

State: Mississippi

Citation	Condition or Requirement
1932(a)(1)(A)	<p>A. Section 1932(a)(1)(A) of the Social Security Act.</p> <p>The State requires mandatory enrollment of certain Medicaid beneficiaries and voluntary enrollment of federally mandated Medicaid beneficiaries 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 <i>not</i> 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. - vi. below).</p>
1932(a)(1)(B)(i) 1932(a)(1)(B)(ii) 42 CFR § 438.50(b)(1)	<p>B. General Description of the Program and Public Process.</p> <p>1. The State will contract with an</p> <ul style="list-style-type: none"><input checked="" type="checkbox"/> i. MCO<input type="checkbox"/> ii. PCCM (including capitated PCCMs that qualify as PAHPs)<input type="checkbox"/> iii. Both
42 CFR § 438.50(b)(2) 42 CFR § 438.50(b)(3)	<p>2. The payment method to the contracting entity will be:</p> <ul style="list-style-type: none"><input type="checkbox"/> i. fee for service;<input checked="" type="checkbox"/> ii. capitation;<input type="checkbox"/> iii. a case management fee;<input type="checkbox"/> iv. a bonus/incentive payment;<input type="checkbox"/> v. a supplemental payment, or<input type="checkbox"/> vi. other. (Please provide a description below).

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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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1905(t) 42 CFR § 438.6(c)(5)(iii)(iv)	<ul style="list-style-type: none">▪ Develop disease management programs for chronic or very high cost conditions including, but not limited to diabetes, asthma, hypertension, obesity, congestive heart disease, 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. <p>3. For states that pay a PCCM on a fee-for-service basis, incentive case management fee, if certain conditions are met.</p> <p>If applicable to this state plan, place a check mark to affirm the state has met <i>all</i> 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)).</p> <ul style="list-style-type: none">___ 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.<input checked="" type="checkbox"/> <u>X</u> vii. Not applicable to this 1932 state plan amendment.
42 CFR § 438.50(b)(4)	<p>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. (<i>Example: public meeting, advisory groups.</i>)</p>

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5. The State requires mandatory and allows voluntary enrollment depending on the beneficiary's code of eligibility into the MississippiCAN program on a statewide basis.

See Section D for Eligibility Groups.

Enrollment limit increased to the greater of:

1. Forty-five percent (45%) of the total enrollment of all Mississippi Medicaid beneficiaries; or
2. The total of eligible beneficiaries enrolled in MSCAN as of January 1, 2014, plus the categories of beneficiaries composed primarily of persons younger than nineteen (19) years of age.

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Medicaid beneficiaries excluded from the program regardless of the category of eligibility include persons:

- In an institution such as a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID),
- Eligible for Medicare,
- Locked-in any Medicaid waiver program, and
- With hemophilia.

All beneficiaries have freedom of choice in selecting the CCO. All beneficiaries initially enrolled in a CCO are allowed to change CCOs “without cause” during the first ninety (90) days of the initial enrollment effective for the first year. After the first year of enrollment in a CCO all beneficiaries are allowed to enroll in a different CCO during the Medicaid annual open enrollment period October 1 through December 15.

Beneficiaries exempt from mandatory enrollment may disenroll during the first ninety (90) days following their initial enrollment in a CCO. After the first year of enrollment, beneficiaries exempt from mandatory enrollment may disenroll during the Medicaid annual open enrollment period October 1 through December 15.

Refer to Section J.4. for disenrollment “with cause”.

C. State Assurances and Compliance with Statutes 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.

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| 1932(a)(1)(A)(i)(I)
1903(m)
42 CFR § 438.50(c)(1) | 1. <input checked="" type="checkbox"/> 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. <input type="checkbox"/> 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) | 3. <input checked="" type="checkbox"/> The state assures that all the applicable requirements of section 1932 |

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42 CFR § 438.50(c)(3)	(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. <u>X</u> 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 Part 438 42 CFR § 438.50(c)(4) 1903(m)	5. <u>X</u> 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. <u>X</u> 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. <u> </u> The state assures that all applicable requirements of 42 CFR § 447.362 for payments under any non-risk contracts will be met.
45 CFR § 74.40	8. <u>X</u> The state assures that all applicable requirements of 45 CFR § 92.36 for procurement of contracts will be met.

D. Eligible groups

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| 1932(a)(1)(A)(i) | 1. List all eligible groups that will be enrolled on a mandatory basis. <ul style="list-style-type: none">• Supplemental Security Income - 1902(a)(10)(A)(i)(II); Only beneficiaries age 19 to 65 in the eligibility category of low income and age 65 or older, blind, or disabled receiving SSI cash assistance or “deemed” to be cash recipients.• Working disabled – 1902(a)(10)(A)(ii)(XIII); Beneficiaries age 19 or older and disabled who work with earnings under 250% of FPL and unearned income under 135% of FPL with a resource limit of \$24,000/\$26,000. A premium is required in certain cases.• Breast/Cervical Cancer Group - 1902(a)(10)(A)(ii)(XVIII). Female beneficiaries ages 19 to 65 whose income level is 250% of FPL with no other health insurance who have been screened and diagnosed with breast or cervical cancer under the CDC’s screening program |
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1932(a)(2)(B) 42 CFR § 438.50(d)(1)	<p data-bbox="633 462 1443 493">administered by the MS State Dept. of Health.</p> <ul data-bbox="584 525 1443 1365" style="list-style-type: none"><li data-bbox="584 525 1443 714">• Pregnant Women Pregnant women, age 8 to 65, whose family income does not exceed 194% of FPL for the appropriate family size which includes the pregnant women, her spouse and children, if applicable, and unborn(s). A pregnant woman's eligibility includes a two (2)-month postpartum period following the month of delivery, miscarriage or other termination of pregnancy.<li data-bbox="584 735 1443 871">• Infants up to age 1 Infants up to age 1 whose family income does not exceed 194% of FPL for the appropriate family size. Infants born from a Medicaid eligible mother automatically receive benefits for one subsequent year.<li data-bbox="584 892 1443 1018">• Parents and Caretaker Relatives with Dependent Children under age 18 Adults age 19 to 65. As a condition of eligibility, the adult must cooperate with child support enforcement requirements for each eligible child deprived due to a parent's continued absence from the home.<li data-bbox="584 1039 1443 1113">• Children age 1 up to 6 Children age 1 up to 6 whose family income does not exceed 143% of FPL.<li data-bbox="584 1134 1443 1207">• Children age 6 up to 19 Children age 6 up to 19 whose family income does not exceed 107% of FPL.<li data-bbox="584 1228 1443 1365">• Quasi-CHIP Children Children age 6 up to 19 whose family income is between 107% - 133% of FPL. These children would have previously qualified for CHIP under the pre-ACA MAGI rules. <p data-bbox="519 1386 1443 1417">2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR § 438.50.</p> <p data-bbox="584 1449 1443 1512">Use a check mark to affirm whether there is voluntary enrollment of any of the following mandatory exempt groups.</p> <p data-bbox="584 1533 1443 1728">i. <input type="checkbox"/> Recipients who are also eligible for Medicare.</p> <p data-bbox="633 1596 1443 1728">If enrollment is voluntary, describe the circumstances of enrollment. <i>(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)</i></p>

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1932(a)(2)(C) 42 CFR § 438.50(d)(2)	ii. <input checked="" type="checkbox"/> 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. <input checked="" type="checkbox"/> 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. <input checked="" type="checkbox"/> Children under the age of 19 years who are eligible under Section 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR § 438.50(3)(iii)	v. <input checked="" type="checkbox"/> 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. <input checked="" type="checkbox"/> Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR § 438.50(3)(v)	vii. <input type="checkbox"/> 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.

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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: (<i>Examples: eligibility database, self-identification</i>) i. Children under 19 years of age who are eligible for SSI under title XVI; The State identifies these children by category of eligibility and age through the MMIS Eligibility Subsystem. ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; The State identifies these children by category of eligibility through the MMIS Eligibility Subsystem. iii. Children under 19 years of age who are in foster care or other out-of-home placement; The State identifies these children by category of eligibility through the MMIS Eligibility Subsystem. iv. Children under 19 years of age who are receiving foster care or adoption assistance. The State identifies these children by category of eligibility through the MMIS Eligibility Subsystem.
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. (<i>Example: self-identification</i>) Any child not initially identified as having special needs may request exemption from mandatory enrollment through self-identification.
1932(a)(2)	6. Describe how the state identifies the following groups who are exempt from

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42 CFR § 438.50(d)	<p>mandatory enrollment into managed care: (<i>Examples: usage of aid codes in the eligibility system, self- identification</i>)</p> <p>i. Recipients also eligible for Medicare.</p> <p>The State identifies these individuals based on the Medicare indicator in the MMIS Eligibility System.</p> <p>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.</p> <p>The State identifies these individuals using information in the MMIS Eligibility Subsystem and through self-identification.</p>
42 CFR § 438.50(2)	<p>F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</p> <p>Refer to B.5.</p>
42 CFR § 438.50(2)	<p>G. List all other eligible groups who will be permitted to enroll on a voluntary basis</p> <ul style="list-style-type: none">• Supplemental Security Income - 1902(a)(10)(A)(i)(II); Only beneficiaries under the age of 19 in the eligibility category of low income and age 65 or older, blind, or disabled 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 19 qualify based on income under 300% of the SSI limit (nursing facility limit) meeting the level of care requirement for nursing facility/intermediate care facility for individuals with intellectual disabilities (ICF/IID) placement. Income and resource criteria are the same as for long term care rules and no parental deeming of income or other resources.• 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 19, if in the custody of the MS Dept. of Human

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	Services and in a licensed foster home, with eligibility based on income/resources of the child and resources not to exceed \$10,000.
	H. Enrollment Process
1932(a)(4) 42 CFR § 438.50	1. Definitions <ul style="list-style-type: none">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 <p>Describe how the state's default enrollment process will preserve:</p> <ul style="list-style-type: none">i. The existing provider-recipient relationship (as defined in H.1.i).<p>Enrollees failing to make a voluntary CCO selection within the initial thirty (30) days of the enrollment process are auto-assigned to a CCO. Auto-assignment rules include a provision to verify paid claims data within a minimum of the past six (6) months and assignment of the enrollee to a CCO which has a contract with the enrollee's primary care physician.</p><p>The use of claims data and CCO relationships for other family members is designed to preserve existing provider-recipient relationships.</p>ii. The relationship with providers that have traditionally served Medicaid recipients (as defined in H.1.ii).<p>Enrollees failing to make a voluntary CCO selection within the initial thirty (30) days of the enrollment process are auto-assigned to a CCO. Auto-assignment rules include provisions to:</p><ul style="list-style-type: none">▪ 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.

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	<ul style="list-style-type: none">▪ Determine if a family member is assigned to a CCO and assign the enrollee to that CCO.▪ If no family member is assigned to a CCO, the enrollee is assigned to an open panel closest to the enrollee's home. If multiple CCOs meet this standard, auto-assignment occurs using a random process.
	<p>CCO provider networks for Medicaid beneficiaries are limited to Medicaid-participating providers. This ensures beneficiaries have a relationship with providers who have traditionally served Medicaid beneficiaries.</p>
iii.	<p>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). <i>(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)</i></p>
	<p>Enrollees failing to make a voluntary CCO selection within thirty (30) days of enrollment are auto-assigned to a CCO. Auto-assignment rules include provisions to:</p>
	<ul style="list-style-type: none">▪ Verify paid claims data within 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 no family member is assigned to a CCO, the enrollee is assigned to an open panel closest to the enrollee's home. If multiple CCOs meet this standard, auto-assignment will occur using a random process.
	<p>Auto-assignment is a hierarchy process, but in no case will auto-assignment exceed the capacity of the CCO's provider network.</p>
	<p>The use of claims data and CCO relationships for other family members is designed to preserve existing provider-recipient relationships.</p>
	<p>CCO provider networks for Medicaid beneficiaries are limited to Medicaid-participating providers. This ensures beneficiaries have a relationship with providers who have traditionally served Medicaid beneficiaries.</p>

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1932(a)(4) 42 CFR § 438.50	<p>3. As part of the state's discussion on the default enrollment process, include the following information:</p> <p>i. The state will <u>X</u> / will not _____ use a lock-in for managed care.</p> <p>ii. The time frame for recipients to choose a health plan before being auto-assigned will be 30 days.</p> <p>iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. (<i>Example: state generated correspondence.</i>)</p> <p>Medicaid beneficiaries auto-enrolled receive State-generated correspondence informing of the assigned CCO.</p> <p>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. (<i>Examples: state generated correspondence, HMO enrollment packets etc.</i>)</p> <p>Medicaid beneficiaries auto-assigned to a CCO receive state-generated correspondence informing them that they may disenroll without cause during the first ninety (90) days of initial enrollment. CCO enrollment packets also provide information regarding disenrollment without cause during ninety (90) days of the initial enrollment date.</p> <p>v. Describe the default assignment algorithm used for auto-assignment. (<i>Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.</i>)</p> <p>If the beneficiary fails to choose a CCO within thirty (30) days of the distribution date of the enrollment packet, the State assigns the beneficiary to a CCO. If it is not possible to determine prior patient/provider relationship, the State randomly assigns members to ensure equitable enrollment among the plans. If the plans have equitable distribution, then a round robin methodology is used to ensure maintenance of an equitable distribution.</p> <p>vi. Describe how the state will monitor any changes in the rate of default assignment. (<i>Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker</i>)</p>

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1932(a)(4) 42 CFR § 438.50	<p>The State monitors for any change in the rate of auto-enrollment through data available from the MMIS Eligibility Subsystem and monthly enrollment reports generated by the enrollment broker.</p> <p>I. State assurances on the enrollment process</p> <p>Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.</p> <ol style="list-style-type: none"><input checked="" type="checkbox"/> 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.<input checked="" type="checkbox"/> 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).<input type="checkbox"/> The state plan program applies the rural exception to choice requirements of 42 CFR § 438.52(a) for MCOs and PCCMs. <input checked="" type="checkbox"/> This provision is not applicable to this 1932 State Plan Amendment.<input type="checkbox"/> 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.) <input checked="" type="checkbox"/> This provision is not applicable to this 1932 State Plan Amendment.<input checked="" type="checkbox"/> 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 two (2) months or less. <input type="checkbox"/> This provision is not applicable to this 1932 State Plan Amendment.
1932(a)(4) 42 CFR § 438.50	<p>J. Disenrollment</p> <ol style="list-style-type: none">The state will <input checked="" type="checkbox"/> /will not <input type="checkbox"/> use lock-in for managed care.The lock-in will apply for up to twelve (12) months.

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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 § 42 438.10(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) 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 and ICF/IID,• Any waiver services, and• Hemophilia services.

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1932 (a)(1)(A)(ii)	<p data-bbox="532 499 1443 558">CCOs are restricted from requiring its membership to utilize a pharmacy that ships, mails, or delivers drugs or devices.</p> <p data-bbox="472 583 1084 615">M. Selective contracting under a 1932 state plan option</p> <p data-bbox="532 646 1443 705">To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.</p> <ol data-bbox="532 737 1443 1045" style="list-style-type: none"><li data-bbox="532 737 1443 798">1. The state will <u>X</u> /will not _____ intentionally limit the number of entities it contracts under a 1932 state plan option.<li data-bbox="532 856 1443 917">2. <u>X</u> The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.<li data-bbox="532 949 1443 1045">3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. (<i>Example: a limited number of providers and/or enrollees.</i>) <p data-bbox="578 1073 1443 1194">The State limits the number of CCOs to no more than three (3) and no less than two (2) based on the number of potential enrollees. The State believes it is not in the best interest of the CCOs financially to divide the potential maximum among more than three (3) plans.</p> <ol data-bbox="532 1224 1443 1260" style="list-style-type: none"><li data-bbox="532 1224 1443 1260">4. _____ The selective contracting provision is not applicable to this state plan.