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

IV. Rehabilitative Services

42 CFR 441.57

42 CFR 440.130 (d)

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

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

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

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

3. Be medically necessary,

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

5. Be provided in a community-based setting.

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

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

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

b. The clinical purpose of day treatment is to improve emotional, behavioral, and social development of all individuals under the age of twenty-one (21) who need significant coping skills to appropriately function in the home, school, and community.

c. The service components of day treatment include:
   1) Treatment plan development and review.
   2) Skill building groups such as social skills training, self-esteem building, anger control, conflict resolution and daily living skills.

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

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

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

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

6d. Other Practitioners' Services:

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

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

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

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

1) Vaccine administration.

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

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

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

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

A. Assurances

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

B. Provider Requirements

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

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

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

   c. Physician Assistants (PA) must hold a Master's degree in a health-related or science field, be licensed by the Mississippi Board of Medical Licensure, must be under the supervision of a psychiatrist or a physician.

   d. Psychiatric Mental Health Nurse Practitioners (PMHNP) must hold a Master's degree in nursing with a specialty in psychiatry, be licensed by the Mississippi Board of Nursing, and must practice within a collaborative/consultative relationship with a physician within an established protocol or practice guidelines.

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

   f. Licensed Certified Social Workers (LCSW) must hold a Master's degree in social work

and be licensed by the Mississippi State Board of Examiners for Social Workers and Marriage and Family Therapists at the LCSW level.

g. Licensed Professional Counselors (LPC) must hold a Master's degree in counseling and be licensed by the Mississippi State Board of Examiners for Licensed Professional Counselors. Provisionally Licensed Professional Counselors (P-LPC) may provide services within the scope of their provisional license.
h. Licensed Marriage and Family Therapists (LMFT) must hold a Master's degree in marriage and family therapy and be licensed by the Mississippi State Board of Examiners for Social Workers and Marriage and Family Therapists. Provisionally Licensed LMFTs may provide services within the scope of their provisional license.

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

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

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

   2) Professional Art Therapists (ATR-BC) must hold a Master's degree in art therapy and be licensed by the Mississippi Department of Health (MSDH).
   3) Registered Nurses (RN) must be a graduate from an approved or accredited RN nursing program, be licensed by the Mississippi Board of Nursing, and must be under the supervision of a psychiatrist, physician, PMHNP, or PA.
   4) Licensed Practical Nurses (LPN) must be a graduate from an approved or accredited LPN nursing program, be licensed by the Mississippi Board of Nursing and supervised by a psychiatrist, physician, PMHNP, PA or RN.
   5) DMH certified staff:
      (a) Certified Mental Health Therapists (CMHT), Certified Intellectual and Developmental Disabilities Therapists (CIDDT) and Certified Addiction

Therapists (CAT) must hold a Master's degree in mental health, human services, intellectual disabilities, addictions, or behavioral health-related fields from an approved educational institution.

(1) Provisionally certified therapists are temporarily certified while fulfilling all the certification requirements, provide the same services as a CMHT, CIDDT and CAT and must be under the supervision of certified therapist of the same discipline. Provisional certification is valid for up to twenty-four (24) consecutive months from the date of issuance.

(2) The certified credential is full certification and renewable every four (4) years as long as renewal requirements are met.

(b) Community Support Specialists must hold a minimum of a Bachelor's degree in a mental health field, be certified by DMH as a Community Support Specialist and must be under the supervision of staff listed in B.1) and B.2)a) through e).

(c) Peer Support Specialist Professionals must hold a minimum of a high school diploma or GED equivalent, be certified by DMH as a Certified Peer Support Specialist and must be under the supervision of a psychiatrist, physician, PMHNP, PA, LCSW, LMSW, LPC, LMFT, CMHT, CIDDT, CAT or a Peer Support Specialist Supervisor who has been trained as a Peer Support Specialist with an emphasis on supervision.

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

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

1. Treatment Plan Development and Review

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

2. Crisis Response Services

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

services,

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

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

3. Crisis Residential Services

a. Crisis Residential Services are defined as time-limited residential treatment services provided in a Crisis Residential Unit which provides psychiatric care, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to beneficiaries who are experiencing a period of acute psychiatric distress which severely impairs their ability to cope with normal life circumstances. The unit provides medically monitored residential services for the purpose of providing psychiatric stabilization on a short-term basis serving as a transition or diversion from inpatient hospitalization.
b. Crisis Residential Services must be provided in a setting other than an acute care hospital or a long-term residential treatment facility which consists of no more than sixteen (16) beds that is certified by the DMH to provide Crisis Residential Services.
c. The clinical purpose of Crisis Residential Services is to provide treatment to an beneficiary not requiring twenty-four (24) hour medical and nursing care, but may benefit from a twenty-four (24) hour supervised, structured living arrangement in order to return them to their pre-crisis level of functioning.
d. The service components for Crisis Residential Services include:
    1. Treatment plan development and review by any of the staff listed in C.3.e.
    2. Medication management provided by a psychiatrist or PMHNP.
    3. Nursing assessment provided by a PMHNP or RN.
    4. Individual therapy provided by master's level staff.
    5. Family therapy provided by master's level staff. Family therapy involves participation of non-Medicaid eligible for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.
    6. Group therapy provided by master's level staff. Group therapy involves participation of non-Medicaid eligible individuals for the benefit of the beneficiary but does not include services directed at the non-Medicaid individuals. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but

remains the focus of the service.

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

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

4. Community Support Services

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

important in the person's life.

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

5. Medication Evaluation and Management

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

6. Medication Administration

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

7. Psychiatric Diagnostic Evaluation

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

8. Psychological Diagnostic Evaluation

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

standardized tests, interviews and behavioral observations.

b. The clinical purpose of a Psychological Diagnostic Evaluation is to identify therapy needs, highlight issues presented in treatment, recommend forms of intervention, and offer guidance about potential outcomes of treatment.
c. Psychological Diagnostic Evaluations must be completed by a licensed psychologist.
d. Psychological Diagnostic Evaluations are limited to eight (8) units per state fiscal year.

9. Mental Health Assessment by a Non-Physician

a. A Mental Health Assessment is defined as the documentation of information from the beneficiary and/or collaterals describing the beneficiary's family background, educational/vocational achievements, presenting problem(s), history of problem(s), previous treatment, medical history, current medication(s), source of referral and other pertinent information to determine the nature of the beneficiary's or family's problem(s), the factors contributing to the problem(s), and the most appropriate course of treatment.
b. The clinical purpose of a Mental Health Assessment is to create a comprehensive picture of the beneficiary in order to develop treatment goals.
c. A Mental Health Assessment must be provided by one of the following: PMHNP, PA, LCSW, LMSW, LPC, LMFT, CMHT, CIDDT, and CAT.
d. Mental Health Assessments are limited to four (4) units per state fiscal year.

10. Brief Emotional/Behavioral Health Assessment

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

11. Nursing Assessment

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

12. Individual Psychotherapy

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

13. Family Psychotherapy

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

14. Group Therapy/Multi-Family Group Therapy

a. Group Therapy is defined as face-to-face therapy addressing the needs of several beneficiaries within a group.

b. The clinical purpose of Group Therapy is to prevent deterioration, to encourage remediation and to provide rehabilitation.

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

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

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

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

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

15. Acute Partial Hospitalization Services

a. Acute Partial Hospitalization Services are defined as a non-residential treatment program for beneficiaries who are experiencing a period of such acute distress that their ability to cope with normal life circumstances is severely impaired. These beneficiaries require more intensive and comprehensive services offered in an outpatient treatment program but require less than twenty- four (24) hour care provided on inpatient basis.

b. The clinical purpose of Acute Partial Hospitalization Services are to provide an alternative to hospitalization for beneficiaries not requiring twenty-four (24) hour supervision but still requiring a high degree of therapeutic support to return to normal daily activities in the home, school, work, and community.

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

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

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

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

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

16. Psychosocial Rehabilitation Services

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

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

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

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

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

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

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

17. Program of Assertive Community Treatment (PACT) Services

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

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

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

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

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

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

designee.

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

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

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

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

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

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

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

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

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

19. Peer Support Services

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

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

c. The service components of Peer Support Services include:
   1) Development of a recovery support plan, and
   2) Skill building for coping with and managing symptoms while utilizing natural resources, and the preservation and enhancement of community living skills.

d. Services are provided by a certified Peer Support Specialist Professional.

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

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

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

6d. Other Licensed Practitioners' (OLP) Services:

Nurse Practitioner and Physician Assistant Services: Reimbursement for nurse practitioner and physician assistant services shall be at 90% of the fee for reimbursement paid to licensed physicians under the statewide physician fee schedule for comparable services under comparable circumstances.

Psychologist, Licensed Certified Social Workers (LCSW), Licensed Professional Counselors (LPC) Services and Licensed Marriage and Family Therapist (LMFT) Services are reimbursed according to the payment methodology on Attachment 4.19-B, Page 13.

OLP services for EPSDT beneficiaries, if medically necessary, which exceed the limitations and scope for Medicaid beneficiaries, as covered in this Plan, are reimbursed according to the methodology in the above paragraph.

Reimbursement to a pharmacy provider, for vaccine administration by a pharmacist, is the same fee as a primary care physician practitioner in Attachment 4.19-B page 5a.

Pharmacy Disease Management Services: The pharmacy disease management services are reimbursed on a per encounter basis with an encounter averaging between fifteen and thirty minutes. The reimbursement is a flat fee established after reviewing Medicaid's physician fee schedule and reimbursement methodologies and fees of other states and third party payers.

Except as otherwise noted in the plan, state-developed uniform fixed fee schedule rates are the same for both governmental and private OLP providers. The Division of Medicaid's fee schedule was set as of September 1, 2020, and is effective for services provided on or after that date. All rates are published on the agency's website at http://www.medicaid.ms.gov/FeeScheduleLists.aspx.

The Division of Medicaid will reduce the rate of reimbursement to providers for any service by five percent (5%) of the allowed amount for that service when applicable. The five percent (5%) reduction has been in place since July 1, 2002 and the fee schedule already incorporates the five percent (5%) reduction. The federal match will be paid based on the reduced amount. Prescription drugs and other covered drugs and services as may be determined by the division are exempt from the 5% exclusion.

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

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

Covered services billed using Healthcare Common Procedure Coding System (HCPCS) are reimbursed according to a statewide uniform fixed fee schedule. In establishing the fee schedule, the Division of Medicaid (DOM) engaged an actuarial firm to establish fees. DOM provided service descriptions and other information for the existing mental health services offered and the proposed new services. The relationships between comparable services for Medicaid programs in other states were examined to develop factors to apply to existing Mississippi fees to calculate the new service group fees with the fees for the existing mental health services. Consideration was given to the service descriptions, required provider credentials and current costs associated with services. Preliminary fees were modified to better reflect the expected provider cost relative to other mental health services. The agency's state developed fee schedule rate is set as of July 1, 2012, and is effective for services provided on or after that date. Effective September 1, 2020 Intensive Community Outreach and Recovery Team (I-CORT) services will be paid the rate established July 1, 2012 for Intensive Outpatient Programs (IOP) and Mental Health Assessments by a Non-Physician will be paid ninety percent (90%) of the Medicaid physician rate for a Psychiatric Diagnostic Evaluation. Effective April 1, 2021, I-CORT will be paid at ninety percent (90%) of the Programs of Assertive Community Treatment (PACT) rate.

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

The Division of Medicaid will reduce the rate of reimbursement to providers for any service by five percent (5%) of the allowed amount for that service when applicable. The five percent (5%) reduction has been in place for community mental health services since July 1, 2002 and the fee schedule already incorporates the five percent (5%) reduction.