

State: Mississippi

Citation

Condition or Requirement

To meet the goals of beneficiary choice, financial stability of the program and administrative ease, no more than three (3) and no less than two (2) CCOs are awarded a contract to administer a care coordination program. The program is statewide with both voluntary and mandatory enrollment depending on the beneficiary's category of eligibility. Medicaid beneficiaries excluded from the program regardless of the category of eligibility are listed in B.5.

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 with standards being 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 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.

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	<p>3. Place a check mark to affirm state compliance.</p> <p><u>X</u> The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR § 438.56(c).</p> <p>4. Describe any additional circumstances of “cause” for disenrollment (if any).</p> <p>A beneficiary may request to disenroll from the CCO “with cause” if:</p> <ul style="list-style-type: none">• The CCO, because of moral or religious objections, does not offer the service the beneficiary seeks,• The beneficiary needs related services to be performed at the same time, but not all related services are available within the network; or, the beneficiary’s primary care provider or another provider determines receiving the services separately would subject the beneficiary to unnecessary risk,• Poor quality of care,• There is a lack of access to services covered under the CCO, or• There is a lack of access to providers experienced in dealing with the beneficiary’s health care needs.
	<p>K. Information requirements for beneficiaries</p> <p>Place a check mark to affirm state compliance.</p> <p><u>X</u> 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.</p>
1932(a)(5) 42 CFR § 438.50 42 CFR § 438.10	
1932(a)(5)(D) 1905(t)	<p>L. List all services that are excluded for each model (MCO & PCCM)</p> <p>Excluded services include:</p> <ul style="list-style-type: none">• Long term care services, including nursing facility, ICF/IID, and PRTF.• Any waiver services.• Hemophilia services.