid Treatment Services**
Opioid Treatment Services include medication assisted treatment, counseling, and recovery support for people with a diagnosis of opioid addiction. The clinical purpose of opioid treatment services is to support the person by utilizing methadone, and/or buprenorphine, including buprenorphine-naloxone formulations, naltrexone, and other medications approved by the federal Food and Drug Administration (FDA), while the person participates in a spectrum of counseling and other recovery support services that

are intended to assist the person with successful recovery from opioid addiction Service components include:
1) Assessments
2) Laboratory services
3) Physician services including Medication Evaluation and Management
4) Medication Administration
5) Therapy Services
6) Medical Services
7) Pharmacy Services

**6.3.2.3.1- BH** ☒ Opioid Use Disorder

**6.3.2.3.2- BH** ☒ Alcohol Use Disorder

**6.3.2.3.3- BH** ☐ Other

**6.3.2.4- BH** ☒ Peer Support
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC and Molina cover:
Peer support ~~is limited to two hundred (200) fifteen (15) minute units per calendar year~~.

**Peer Support Services**
Peer Support Services are non-clinical activities with a rehabilitation and resiliency/recovery focus that allow a person receiving mental health services and substance use 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. Natural resources are utilized to enhance community living skills, community integration, rehabilitation, resiliency and recovery. Peer Support is a helping relationship between peers and/or family members that is directed toward the achievement of specific goals defined by the person. Peer Support Services are provided by Certified Peer Support Specialist Professionals. A Certified Peer Support Specialist Professional is a person with significant life-altering experience, also referred to as lived experience, who has successfully completed peer support competencies-based training and testing.

**6.3.2.5- BH** ☐ Caregiver Support
Provided for: ☐ Mental Health ☐ Substance Use Disorder

**6.3.2.6- BH** ☐ Respite Care
Provided for: ☐ Mental Health ☐ Substance Use Disorder

**6.3.2.7- BH** ☒ Intensive in-home services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC and Molina covers:
PACT services ~~are limited to sixteen hundred (1600) units (15 minute unit) per state calendar year and forty (40) units per day~~. Prior authorization required.

Program of Assertive Community Treatment (PACT) is an individual-centered, recovery-oriented mental health service delivery model for facilitating community living, psychological rehabilitation and recovery for persons who have the most severe and persistent mental illnesses, have severe symptoms and impairments, and have not benefited from traditional outpatient programs. The important characteristics of Programs of Assertive Community Treatment (PACT) are:

1. PACT serves individuals who may have gone without appropriate services. Consequently, the individual group is often over represented among the homeless and in jails and prisons, and has been unfairly thought to resist or avoid involvement in treatment.
2. PACT services are delivered by a group of multidisciplinary mental health staff who work as a team and provide the majority of the treatment, rehabilitation, and support services individuals need to achieve their goals. Many, if not all, staff share responsibility for addressing the needs of all individuals requiring frequent contact.
3. PACT services are individually tailored with each individual and address the preferences and identified goals of each individual. The approach with each individual emphasizes relationship building and active involvement in assisting individuals with severe and persistent mental illness to make improvements in functioning, to better manage symptoms, to achieve individual goals, and to maintain optimism.
4. The PACT team is mobile and delivers services in community locations to enable each individual to find and live in their own residence and find and maintain work in community jobs rather than expecting the individual to come to the program.
5. PACT services are delivered in an ongoing rather than time-limited framework to aid the process of recovery and ensure continuity of caregiver. Severe and persistent mental illnesses are episodic disorders and many individuals benefit from the availability of a longer-term treatment approach and continuity of care. This allows individuals opportunity to recompensate, consolidate gains, sometimes slip back, and then take the next steps forward until they achieve recovery.

PACT Admissions criteria includes:

PACT Teams serve individuals with severe and persistent mental illness as listed in the most current edition of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association that seriously impair their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability. Individuals with other psychiatric illnesses are eligible dependent on the level of the long-term disability. (Individuals with a primary diagnosis of a substance abuse disorder, intellectual disability or other Axis II disorders are not the intended individual group. Additionally, individuals with a chronically violent history may not be appropriate for this service.)

Individuals with significant functional impairments as demonstrated by at least one of the following conditions:

1. Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives.
2. Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities).
3. Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).

Individuals must have one or more of the following problems, which are indicators of continuous high-service needs (i.e., greater than eight hours per month):
1. High use of acute psychiatric hospitals (e.g., two [2] or more admissions per year) or psychiatric emergency services.
2. Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).
3. Coexisting substance abuse disorder of significant duration (e.g., greater than six [6] months).
4. High risk or recent history of criminal justice involvement (e.g., arrest, incarceration).
5. Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or in imminent risk of becoming homeless.
6. Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available.
7. Difficulty effectively utilizing traditional office-based outpatient services

**6.3.2.8- BH** ☒ Intensive outpatient
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC and Molina cover:
~~Effective 9/1/2020~~ Intensive Community Outreach and Recovery Team (ICORT) (previously referred to as Intensive Outpatient Psychiatric (IOP)) ~~is limited to two hundred seventy (270) days of service provision per calendar year~~. Prior authorization required. ICORT is provided in the community setting.

ICORT is a recovery and resiliency oriented, intensive, community-based rehabilitation and outreach service for children and adults with a 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. ICORT services are provided primarily in natural settings and are delivered face-to-face with the person and their family/significant other as appropriate, to the primary well-being and benefit of the recipient. Intensive Community Outreach and Recovery assists in the setting and attaining of individually defined recovery/resiliency goals. ICORT primary treatment objective 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.

**6.3.2.9- BH** ☒ Psychosocial rehabilitation
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC covers:
Psychosocial Rehabilitation Services ~~are limited to five (5) hours per day, five (5) days a week~~.

Molina covers:
Psychosocial Rehabilitation Services ~~are limited to five (5) hours per day, five (5) days a week~~. Prior authorization required.

**Psychosocial Rehab**
Psychosocial Rehabilitative Services (PSR) consists of a network of services designed to support and restore community functioning and well-being of adults with a serious and persistent mental illness. The purpose of the service is to promote recovery, resiliency, and empowerment of the person in his/her community. Service activities aim to improve reality orientation, social skills and adaptation, coping skills, effective management of time and resources, task completion, community and family integration, vocational and academic skills, and activities to incorporate the personal into independent community living; as well as to alleviate psychiatric decompensation, confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth. PSR Psychosocial Rehabilitative Services must utilize systematic, curriculum-based interventions for recovery skills development for participants. The curriculum-

based interventions must be evidence-based or recognized best practices in the field of mental health as recognized by Substance Abuse and Mental Health Services Administration (SAMHSA).

Guidance: If the state considers day treatment and partial hospitalization to be the same benefit, please indicate that in the benefit description. If there are differences between these benefits, such as the staffing or intensity of the setting, please specify those in the description of the benefit's amount, duration, and scope.

**6.3.3- BH** ☒ Day Treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC and Molina covers:
Day Treatment Services~~Beneficiaries may participate in the program a maximum of five (5) hours per day, five(5) days per week~~. Prior authorization required.

**Day Treatment**
Day Treatment Services are the most intensive outpatient services available to children/youth with serious emotional disturbance. The services must provide an alternative to residential treatment or acute psychiatric hospitalization or serve as a transition from these services. Day Treatment Services are a behavioral intervention and strengths-based program, provided in the context of a therapeutic milieu, which provides primarily school-age children/adolescents with serious emotional disturbances the intensity of treatment necessary to enable them to live in the community. Day Treatment Services are based on behavior management principles and include, at a minimum, positive feedback, self-esteem building and social skills training. Additional components are determined by the needs of the participants at a particular service location and may include skills training in the areas of impulse control, anger management, problem solving, and/or conflict resolution.

**6.3.3.1- BH** ☒ Partial Hospitalization
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC covers and Molina covers with prior authorization:
Acute Partial Hospitalization Services~~ are limited to one hundred (100) days per calendar year~~.

Acute Partial Hospitalization Services provide medical supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to people who are experiencing a period of such acute distress that their ability to cope with normal life circumstances is severely impaired. Acute Partial Hospitalization Services are designed to provide an alternative to inpatient hospitalization for such people or to serve as a bridge from inpatient to outpatient treatment. Service content may vary based on need but must include close observation/supervision and intensive support with a focus on the reduction/elimination of acute symptoms. Acute Partial Hospitalization Services may be provided to children/youth with serious emotional disturbance or people with substance use disorders.

**6.3.4- BH** ☒ Inpatient services, including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Sections 2110(a)(10) and 2110(a)(18))

Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC and Molina cover:
No limitations, prior authorization required.

Guidance: If applicable, please clarify any differences within the residential treatment benefit (e.g. intensity of services, provider types, or settings in which the residential treatment services are provided).

**6.3.4.1- BH** ☒ Residential Treatment

Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC and Molina cover:
Psychiatric residential treatment facilities (PRTFs) are residential services for children under twenty-one (21). Prior authorization required.

**Psychiatric Residential Treatment Facility**
Psychiatric Residential Treatment Facility is defined as any non-hospital establishment with permanent facilities which provides a twenty-four (24) hour program of care by qualified therapists for children under the age of 21, with an average length of stay of 6 months. These services include, but are not limited to, duly licensed mental health professionals, psychiatric mental health nurse practitioners, psychiatrists, psychologists and licensed certified social workers, for emotionally disturbed children and adolescents referred to such facility by a court, local school district or by the Department of Human Service. These children are not in an acute phase of illness requiring the services of a psychiatric hospital, and are in need of such restorative treatment services. For purposes of this service, the term "serious emotionally disturbed" means a condition exhibiting one or more of the following characteristics over along period of time and to a marked degree, which adversely affects educational performance:
1. An inability to learn which cannot be explained by intellectual, sensory or health factors;
2. An inability to build or maintain satisfactory relationships with peers and teachers;
3. Inappropriate types of behavior or feelings under normal circumstances;
4. A general pervasive mood of unhappiness or depression; or
5. A tendency to develop physical symptoms or fears associated with personal or school problems.

**6.3.4.2- BH** ☒ Detoxification

Provided for: ☒ Substance Use Disorder

UHC and Molina cover:
No limitations. Prior authorization required. Ambulatory detox in the outpatient setting is provided if it does not require 24 hour medical observation but if so, it would be provided in an inpatient detox setting.

**Detox**
Detoxification is a set of interventions aimed at managing acute and intoxication and withdrawal. It denotes a clearing of toxins from the body of the patient who is acutely intoxicated and/or dependent on substances of abuse. Detoxification seeks to minimize the physical harm caused by the abuse of substances and is available in the acute, sub-acute and residential setting.

Guidance: Crisis intervention and stabilization could include services such as mobile crisis, or short term residential or other facility based services in order to avoid inpatient hospitalization.

**6.3.5- BH** ☒ Emergency services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC and Molina cover:
Emergency services are not limited and do not require prior authorization.

**Emergency/Crisis Response Services**
Emergency crisis services are available at all emergency rooms in the state for members on a walk in basis or if 911 and emergency transport is involved. Emergency/crisis response in the community mental health setting is defined as a time-limited intensive intervention, available twenty-four (24) hours a day, seven (7) days a week. Crisis response services allow for the assessment of the crisis and ability to activate a mobile crisis team. Trained crisis response staff provides crisis stabilization directed toward preventing hospitalization. Children or adults requiring crisis services are those who are experiencing a significant emotional/behavioral crisis. A crisis situation is defined as a situation in which an individual's mental health and/or behavioral health needs exceed the individual's resources, in the opinion of the mental health professional assessing the situation. Staff must be able to triage and make appropriate clinical decisions, including accessing the need for inpatient services or less restrictive alternatives. These services are available throughout the entire state and catchment areas.

**6.3.5.1- BH** ☒ Crisis Intervention and Stabilization
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC and Molina covers:
Crisis Response Services are not limited. No prior authorization required.
Crisis Residential Services ~~are limited to sixty (60) days per calendar year~~. Prior authorization required.

Crisis Response is an intensive therapeutic service which allows for the assessment of and intervention in a mental health crisis. Crisis Response Services are provided to children/youth who are experiencing a significant emotional/behavioral crisis in which the person's mental health and/or behavioral health needs exceed the person's resources (in the opinion of the mental health professional assessing the situation.) Trained Crisis Response personnel provide crisis stabilization directed toward preventing hospitalization. Employees triage and make appropriate clinical decisions, including assessing the need for inpatient services or less restrictive alternatives. Crisis Response Services facilitate and verify formal initial assessment and therapy appointments, when the crisis situation subsides, with the mental health provider of the person's choice (if the person is able to remain in the community) utilizing the "warm handoff" method. A "warm handoff" is an approach to care transitions in which health care providers directly link people with typical service providers, using face-to-face or phone transfer.

Crisis Residential Services are time-limited residential treatment services provided in a Crisis Residential Unit which provides psychiatric supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to people who are experiencing a period of acute psychiatric distress which severely impairs their ability to cope with normal life circumstances. Crisis Residential Services prevent civil commitment and/or longer term inpatient psychiatric hospitalization by addressing acute symptoms, distress and further decomposition. Crisis Residential Services content may vary based on each person's needs but must include close observation/supervision and intensive support with a focus on the reduction/elimination of acute symptoms.

**6.3.6- BH** ☒ Continuing care services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC and Molina covers:
Wraparound ~~limited to one hundred (100) units (15 minute unit) per state calendar year and eight (8) units per day~~. No prior authorization required.

**Wraparound**
Wraparound facilitation is the creation and facilitation of a child and family team for the purpose of developing a single plan of care to address the needs of youth with complex mental health challenges and their families.

Activities include:
1. Engaging the family;
2. Assembling the child and family team;
3. Facilitating a child and family team meeting at a minimum every thirty (30) days;
4. Facilitating the creation of a plan of care, which includes a plan for anticipating, preventing and managing crisis, within the child and family team meeting;
5. Working with the team in identifying agency providers of services and other community resources to meet family and youth needs;

6. Making necessary referrals for youth;
7. Documenting and maintaining all information regarding the plan of care, including revisions and child and family team meetings;
8. Presenting plan of care for approval by the family and team;
9. Providing copies of the plan of care to the entire team including the youth and family parent(s)/legal guardian(s);
10. Monitoring the implementation of the plan of care and revising if necessary to achieve outcomes;
11. Maintaining communication between all child and family team members;
12. Monitoring the progress toward needs met and whether or not the referral behaviors are decreasing;
13. Leading the team to discuss and ensure the supports and services the youth and family are receiving continue to meet the caregiver and youth's needs;
14. Educating new team members about the wraparound process; and,
15. Maintaining team cohesiveness.

**6.3.7- BH** ☒ Care Coordination
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC and Molina cover:
Community Support Services ~~are limited to four hundred (400) fifteen (15) minute units per calendar year with no prior authorization~~.

Community Support Services are directed towards children, adolescents and families and will vary with respect to hours, type and intensity of services, depending on the changing needs of each person. The purpose/intent is to provide specific, measurable, and individualized services to each person served focusing on the person's ability to succeed in the community; to identify and access needed services; and, to show improvement in school, work, family, and community participation.

Community Support Services should be person-centered and focus on the person's recovery and ability to succeed in the community; to identify and access needed services; and, to show improvement in home, health, purpose and community.

**6.3.7.1- BH** ☐ Intensive wraparound
Provided for: ☐ Mental Health ☐ Substance Use Disorder

MYPAC is not covered by either UHC or Molina.

**6.3.7.2- BH** ☒ Care transition services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC and Molina cover:
Transition of Care program for CHIP members discharging for institutional or inpatient

settings.

**Care Coordination/Transition of Care**
Individuals with mental health and substance abuse disorders frequently rely on multiple organizations and treatment professionals to provide their health care. Additionally, a significant number of people with serious medical conditions also have behavioral health conditions.

Effectively coordinating care between these treatment professionals can lead to improved health outcomes, result in reduced healthcare costs, and benefit practitioners by enhancing networking with other professionals.

UHC and Molina provide a full array of care coordination services as well as a full transition of care program to their members ensuring the members are appropriately transitioned from any inpatient setting to the community to re-engage in life and work. This process begins with any hospital or residential setting notification of admission and the staff began to engage in discharge planning creating a transitional plan of care with the hospital staff, member, family, and outpatient professionals to ensure that the there is a multi disciplinary team who is supporting the member.

**6.3.8- BH** ☒ Case Management
Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC covers:
Targeted Case Management – no prior authorization but conducts outlier medical necessity review per member.

Molina covers:
Targeted Case Management ~~are limited to two hundred sixty (260) fifteen (15) minute units per calendar year~~.

**Targeted Case Management**

Targeted Case Management is defined as services that provide information/referral and resource coordination to the member and/or his/her collaterals. Case Management Services are directed towards helping the member maintain his/her highest possible level of independent functioning. Case managers monitor the treatment plan and ensure team members complete tasks that are assigned to them, that follow up and follow through occur and help identify when the treatment team may need to review the treatment plan for updates if the established plan is not working.

Targeted case management may be provided face-to- face or via telephone and is not designed to be a mobile service, but there is no prohibition on services being provided in a location other than the community mental health center. Targeted case management must be included in the individual's treatment plan and the frequency of case

management services will be determined by the complexity of the case and the need of the beneficiary, but shall not occur less than once monthly.

**6.3.9- BH** ☒ Other

Provided for: ☒ Mental Health ☒ Substance Use Disorder

UHC covers and Molina covers with prior authorization:
Neonatal alcohol fetal syndrome treatment.

## 6.4- BH Assessment Tools

**6.4.1- BH** Please specify or describe all of the tool(s) required by the state and/or each managed care entity: United Healthcare utilizes all tools check except InterQual. Molina only utilizes InterQual. The Division of Medicaid does not require specific assessment tools to be used.

☒ ASAM Criteria (American Society Addiction Medicine)
☒ Mental Health ☐ Substance Use Disorders

☒ InterQual
☒ Mental Health ☒ Substance Use Disorders

Molina only utilizes this tool.

☐ MCG Care Guidelines
☐ Mental Health ☐ Substance Use Disorders

☒ CALOCUS/LOCUS (Child and Adolescent Level of Care Utilization System)
☒ Mental Health ☒ Substance Use Disorders

☒ CASII (Child and Adolescent Service Intensity Instrument)
☐ Mental Health ☐ Substance Use Disorders

☐ CANS (Child and Adolescent Needs and Strengths)
☐ Mental Health ☐ Substance Use Disorders

☐ State-specific criteria (e.g. state law or policies) (please describe)
☐ Mental Health ☐ Substance Use Disorders

☐ Plan-specific criteria (please describe)
☐ Mental Health ☐ Substance Use Disorders

☒ Other (please describe)
☒ Mental Health ☒ Substance Use Disorders

United Healthcare also utilized ESPII.

☐ No specific criteria or tools are required
☐ Mental Health ☐ Substance Use Disorders

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools to determine possible treatments or plans of care, providing education, training, and technical resources, and covering the costs of administering or purchasing the assessment tools.

**6.4.2- BH** ☒ Please describe the state's strategy to facilitate the use of validated assessment tools for the treatment of behavioral health conditions.

Providers are encouraged to use -validated assessment tools for the treatment of behavioral health conditions. The CCOs are responsible for conducting trainings and communications to providers to utilize - validated assessment tools. The CCOs are responsible for follow-up for compliance. The CCOs encourage use through education, bulletins and clinical reviews.

**6.2.5- BH Covered Benefits** The State assures the following related to the provision of behavioral health benefits in CHIP:

☒ All behavioral health benefits are provided in a culturally and linguistically appropriate manner consistent with the requirements of section 2103(c)(6), regardless of delivery system.

☒ The state will provide all behavioral health benefits consistent with 42 CFR 457.495 to ensure there are procedures in place to access covered services as well as appropriate and timely treatment and monitoring of children with chronic, complex or serious conditions.