State:

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State enrolls Medicaid beneficiaries on a voluntary basis into coordinated care organizations (CCOs) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to enroll certain categories of Medicaid beneficiaries in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

_**X**__ i. MCO
____ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

____i. fee for service;
_**X**__ii. capitation;
____iii. a case management fee;
____iv. a bonus/incentive payment;
____ v. a supplemental payment, or
____vi. other. (Please provide a description below).

To meet goals of choice for beneficiaries, financial stability of the program and administrative ease, no more than three (3) CCOs will be awarded a contract to administer a care coordination program. The program will be statewide with voluntary enrollment.

Citation	Condition or Requirement

CCOs are defined as organizations that meet the requirements for participation as a contractor in the Mississippi Coordinated Access Network (MississippiCAN) program and that manage the purchase and provision of health care services to MississippiCAN enrollees.

Contracted CCOs are selected through a competitive Request for Proposals process.

CCOs are required to:

- **Demonstrate information systems are in place to meet all of the operating and reporting requirements of the program, including the collection of third party liability payments;**
- **Operate both member and provider call centers. [The member call center must be available to members twenty-four (24) hours a day, seven (7) days a week. The provider call center must operate during normal providers' business hours.];**
- **Process claims in compliance with established minimum standards for financial and administrative accuracy and timeliness of processing (standards will be no less than current Medicaid fee-for-service standards);**
- **Submit complete encounter data that meets federal requirements and allows DOM to monitor the program. CCOs that do not meet standards will be penalized.**

CCOs are required to provide a comprehensive package of services that include, at a minimum, the current Mississippi Medicaid benefits. CCOs are not responsible for inpatient hospital services, mental health services or non-emergency transportation, which will be carved out. However, psychotropic medications will be provided by CCOs because many of these medications are prescribed by primary care physicians. In addition, CCOs are required to:

- **Participate as partners with providers and beneficiaries to arrange delivery of quality, cost-effective health care services, with medical homes and comprehensive care management programs to improve health outcomes.**
- **Ensure annual wellness physical exams to establish a baseline, to measure change and to coordinate care appropriately by developing a health and wellness plan with interventions identified to improve outcomes.**
- **Develop disease management programs for chronic or very high cost conditions including, but not limited to diabetes, asthma,**

Citation	Condition or Requirement

hypertension, obesity, congestive heart disease, hemophilia, organ transplants, and improved birth outcomes with a comprehensive health education program to support disease management.

- **Establish quality assurance programs to assess actual performance and ensure that members receive medically appropriate care on a timely basis with positive or improved outcomes, access to effective complaint resolution and grievance processes and support for electronic medical records in provider offices to promote efficient coordinated care with improved outcomes.**

1905(t)
42 CFR 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive case management fee, if certain conditions are met.

If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

____i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

____ii. Incentives will be based upon specific activities and targets.

____iii. Incentives will be based upon a fixed period of time.

____iv. Incentives will not be renewed automatically.

____v. Incentives will be made available to both public and private PCCMs.

____vi. Incentives will not be conditioned on intergovernmental transfer agreements.

____vii. Not applicable to this 1932 state plan amendment.

CFR 438.50(b)(4)

4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)*

Citation	Condition or Requirement
	The MississippiCAN program was authorized through State legislation in accordance with Miss. Code Section 43-13-117 (H). <u>The Division of Medicaid initially issued a public notice requesting input on a proposed care coordination program. The public notice was emailed to various provider associations and advocacy groups in addition to posting it on the agency website seeking comments/revisions/input.</u> **<u>In addition, the agency met with Mississippi legislative leaders and two (2) public hearings were held at the State Capitol to allow for a presentation of the proposed program by agency staff. Various providers, advocacy organizations and many legislators provided input at these hearings. The Governor also called a meeting with various provider groups to discuss the program, seek input, and answer any questions. In addition, agency staff met with various provider groups to discuss the program and seek input. The program information was also submitted to the Medical Care Advisory Committee.</u>** **<u>The program design summary, RFP and responses to frequently asked questions were posted and updated, as necessary, on the state's website to keep stakeholders informed of the program and to respond to questions from individual stakeholders/providers/advocates as well.</u>** **The State will continue to utilize every opportunity to talk with the various stakeholders such as consumers, providers, advocates, etc. At a minimum, the State will meet with stakeholders at least two (2) times a year.**
1932(a)(1)(A)	5. The State will implement voluntary enrollment into the MississippiCAN program on a statewide basis. **Enrollment will be limited to no more than fifteen (15) percent of the Mississippi Medicaid population with the ability to opt out of the program and return to the fee-for-service program. The persons eligible for the program and in the categories of eligibility represent no more than fifteen (15) percent of the Mississippi Medicaid population.** **All beneficiaries will have the ability to select the CCO of their choice. Enrolled beneficiaries will have an open enrollment period during the ninety (90) days following their initial enrollment in a CCO during which they can enroll in a different CCO "without cause," and an open**

Citation	Condition or Requirement
	enrollment period at least once every twelve (12) months after the initial date with the option to opt out or select another CCO during this period.
	C. State Assurances and Compliance with the Statute and Regulations. If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.
1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	1. _**X**__The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. ____The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. _**X**__The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4. _**X**__The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5. _**X**__The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. _**X**__The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7. ____The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.
45 CFR 74.40	8. _**X**__The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

Citation	Condition or Requirement

D. Eligible groups

1932(a)(1)(A)(i)

1. List all eligible groups that will be enrolled on a mandatory basis.

Not applicable.

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.

1932(a)(2)(B)
42 CFR 438(d)(1)

i. ____Recipients who are also eligible for Medicare.

If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*

1932(a)(2)(C)
42 CFR 438(d)(2)

ii. _**X**_Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

1932(a)(2)(A)(i)
42 CFR 438.50(d)(3)(i)

iii. _**X**_Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.

1932(a)(2)(A)(iii)
42 CFR 438.50(d)(3)(ii)

iv. _**X**__Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.

1932(a)(2)(A)(v)
42 CFR 438.50(3)(iii)

v. _**X**__Children under the age of 19 years who are in foster care or other out-of-the-home placement.

1932(a)(2)(A)(iv)
42 CFR 438.50(3)(iv)

vi. _Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.

Citation	Condition or Requirement
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. _Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.
	E. Identification of Mandatory Exempt Groups
1932(a)(2) 42 CFR 438.50(d)	1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)* **Not applicable.**
1932(a)(2) 42 CFR 438.50(d)	2. Place a check mark to affirm if the state's definition of Title V children is determined by: _i. program participation, ____ii. special health care needs, or ____iii. both
1932(a)(2) 42 CFR 438.50(d)	3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system. _i. yes ____ii. no
1932(a)(2) 42 CFR 438.50 (d)	4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)* i. Children under 19 years of age who are eligible for SSI under title XVI; **Not applicable. All enrollment is voluntary.** ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; **Not applicable. All enrollment is voluntary.** iii. Children under 19 years of age who are in foster care or other out-

Citation	Condition or Requirement

of-home placement;

Not applicable. All enrollment is voluntary.

iv. Children under 19 years of age who are receiving foster care or adoption assistance.

Not applicable. All enrollment is voluntary.

1932(a)(2)
42 CFR 438.50(d)

5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)*

Not applicable. All enrollment is voluntary.

1932(a)(2)
42 CFR 438.50(d)

6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)*

i. Recipients who are also eligible for Medicare.

Not applicable.

ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

Not applicable.

42 CFR 438.50

F. <u>List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</u>

Not applicable. All enrollment is voluntary.

42 CFR 438.50

G. <u>List all other eligible groups who will be permitted to enroll on a voluntary basis</u>

Citation | Condition or Requirement

Mississippi Medicaid beneficiaries who are eligible to enroll in the MississippiCAN program are limited to those eligible for Medicaid through:

- **Supplemental Security Income - 1902(a)(10)(A)(i)(II);**
  Beneficiaries who are low income and age 65 or older, blind, or disabled (birth to age 65) who are receiving SSI cash assistance or "deemed" to be cash recipients.

- **Disabled child at home - 1902 (e)(3);**
  Beneficiaries who are disabled and under the age of 18 qualify based on income under 300% of the SSI limit (nursing facility limit) who meet the level of care requirement for nursing facility/intermediate care facility for the mentally retarded placement. Income and resource criteria are the same as for long term care rules and no parental deeming of income or resources.

- **Working disabled – 1902(a)(10)(A)(ii)(XIII);**
  Beneficiaries who are any age and disabled, but work and have earnings under 250% of FPL, unearned income under 135% FPL with a resource limit of $24,000/26,000. A premium is required in certain cases.

- **Department of Human Services Foster Care and Adoption Assistance**
  Children - 1902(a)(10)(A)(ii)(I) and 1902(a)(10)(A)(ii)(VIII);
  Beneficiaries up to age 21, if in the custody of the MS Dept of Human Services and in a licensed foster home, with eligibility based on income/resources of the child and resources not to exceed $10,000.

- **Breast/Cervical Group - 1902(a)(10)(A)(ii)(XVIII).**
  Female beneficiaries under age 65 with no other insurance who have been screened and diagnosed with breast or cervical cancer under the CDC's screening program administered by the MS State Dept of Health. The income limit is 250% of FPL.

Persons in an institution such as a nursing facility, intermediate care facility for the mentally retarded (ICF/MR) or psychiatric residential treatment facility (PRTF); and other waiver members are excluded from the program regardless of the category of eligibility. Each of the groups excluded from the program will be identified by the lock-in segment currently on file for each group.

Citation	Condition or Requirement

Dual eligibles (Medicare and Medicaid) are also excluded from the program regardless of eligibility and these persons will be identified systematically by the Medicare indicator on file in the MMIS.

H. Enrollment process.

1932(a)(4)
42 CFR 438.50

1. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience or through contact with the recipient.

ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Describe how the state's default enrollment process will preserve:

i. the existing provider-recipient relationship (as defined in H.1.i).

Enrollees who fail to make a voluntary CCO selection within the initial thirty (30) days of the enrollment process will be auto-assigned to a CCO. Auto-assignment rules will include a provision to verify paid claims data within a minimum of the past six (6) months and assign the enrollee to a CCO which has a contract with the enrollee's primary care physician.

The use of claims data and CCO relationships for other family members are designed to preserve existing provider-recipient relationships.

ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

Enrollees who fail to make a voluntary CCO selection within the initial thirty (30) days of the enrollment process will be auto-

Citation	Condition or Requirement

assigned to a CCO. Auto-assignment rules will include provisions to:

- **Verify paid claims data within a minimum of the past six (6) months and assign the enrollee to a CCO which has a contract with the enrollee's primary care physician.**
- **Determine if a family member is assigned to a CCO and assign the enrollee to that CCO.**
- **If not, assign the enrollee to an open panel closest to the enrollee's home. If multiple CCOs meet this standard, auto-assignment will occur using a random process.**

CCO provider networks for Medicaid beneficiaries are limited to Medicaid-participating providers. This will ensure beneficiaries a relationship with providers who have traditionally served Medicaid beneficiaries.

iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

Enrollees who fail to make a voluntary CCO selection within the initial thirty (30) days of the enrollment process and the auto–assignment processes as noted in H.2.i and H.2.ii are not sufficient to auto-assign someone. For those beneficiaries for whom it is not possible to determine any prior patient/provider relationship, the State will randomly assign members to ensure equitable enrollment among the plans. If the plans have equitable distribution, then a round robin methodology will be used to ensure maintenance of an equitable distribution.

Auto-assignment will use a random process, but in no case will auto-assignment exceed the capacity of the CCO's provider network.

1932(a)(4) 3. As part of the state's discussion on the default enrollment process, include

Citation	Condition or Requirement
42 CFR 438.50	the following information:

i. The state will_**X**__/will not____ use a lock-in for managed care.

ii. The time frame for recipients to choose a health plan before being auto-assigned will be **30 days**.

iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

Medicaid beneficiaries who are auto-enrolled will receive State-generated correspondence informing them of the CCO to which they have been assigned.

iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

State-generated correspondence informing Medicaid beneficiaries of their auto-assignment to a CCO in the MississippiCAN program will inform members that they may disenroll without cause within ninety (90) days of their enrollment date or to select an alternative CCO. Additionally, CCO enrollment packets will also provide information to members that they may disenroll without cause within ninety (90) days of their enrollment date.

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

If the beneficiary fails to choose a CCO within thirty (30) days of the distribution date of the enrollment packet, the State will assign the beneficiary to a CCO. For those beneficiaries for whom it is not possible to determine any prior patient/provider relationship, the State will randomly assign members to ensure equitable enrollment among the plans. If the plans have equitable distribution, then a round robin methodology will be used to ensure maintenance of an equitable distribution.

Citation	Condition or Requirement

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

The State will monitor any changes in the rate of auto-enrollment through data available from the MMIS and monthly enrollment reports.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. _**X**_ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. _**X**__ The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. ____ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

   _**X**_ This provision is not applicable to this 1932 State Plan Amendment.

4. ____The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

   _**X**_ This provision is not applicable to this 1932 State Plan Amendment.

5. _**X**__ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

   ___This provision is not applicable to this 1932 State Plan Amendment.

Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.50	J. Disenrollment 1. The state will_**X**_/will not___ use lock-in for managed care. 2. The lock-in will apply for up to 12 months. 3. Place a check mark to affirm state compliance. _**X**__The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c). 4. Describe any additional circumstances of "cause" for disenrollment (if any). **Various "for cause" reasons for disenrollment at other times will incorporate federal requirements, such as: providers that do not (for religious or moral reasons) offer needed services; not all related services are available in the plan's network; or the plan lacks providers experienced in dealing with the enrollee's health care needs.**
	K. Information requirements for beneficiaries Place a check mark to affirm state compliance.
1932(a)(5) 42 CFR 438.50 42 CFR 438.10	_**X**__The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments.
1932(a)(5)(D) 1905(t)	L. List all services that are excluded for each model (MCO & PCCM) **Excluded services include:** ▪ **Behavioral health services; however, psychotropic medications will be provided by CCOs because many of these medications are prescribed by primary care physicians.** ▪ **Inpatient hospital services.** ▪ **Non-emergency transportation which will continue to be provided via the existing broker program.**

Citation	Condition or Requirement

- **Long term care services, including nursing facility, ICF-MR, PRTF and home and community-based waiver services.**

CCOs are restricted from requiring its membership to utilize a pharmacy that ships, mails, or delivers drugs or devices.

1932 (a)(1)(A)(ii) M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will_**X**_/will not_____ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. _**X**__ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)* **Number of contracting entities will be determined based on number of enrollees.**

4. ____ The selective contracting provision is not applicable to this state plan.