MISSISSIPPI

This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.

Types of Facilities

Mental Health (MH) and Substance Use Disorder (SUD): Mississippi regulates publicly-funded treatment facilities.

Mental Health (MH): In addition to general regulations specific to publicly-funded facilities, Mississippi regulates Crisis Stabilization Services, which are provided as time-limited residential services in a Crisis Stabilization Unit. Crisis Stabilization Services must be designed to prevent civil commitment and/or longer term inpatient psychiatric hospitalization by addressing acute symptoms, distress and further decomposition.

Substance Use Disorder (SUD): Mississippi regulates all publicly-funded SUD treatment programs. Specifically identified program types are:

- Withdrawal Management (WM) facilities at levels based on the ASAM criteria for Level 3.2-WM: Clinically Managed Residential Withdrawal Management (sometimes referred to as "social detox") and 3.7 Medically Monitored Inpatient Withdrawal Management. These services must be provided in conjunction with Primary Residential services within Community Mental Health Centers (CMHCs).

- CMHCs must provide Primary Residential Services as a core adult service for individuals in need of SUD treatment and rehabilitation services residing in the CMHC's entire catchment area. Services are offered in a community based treatment setting and support individuals as they develop the skills and abilities necessary to improve their health and wellness, live self-directed lives, and strive to reach their full potential in a life of recovery. The residential continuum of care for SUD Residential Treatment Services includes Primary Residential Services and Transitional Residential Services for individuals with SUD.
    - Primary Residential Services is the highest community based level of care for the treatment of SUDs. This level of treatment provides a safe and stable group living environment where the individual can develop, practice and demonstrate necessary recovery skills.
    - Transitional Residential Services are provided in a safe and stable group living environment which promotes recovery while encouraging the pursuit of vocational or related opportunities.

Unregulated Facilities: Facilities not receiving public funds are unregulated.

Approach

The Mississippi Department of Mental Health (DMH) regulates publicly-funded treatment facilities. This include CMHCs, which are operated under the authority of regional commissions and other community mental health service providers operated by entities other than the DMH that meet the requirements of and are determined necessary by DMH to be a designated and approved mental health center.

Processes of Licensure or Certification and Accreditation

Mental Health (MH) and Substance Use Disorder (SUD): All publicly-funded treatment facilities must be certified by the DMH and are subject to a DMH- approved peer review/quality assurance evaluation process. All providers seeking certification must participate in an orientation and submit an application. The application focuses, among other things, on services to be provided, adherence to DMH standards, and fiscal responsibility.

- Accreditation is not required.

- Administrative (document review) and On-Site Compliance Reviews will take place (if applicable) for the certification of the following: (1) New service provider organizations; (2) New services or program locations for an existing DMH Certified Provider; (3) Additional services or program locations for an existing DMH Certified Provider; and (4) Adherence to an accepted Plan of Compliance.

- A Certificate of Need is not required for operation but the DMH does require a showing of need as part of certification.

- Certification is for 3 years unless otherwise stated at certification.

Substance Use Disorder (SUD): In addition to the general requirements for all DMH-certified facilities:

- Accreditation is not required but, for SUD programs classified as a state or federal institution or correctional facility that are certified by CARF, The Joint Commission, the American Corrections Association or other certification body approved by the DMH, the DMH may accept those certifications in lieu of the DMH standards, with the exception of standards related to clinical program operation and personnel requirements. Programs must be in good standing with the applicable certification body for approval to be granted. The Joint Commission (TJC) accredited SUD treatment providers (not funded by

the DMH) seeking DMH certification must submit documentation of TJC accreditation in the specific SUD area(s) that corresponds with the SUD service area(s) included in the DMH standards. The DMH will determine if the documentation is sufficient to support certification in the specific SUD services areas.

Cause-Based Monitoring

Mental Health (MH) and Substance Use Disorder (SUD): Administrative and on-site compliance reviews will take place, during the certification period to ensure continued adherence to DMH standards, guidelines, contracts, and grant requirements. The DMH reviews may be unannounced. If found to be out of compliance with the criteria for certification during an administrative or on-site compliance review, the DMH will require a plan of correction (POC) by the provider. The DMH may determine the need to take administrative action to suspend, revoke or terminate certification.

Access Requirements

Mental Health (MH) and Substance Use Disorder (SUD): The provider must implement written policies and procedures for providing appointments for individuals being discharged from inpatient care that: (1) Provide a phone number where contact can be made to arrange for an appointment; and (2) Assure the person requesting services only has to make one call to arrange an appointment. Written policies and procedures must address admission to services and must, among other things, assure equal access to treatment and services and non-discrimination based on ability to pay, race, sex, age, creed, national origin, or disability for individuals who meet eligibility criteria; describe procedures for maintaining and addressing a waiting list for admission or readmission to service(s) available by the provider; and assure equal access to treatment and services for HIV-positive persons who are otherwise eligible.

Mental Health (MH): Crisis Stabilization Services must be designed to accept admissions (voluntary and involuntary) twenty-four (24) hours per day, seven (7) days per week.

Substance Use Disorder (SUD): Pregnant women have top priority for admission, may not be placed on a wait list and must be admitted within 48 hours. Individuals who use IV drugs have priority for admission over non-IV drug users and must be admitted within 48 hours. For both populations, there are regulatory requirements if access is not possible within 48 hours.

Staffing

Mental Health (MH) and Substance Use Disorder (SUD): All services and programs must provide the level of staffing needed to ensure the health, safety, and welfare of the individuals served,

and provide essential administrative and service functions. Only a licensed health care professional can provide nursing care, medical services, or medication, in accordance with the criteria, standards, and practices set forth by their respective licensing entity. To ensure initial and continuing receipt of certification/funding from the DMH or other approved sources, the provider must maintain documentation that staff meet specific qualifications including related to education and experience and fulfill specific responsibilities for the following positions: (1) One full-time Executive Director. (2) Director(s) with overall responsibility for a service, service area(s) or multiple services provided at/from a single location. Medication evaluation and monitoring, the initial evaluation, prescribing of medications, and regular/periodic monitoring of the therapeutic effects of medication prescribed for mental health purposes are provided by: (1) A Board-certified or Board-eligible psychiatrist. (2) A psychiatric/mental health nurse. (3) If documented efforts, including efforts to work with the Department of Health to recruit a licensed psychiatrist through the J-I Visa or Public Health Service Program during the certification period are unsuccessful, psychiatric services may be provided by other physician(s) licensed by the Mississippi Board of Medical Licensure…. (6) Medical services are provided by a psychiatrist or other physician. (7) Nursing services are provided by a Registered Nurse or a Licensed Practical Nurse. (8) Psychological services are provided by a psychologist. (9) Therapy or Counseling services are provided by an individual with at least a master's degree in mental health and specific licensure…. (16) Peer Support Services. (17) Wraparound Facilitators…. (18) Direct care staff. (19) Specialists such as Audiologists, Speech/Language Pathologists, Occupational Therapists, Dieticians, Physical Therapists, etc…. (23) Targeted case management providers.

Community Mental Health Center providers must have a multidisciplinary staff, with at least the following disciplines represented, by individuals with specific qualification: (1) A psychiatrist (available on a contractual, part-time or full-time basis). (2) A psychologist (available on a contractual, part-time or full-time basis). (3) A full-time or full-time equivalent registered nurse. (4) A full-time or full-time equivalent Licensed Master Social Worker, Licensed Professional Counselor (LPC), or Licensed Marriage and Family Therapist (LMFT). (5) A full-time or full-time equivalent business manager. 6. A full-time or full-time equivalent records practitioner or designated records clerk.

All new employees and regularly scheduled volunteers and interns must attend a General Orientation program within thirty (30) days of hire/placement, except for direct service providers and direct service interns/volunteers. All direct service staff must complete all required orientation prior to contact with individuals receiving services and/or service delivery. Volunteers (not regularly scheduled) that have not attended orientation should never be alone with individuals receiving services unsupervised by program staff. Specific requirements are provided for General Orientation, an ongoing staff training program to be provided within ninety (90) days of hire and consist of a minimum of twenty (20) hours of training for nonmedical personnel, a position-specific annual continuing education. Among other things, crisis intervention and prevention must be addressed.

Mental Health (MH): Crisis Stabilization Services must have a full-time (forty (40) hours per week) on-site director. Crisis Stabilization Services must have a full-time (forty (40) hours per week) on-site mental health therapist. Crisis Stabilization Services must maintain at least a one (1) direct service staff to four (4) residents ratio twenty-four (24) hours per day, seven (7) days per week. A Registered Nurse must be on-site during all shifts and may be counted in the required staffing ratio. All Crisis Stabilization Services staff must successfully complete training and hold certification in a nationally recognized or DMH-Approved Program for managing aggressive or risk-to-self behavior.

Substance Use Disorder (SUD):

- Primary Residential Services must ensure access to each of the following professionals either through program staff or affiliation agreement/contract: (1) A licensed psychiatrist or psychologist with experience in the treatment of SUD; or (2) A licensed physician with experience in the treatment of SUD.

- Staffing for Primary Residential Services and Transitional Residential Services must be sufficient to meet service requirements. Male and female (as appropriate) staff must be on-site and available twenty-four (24) hours per day, seven (7) days per week. Caseloads for residential services must have no more than twelve (12) adults assigned to a single therapist or counselor.

- WM at Level 3.2-WM do not require onsite medical and nursing personnel. Staff supervising self-administered medications must be appropriately licensed or credentialed by the State of Mississippi.

- WM at Level 3.7-WM require medical and nursing personnel and must include: (1) A physician or appropriately licensed staff performing the duties as a physician under a collaborative agreement or other requirements of the medical practice act. (2) A physician or licensed designee available twenty-four (24) hours a day by telephone and who is available for assessment within 24 hours of admission, earlier if medically necessary. (3) A registered nurse or other licensed and credentialed nurse available to conduct a nursing assessment on admission. (4) An interdisciplinary team of appropriately trained staff available to assess and treat the individual.

Placement

Mental Health (MH) and Substance Use Disorder (SUD): Written policies and procedures must, among other things, define criteria for admission or readmission to service(s) and describe the process for when admission or readmission to service(s) offered by the provider is not appropriate for the individual, including referral to other agencies and follow-up, as appropriate.

Adults with a serious mental illness (SMI) must be seen in person or by telemedicine and evaluated by a licensed physician, licensed psychologist, psychiatric/mental health nurse practitioner, physician assistant, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), or Licensed Certified (clinical) Social Worker (LCSW) to certify that the services planned are medically/therapeutically necessary for the treatment of the individual. This must be recertified annually.

For all individuals receiving MH and/or SUD services, initial and subsequent face-to-face biopsychosocial assessment are required and must be completed by specified credentialed professionals. Individuals with SMI, including: (1) Individuals discharged from an inpatient psychiatric facility. (2) Individuals discharged from an institution. (3) Individuals discharged or transferred from Crisis Stabilization Services. (4) Individuals referred from Crisis Response Services, must receive an Initial Assessment within fourteen (14) days of the date that services are sought and/or the date the referral is made.

For individuals receiving SUD services, a DMH approved functional assessment must be conducted within timelines according to the service(s) received. For Alcohol and Other Drug Disorders Services, all individuals receiving SUD treatment services must receive the TB and HIV/AIDS Risk Assessment at the time of the Intake/Initial Assessment with certain exceptions.

Mental Health (MH): Crisis Stabilization Services must provide the following within twenty-four (24) hours of admission to determine the need for those services and to rule out the presence of mental symptoms that are judged to be the direct physiological consequence of a general medical condition and/or illicit substance/medication use: (1) Initial assessment; (2) Medical screening; (3) Drug toxicology screening; and (4) Psychiatric consultation.

Substance Use Disorder (SUD):

For all SUD treatment facilities, providers must provide and document that all individuals receiving SUD treatment receive a risk assessment for HIV at the time of intake. For individuals determined to be high risk by the HIV assessment, testing options are determined by level of care and must be provided as required for specific residential settings.

All Primary and Transitional Residential providers must document that all individuals received a risk assessment for Tuberculosis (TB) at the time of intake. Any individual determined to be at high risk cannot be admitted into a treatment program until testing confirms the individual does not have TB.

Transitional Residential Services: An individual must have successfully completed a primary residential SUD treatment program in order to be eligible for admission to Transitional Residential Services. The primary SUD residential treatment program must be at least four (4) weeks long.

All WM programs must utilize the results of a medical screening instrument(s) identifying the need for Withdrawal Management Services. The screening assessments should be conducted as often as the individual case warrants. All WM programs must have written policies regarding criteria for admission.

Treatment and Discharge Planning and Aftercare Services

Mental Health (MH) and Substance Use Disorder (SUD): Facilities must have an individual plan that directs the treatment and support of the individual receiving services. The individual plan should be designed to increase or support independence and community participation. The individual plan may be referred to as the Treatment Plan, Plan of Services and Supports, Individual Service Plan, Wraparound Plan or Person-Centered Plan. The name of the plan is dependent upon the population being served and the process utilized to develop the plan. The plan must be based on the strengths, challenges, desired outcomes, and activities to support outcomes of the individual receiving services and his/her family/legal representative (if applicable). Outcomes should be identified by the individual, family/legal representative (if applicable), and treatment/support team. Providers must utilize planning approaches that are considered to be best practices or evidence-based by their respective areas of focus. Planning approaches must be documented and implemented through the development of policies and procedures specific to this process and the population being served. Planning approaches must address the following, among other things: (1) The development of an individualized treatment/support team that includes the individual, service providers and other supports (as appropriate) that may be identified and utilized by the individual or team members; (2) A focus on recovery/resiliency and/or person centeredness, depending on the population; (3) A focus on individual strengths and how to build upon strengths to achieve positive outcomes; and, (4) Proactive crisis planning, depending on the individual receiving services.

Mental Health (MH): Crisis Stabilization Services must complete a trauma history questionnaire within 48 hours of admission. Results of trauma history questionnaire should be incorporated into ISP and subsequent services. Prior to discharge from Crisis Stabilization Services, an appointment must be made for the individual to begin or continue services from the local Community Mental Health Center or other mental health provider.

Treatment Services

Mental Health (MH) and Substance Use Disorder (SUD): Activities must be designed to address objectives/outcomes in the individual plan directing treatment/support for the person. Programs must be designed to provide a Person-Centered Recovery Oriented system of services with a framework of supports that are self-directed, individualized, culturally responsive, trauma informed, and that provide for community participation opportunities. Services should be measurable and individualized. Services and programs must be designed to promote and

allow independent decision making by the individual and encourage independent living, without compromising the health and safety of the individuals being served. Providers must present information in a manner understandable to the individual so that he/she can make informed choices regarding service delivery and design, available providers and activities which comprise a meaningful day for him/her. Programs must provide each individual with activities and experiences to develop the skills they need to support a successful transition to a more integrated setting, level of service, or level of care. The services provided as specified in the individual plan must be based on the requirements of the individual rather than on the availability of services/staff. All efforts must be implemented to design a service environment that is safe and conducive to positive learning and life experiences. Persons served in the program whose behaviors are significantly disruptive to others in the same environment must be afforded the opportunity and assistance to change those behaviors through a systematic support plan. Persons receiving services may not be discharged from a service or program due to disruptive behaviors unless they pose a risk for harm to other people receiving the service. Efforts to keep an individual enrolled in the service or program must be included in the plan and documented in the record.

Mental Health (MH): Crisis Stabilization Services content may vary based on each individual's needs but must include close observation/supervision and intensive support with a focus on the reduction/elimination of acute symptoms. Crisis Stabilization Services must consist of: (1) Evaluation; (2) Observation; (3) Supportive counseling; (4) Substance abuse counseling; (5) Individual, Group and Family Therapy; (6) Targeted Case Management and/or Community Support Services; (7) Family Education; (8) Therapeutic Activities (i.e., recreational, psycho-educational, social/interpersonal). Direct services (i.e., Supportive counseling, therapy, recreational, psycho-education, social/interpersonal activities) can be provided seven (7) days per week but must at a minimum be: (1) Provided five (5) days per week; and (2) Provided five (5) hours per day. Crisis Stabilization Services must also provide adequate nursing and psychiatric services to all individuals served. At a minimum, these services must be provided every seven (7) days (or more often if clinically indicated).

Substance Use Disorder (SUD): All SUD treatment facilities must have policies and procedures related to acceptance and accommodation of individuals entering treatment services utilizing medication assisted treatment (MAT). Specific requirements regarding HIV, Hepatitis, STDs, and TB counseling and education are included.

- All WM programs must have protocols for referral to acute care facilities and all SUD residential facilities must have a current contract on file with a Medically Managed Intensive Inpatient Withdrawal Management Provider. For all SUD residential facilities that serve pregnant females, the contract with the Medically Managed Intensive Inpatient Withdrawal Management Provider, must state that women will not be detoxed during pregnancy without consideration by a physician or nurse practitioner of the impact it would have on the mother or her fetus. All Residential Programs are responsible for ensuring that pregnant women are evaluated immediately by a physician, hospital, or medical clinic when symptoms of intoxication, impairment, or withdrawal are evident. All

Residential Programs must provide transportation for pregnant women that are referred to a physician, hospital, medical clinic or other appropriate Residential Facility. Withdrawal management services for pregnant/prenatal women will take into account up-to-date medical research.

- WM programs providing Level 3.2-WM: Clinically Managed Residential Withdrawal Management Services must contain the following: Staff must: (a) Observe and supervise the individual; (b) Determine the individual's appropriate level of care; (c) Facilitate the individuals transition to continuing care. There must be 24 hour a day medical evaluation and consultation. The WM must have a written agreement or contract with a local hospital able to provide Medically Managed Withdrawal Management Services as defined by ASAM.
- WM programs providing Level 3.7-WM: Medically Monitored Inpatient Withdrawal Management Services must include: (1) Assessment by a physician or licensed designee within 24 hours of admission or earlier if medically necessary. (2) A registered nurse or other licensed and credentialed nurse is available to conduct a nursing assessment on admission. (3) Documentation of hourly observation of the individual receiving services during the first twenty-four (24) hours of the withdrawal management. (4) Programs providing this service must have a written plan describing the handling of medical emergencies which includes the roles of staff members and physicians.

- Transitional Residential Services: Program components include at a minimum: (1) At least one (1) hour of individual therapy per week with each individual. (2) A minimum attendance of at least two (2) hours of group therapy per week. Group therapy must be offered at times that accommodate the schedules of the individuals. (3) Family therapy must be offered and available as needed. Documentation of attendance or refusal is required. (4) Psychoeducational groups individualized to the residents. Topics to be address may include, but are not limited to, vocation, education, employment, recovery, or related skills. (5) Therapeutic and leisure/recreational/physical exercise activities (with physician's approval). A written master schedule of activities that documents the provision of the following services: (1) Group therapy; (2) Psychoeducational groups; and (3) Therapeutic and leisure/recreational/physical exercise activities. Employment for individuals in Transitional Residential Services must be community based and not as part of the onsite program.

- Primary Residential Services: Individuals admitted into Primary Residential Services must receive a medical assessment within forty-eight (48) hours of admission to screen for health risks. The program components include at a minimum: (1) At least one (1) hour of individual therapy per week with each individual. (2) A minimum attendance of at least five (5) hours of group therapy per week with each individual. (3) Family therapy must be offered and available at least twice (2) during the course of treatment. Documentation of attendance or refusal by the individual or family is required. (4) At least twenty (20) hours of psychoeducational groups individualized to the residents. Topics to be address may include, but are not limited to, substance use disorders, self-help/personal growth,

increasing self-esteem, wellness education, social skills, anger management, the recovery process, and a philosophy of living which will support recovery. (5) At least three (3) hours of family-oriented education activities during the course of treatment. (6) Therapeutic and leisure/recreational/physical exercise activities (with physician's approval). (7) Vocational counseling and planning/referral for follow-up vocational services. A written master schedule that documents the provision of the following services: (1) Group therapy; (2) Psychoeducational groups; (3) Family-oriented education; (4) Therapeutic and leisure/recreational/physical exercise activities; and (5) Vocational counseling and planning/referral.

Patient Rights and Safety Standards

Mental Health (MH) and Substance Use Disorder (SUD): There must be written policies and procedures for implementation of a process through which individuals' grievances can be reported and addressed at the local program/center level. Providers are prohibited from the use of mechanical restraints, unless being used for adaptive support. Providers are prohibited from the use of seclusion except for certified Crisis Stabilization Services. Providers are prohibited from the use of chemical restraints. Providers must ensure that all direct service staff who utilize physical restraint/escort has successfully completed training and hold nationally recognized certification or DMH-approved training for managing aggressive or risk-to-self behavior (which includes verbal and physical de-escalation). Providers utilizing physical restraint(s)/escort must establish, implement, and comply with written policies and procedures specifying appropriate use of physical restraint/escort. Programs utilizing time-out must have written policies and procedures that govern the use of time-out and documentation of implementation of such procedures in case records of individuals receiving services. Serious incidents must be reported to the DMH within 24 hours, including but not limited to use of seclusion or restraint that was not part of an individual's treatment Behavior Management Plan or that was planned but not implemented properly, or resulted in discomfort or injury for the individual, as well as abuse or neglect. Certain other serious incidents must be reported to DMH within 8 hours. The governing authority or a committee designated by the governing authority must review all serious incidents and conduct a written analysis of all serious incidents at least quarterly. Written analysis must be made available to DMH for review upon request. Among other things, patients have a right of confidentiality, privacy, communication, to be free of abuse or harassment, to respectful treatment, and to have language assistance services as needed.

Mental Health (MH): The DMH only allows seclusion to be used in Crisis Stabilization Services with individuals over the age of 18 and imposes requirements on the practice related to emergency use, room size, the need for written policies and procedures, and other matters. DMH states, "Providers are prohibited from the use of chemical restraints." However, a therapeutic agent may be used to treat behavioral symptoms during a crisis in certain circumstances. Patients have a right to privacy.

Substance Use Disorder (SUD): Primary Residential Services and Transitional Residential Services residents must receive a handbook during orientation that covers specific subjects, including but not limited to rules and rights.

Quality Assurance or Improvement

Mental Health (MH) and Substance Use Disorder (SUD): Providers must have quality management strategies that at a minimum: (1) Allow for collection of performance measures as required by DMH. (2) Develop and implement policies and procedures for the oversight of collection and reporting of DMH-required performance measures, analysis of serious incidents, periodic analysis of DMH required client level data collection, review of agency wide Recovery and Resiliency Activities and oversight for the development and implementation of DMH required plans of compliance. (3) Collect demographic data to monitor and evaluate cultural competency and the need for Limited English Proficiency services.

Mental Health (MH): Crisis Stabilization Service providers must conduct an assessment, at least annually, of: (1) The level of observation that is required for all individuals receiving services. Policy and procedures should allow for assessment upon admission and at regular intervals during treatment. If the assessment or clinical judgement indicates a greater frequency of observation is necessary, policies and procedures should reflect those practices. Policy and procedures should identify who is responsible for conducting assessment(s). (2) Review of the physical environment of care to assess for potential risks and /or access to lethal means. Mitigation efforts must be put into place when risks are identified.

Governance

Mental Health (MH) and Substance Use Disorder (SUD): All facilities must have a governing authority which, among other things, is responsible for operational standards, an annual operational plan, and policies and procedures. The provider has specific fiscal responsibility requirements that must be satisfied.

Special Populations

Mental Health (MH): Requirements not located.

Substance Use Disorder (SUD): The regulations include specific access requirements for pregnant women and IV drug users. They also include specific service provisions for pregnant women.

Location of Regulatory and Licensing Requirements

Department of Mental Health Operational Standards For Mental Health, Intellectual/Developmental Disabilities, and Substance Use Disorders Community Service Providers[1]; Department of Mental Health Record Guide For Mental Health, Intellectual and Developmental Disabilities, and Substance Use Disorders Community Providers[2]. Regulatory requirements reviewed June 17, 2019.

Other Information Sources

M. Lewis (MS DMH); National Conference of State Legislatures CON Program Overview, http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx

[1] See http://www.dmh.ms.gov/wp-content/uploads/2016/08/Final-Master-2016-Operational-Standards-for-Distribution-6-17-16.pdf.

[2] See http://www.dmh.ms.gov/wp-content/uploads/2016/08/Final-PDF-2016-Record-Guide-for-Distribution.pdf.

MISSISSIPPI MEDICAID

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Approach

The Mississippi Division of Medicaid oversees the state Medicaid program. Mississippi does not have a relevant Section 1115 waiver that affects reimbursement of residential services in Institutions for Mental Diseases (IMDs). It historically has not relied on Disproportionate Share Hospital (DSH) payments and, prior to FY2020, had not relied on the in lieu of provision to reimburse services in IMDs.

Types of Facilities

Mental Health (MH): Mississippi Medicaid provides reimbursement for Crisis Residential programs for adults with a serious and persistent mental illness. Crisis residential services are designed to prevent inpatient hospitalization, address acute symptoms, distress, and further decomposition, and also help transition from hospitalization to community based services. Services must be provided at a facility licensed to service no more than sixteen (16) individuals at a time. Medicaid reimbursement for crisis residential does not include room and board costs and is limited to sixty (60) days per state fiscal year. Crisis residential must be prior authorized by the Division of Medicaid or its designee.

Substance Use Disorder (SUD): No evidence of Medicaid coverage of SUD residential treatment facilities for adults was located.

Processes of Medicaid Enrollment

Mental Health (MH): All providers enrolled as community mental health providers must be certified for the provision of the mental health services they provide by the DMH on the date of service. Certified providers, including those providing crisis services, are subject to the DMH standards for the provision of services.

Substance Use Disorder (SUD): State Medicaid regulations do not specify requirements related to enrollment of residential SUD behavioral health treatment.

Staffing

Mental Health (MH): Staff providing mental health services must meet minimum qualifications as established by the Division of Medicaid. A staff member must hold at a minimum, a bachelor's degree in a mental health field, in order to provide services billed to Medicaid unless specifically stated in a rule defining a service. Bachelor's level staff shall not provide therapy services. All services billed to Medicaid must be approved by a licensed independent practitioner in accordance with the appropriate scope of practice. These practitioners are limited to: a Mississippi licensed Physician who holds a specialty in psychiatry, a Mississippi licensed physician with minimum of five (5) years' experience in mental health, a Mississippi licensed Psychologist, a Mississippi Licensed Certified Social Worker (LCSW), a Mississippi Licensed Professional Counselor (LPC), a Mississippi Licensed Marriage and Family Therapist (LMFT), a Psychiatric Mental Health Nurse Practitioner under an approved protocol, or a Physician Assistant.

- For crisis residential programs, a psychiatrist, psychiatric mental health nurse practitioner or psychologist must be at the location of the crisis residential program and immediately available if needed.

Substance Use Disorder (SUD): No evidence of Medicaid-based staffing requirements for residential SUD treatment facilities for adults was located.

Placement

Mental Health (MH): State Medicaid rules require PASRR evaluation to ensure the appropriate placement of persons with mental illnesses. Crisis residential services are provided to beneficiaries who are experiencing a period of such acute distress that their ability to cope with normal life circumstances is severely impaired. Crisis residential must be ordered by a psychiatrist, psychiatric mental health nurse practitioner or licensed psychologist.

Substance Use Disorder (SUD): No evidence of Medicaid-based placement requirements for residential SUD treatment facilities for adults was located.

Treatment and Discharge Planning and Aftercare Services

Mental Health (MH) and Substance Use Disorder (SUD): All services billed to Medicaid must be included in a treatment plan. A treatment plan may be referred to as the plan of care, individualized service plan, wraparound plan or person-centered plan depending on the service. It is the plan that directs the treatment of the Medicaid beneficiary.

Treatment Services

Mental Health (MH): Crisis residential programs provide medical supervision, nursing services, structured therapeutic activities, and intensive psychotherapy (individual, family and/or group) at a facility based site. Program content may vary based on beneficiary need but must include close observation/supervision and intensive support with the focus on reduction/elimination of acute symptoms.

Substance Use Disorder (SUD): No evidence of Medicaid-based treatment service requirements for residential SUD treatment facilities for adults was located.

Care Coordination

Mental Health (MH) and Substance Use Disorder (SUD): No evidence of Medicaid-based care coordination requirements for residential treatment facilities for adults was located.

Quality Assurance or Improvement

Mental Health (MH) and Substance Use Disorder (SUD): No evidence of Medicaid-based quality assurance or improvement requirements for residential treatment facilities for adults was located.

Special Populations

Mental Health (MH) and Substance Use Disorder (SUD): No evidence of Medicaid-based special population requirements for residential treatment facilities for adults was located.

Location of Medicaid Requirements

Mississippi Medicaid Rules and Regulations[3]; Department of Mental Health Operational Standards For Mental Health, Intellectual/Developmental Disabilities, and Substance Use Disorders Community Service Providers[4]; Department of Mental Health Record Guide For Mental Health, Intellectual and Developmental Disabilities, and Substance Use Disorders Community Providers[5]. Regulatory data collected December 2019.

[3] See https://medicaid.ms.gov/providers/administrative-code/.

[4] See http://www.dmh.ms.gov/wp-content/uploads/2016/08/Final-Master-2016-Operational-Standards-for-Distribution-6-17-16.pdf.

[5] See http://www.dmh.ms.gov/wp-content/uploads/2016/08/Final-PDF-2016-Record-Guide-for-Distribution.pdf.

Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services

This state summary is part of the report **"State Residential Treatment for Behavioral Health Conditions: Regulation and Policy"**. The full report and other state summaries are available at https://aspe.hhs.gov/state-bh-residential-treatment.