

State: Mississippi

| Citation   | Condition or Requirement   |
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| 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. - vii. below).</p> |
| 1932(a)(1)(B)(i)<br>1932(a)(1)(B)(ii)<br>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"><li><input checked="" type="checkbox"/> i. MCO</li><li><input type="checkbox"/> ii. PCCM (including capitated PCCMs that qualify as PAHPs)</li><li><input type="checkbox"/> iii. Both</li></ul>   |
| 42 CFR 438.50(b)(2)<br>42 CFR 438.50(b)(3)                   | <p>2. The payment method to the contracting entity will be:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> i. fee for service;</li><li><input checked="" type="checkbox"/> ii. capitation;</li><li><input type="checkbox"/> iii. a case management fee;</li><li><input type="checkbox"/> iv. a bonus/incentive payment;</li><li><input type="checkbox"/> v. a supplemental payment, or</li><li><input type="checkbox"/> vi. other. (Please provide a description below).</li></ul>   |

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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 A.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 not responsible for inpatient hospital services or non-emergency transportation. 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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TN No. 2012-013  
Supersedes  
TN No. 10-004

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Received Date 10/24/12  
Approval Date 01/22/13  
Effective Date 12/01/2012

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| 1905(t)<br>42 CFR 438.6(c)(5)(iii)(iv) | <ul style="list-style-type: none"><li>▪ 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.</li><li>▪ 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.</li></ul> <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"><li>___ 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.</li><li>___ ii. Incentives will be based upon specific activities and targets.</li><li>___ iii. Incentives will be based upon a fixed period of time.</li><li>___ iv. Incentives will not be renewed automatically.</li><li>___ v. Incentives will be made available to both public and private PCCMs.</li><li>___ vi. Incentives will not be conditioned on intergovernmental transfer agreements.</li><li><input checked="" type="checkbox"/> vii. Not applicable to this 1932 state plan amendment.</li></ul> |
| 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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| 1932(a)(1)(A) | <p>The MississippiCAN program was authorized in 2010, with an effective date of 1/1/2011, through State legislation in accordance with Miss. Code Section 43-13-117 (H). The Division of Medicaid initially issued a public notice requesting input on a proposed care coordination program. The public notice was e-mailed to various provider associations and advocacy groups in addition to posting it on the agency website seeking comments/revisions/input.</p> <p>The agency also 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.</p> <p>The initial program design summary, request for proposal (RFP) and responses to frequently asked questions were posted and updated on the State's website prior to the implementation of the program.</p> <p>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 two (2) times a year.</p> <p>The Division of Medicaid will request comments on proposed changes to the MississippiCAN program by issuing a public notice(s) via e-mail to various provider associations and advocacy groups in addition to posting it on the agency's website.</p> <p>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.</p> <p>See Section M for Eligibility Groups.</p> <p>Enrollment is limited to no more than forty-five (45) percent of the Mississippi Medicaid population.</p> <p>Medicaid beneficiaries excluded from the program regardless of the category of eligibility include persons:</p> <ul style="list-style-type: none"><li>• In an institution such as a nursing facility, intermediate care facility for the mentally retarded (ICF/MR) or psychiatric residential treatment facility (PRTF),</li></ul> |

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- 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 15 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 15 through December 15.

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

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.  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.  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.  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.

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| 1932(a)(1)(A)<br>42 CFR 438<br>42 CFR 438.50(c)(4)<br>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)<br>42 CFR 438.6(c)<br>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)<br>CFR 447.362<br>42 CFR 438.50(c)(6)           | 7. _____ The state assures that all applicable requirements of 42 CFR 447.362 for 42 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  |
| 1932(a)(1)(A)(i)  | 1. List all eligible groups that will be enrolled on a mandatory basis. <ul style="list-style-type: none"><li>• Supplemental Security Income - 1902(a)(10)(A)(i)(II); Only beneficiaries age 19 to age 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.</li><li>• 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.</li><li>• 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 administered by the MS State Dept. of Health.</li><li>• Pregnant Women and Children Under Age 1<br/>Pregnant women and children up to age 1 whose family income does not exceed 185% of FPL for the appropriate family size which includes the pregnant women, her spouse and children, if applicable, and unborn(s). The expected due date must be verified by a healthcare professional. Eyeglass</li></ul> |

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|                                   | <p>and dental services are not available to pregnant women in this program. A pregnant woman's eligibility includes a two (2)-month postpartum period following the month of delivery, miscarriage or other termination of pregnancy.</p> <ul style="list-style-type: none"><li>• <b>Medical Assistance-Intact Family</b><br/>Children up to age 1 and adults age 19 to 65. Children must be deprived of the support of one or both parents due to incapacity, death, continued absence or under/unemployment. As a condition of eligibility, the adult must cooperate with child support enforcement requirements for each child deprived due to a parent's continued absence from the home.</li><li>• <b>Children Up to Age 6</b><br/>Only children up to age 1 whose family income does not exceed 133% if FPL are mandated to enroll.</li><li>• <b>Children Under Age 19</b><br/>Only children up to age 1 whose family income does not exceed 100% of FPL are mandated to enroll.</li></ul> <p>2. <b>Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.</b></p> <p>Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.</p> <p>i. <input type="checkbox"/> Recipients who are also eligible for Medicare.</p> <p>If enrollment is voluntary, describe the circumstances of enrollment.<br/><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> <p>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.</p> <p>iii. <input checked="" type="checkbox"/> Children under the age of 19 years, who are eligible for Supplemental</p> |
| 1932(a)(2)(B)<br>42 CFR 438(d)(1) |  |
| 1932(a)(2)(C)<br>42 CFR 438(d)(2) |  |
| 1932(a)(2)(A)(i)                  |  |

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| 42 CFR 438.50(d)(3)(i)                        | Security Income (SSI) under title XVI.  |
| 1932(a)(2)(A)(iii)<br>42 CFR 438.50(d)(3)(ii) | iv. <input checked="" type="checkbox"/> Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.  |
| 1932(a)(2)(A)(v)<br>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)<br>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)<br>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.
- 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*)

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|                                | <p>i. Children under 19 years of age who are eligible for SSI under title XVI;</p> <p>The State identifies these children by category of eligibility and age through the MMIS Eligibility Subsystem.</p>  |
|                                | <p>ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;</p> <p>The State identifies these children by category of eligibility through the MMIS Eligibility Subsystem.</p>  |
|                                | <p>iii. Children under 19 years of age who are in foster care or other out-of-home placement;</p> <p>The State identifies these children by category of eligibility through the MMIS Eligibility Subsystem.</p>   |
|                                | <p>iv. Children under 19 years of age who are receiving foster care or adoption assistance.</p> <p>The State identifies these children by category of eligibility through the MMIS Eligibility Subsystem.</p>   |
| 1932(a)(2)<br>42 CFR 438.50(d) | <p>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>)</p> <p>Any child not initially identified as having special needs may request exemption from mandatory enrollment through self-identification.</p>  |
| 1932(a)(2)<br>42 CFR 438.50(d) | <p>6. Describe how the state identifies the following groups who are exempt from 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.</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</p> |

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|                             | <p>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               | <p>F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</p> <p>Refer to A.5.</p>  |
| 42 CFR 438.50               | <p>G. List all other eligible groups who will be permitted to enroll on a voluntary basis</p> <ul style="list-style-type: none"><li data-bbox="597 932 1401 1052">• Supplemental Security Income - 1902(a)(10)(A)(i)(II); Only beneficiaries age 0 to 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.</li><li data-bbox="597 1085 1401 1297">• 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 the mentally retarded (ICF/MR) placement. Income and resource criteria are the same as for long term care rules and no parental deeming of income or other resources.</li><li data-bbox="597 1331 1443 1480">• 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 Services and in a licensed foster home, with eligibility based on income/resources of the child and resources not to exceed \$10,000.</li></ul> |
| 1932(a)(4)<br>42 CFR 438.50 | <p>H. Enrollment Process</p> <p>1. Definitions</p> <p>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</p>  |

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| 1932(a)(4)<br>42 CFR 438.50 | <p data-bbox="683 464 1443 527">previous managed care enrollment or fee-for-service experience or through contact with the recipient.</p> <p data-bbox="589 558 1386 621">ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.</p> <p data-bbox="532 646 1005 678">2. State process for enrollment by default</p> <p data-bbox="589 709 1292 741">Describe how the state's default enrollment process will preserve:</p> <p data-bbox="589 772 1377 804">i. The existing provider-recipient relationship (as defined in H.1.i).</p> <p data-bbox="683 835 1443 1014">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 data-bbox="683 1045 1443 1108">The use of claims data and CCO relationships for other family members are designed to preserve existing provider-recipient relationships.</p> <p data-bbox="589 1140 1338 1203">ii. The relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).</p> <p data-bbox="683 1234 1443 1318">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 data-bbox="732 1350 1443 1623" style="list-style-type: none"><li>▪ 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.</li><li>▪ Determine if a family member is assigned to a CCO and assign the enrollee to that CCO.</li><li>▪ 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.</li></ul> <p data-bbox="683 1654 1443 1713">CCO provider networks for Medicaid beneficiaries are limited to Medicaid-participating providers. This ensures beneficiaries a</p> |

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| 1932(a)(4)<br>42 CFR 438.50 | <p data-bbox="688 468 1443 525">relationship with providers who have traditionally served Medicaid beneficiaries.</p> <p data-bbox="586 560 1443 741">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). <i>(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)</i></p> <p data-bbox="664 772 1443 863">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 data-bbox="678 911 1443 1167" style="list-style-type: none"><li>▪ 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.</li><li>▪ Determine if a family member is assigned to a CCO and assign the enrollee to that CCO.</li><li>▪ 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.</li></ul> <p data-bbox="646 1199 1443 1260">Auto-assignment is a random process, but in no case will auto-assignment exceed the capacity of the CCO’s provider network.</p> <p data-bbox="646 1297 1443 1358">The use of claims data and CCO relationships for other family members are designed to preserve existing provider-recipient relationships.</p> <p data-bbox="646 1390 1443 1480">CCO provider networks for Medicaid beneficiaries are limited to Medicaid-participating providers. This ensures beneficiaries a relationship with providers who have traditionally served Medicaid beneficiaries.</p> <p data-bbox="529 1514 1443 1722">3. As part of the state’s discussion on the default enrollment process, include the following information:</p> <ul data-bbox="586 1604 1443 1722" style="list-style-type: none"><li>i. The state will <u>X</u> / will not____ use a lock-in for managed care.</li><li>ii. The time frame for recipients to choose a health plan before being auto-assigned will be 30 days.</li></ul> |

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|                             | <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 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> <p>The State monitors for any change in the rate of auto-enrollment through data available from the MMIS and monthly enrollment reports generated by the enrollment broker.</p>  |
| 1932(a)(4)<br>42 CFR 438.50 | <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>  |

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|                             | <p>1. <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.</p> <p>2. <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).</p> <p>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.</p> <p><input checked="" type="checkbox"/> This provision is not applicable to this 1932 State Plan Amendment.</p> <p>4. <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.)</p> <p><input checked="" type="checkbox"/> This provision is not applicable to this 1932 State Plan Amendment.</p> <p>5. <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 2 months or less.</p> <p><input type="checkbox"/> This provision is not applicable to this 1932 State Plan Amendment.</p> |
| 1932(a)(4)<br>42 CFR 438.50 | <p>J. Disenrollment</p> <p>1. The state will <input checked="" type="checkbox"/> /will not <input type="checkbox"/> use lock-in for managed care.</p> <p>2. The lock-in will apply for up to 12 months.</p> <p>3. Place a check mark to affirm state compliance.</p> <p><input checked="" type="checkbox"/> 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>  |

State: Mississippi

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|  | <ul style="list-style-type: none"><li>• The CCO, because of moral or religious objections, does not offer the service the beneficiary seeks,</li><li>• 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,</li><li>• Poor quality of care,</li><li>• There is a lack of access to services covered under the CCO, or</li><li>• There is a lack of access to providers experienced in dealing with the beneficiary's health care needs.</li></ul> |
|  | K. Information requirements for beneficiaries<br><br>Place a check mark to affirm state compliance.  |
| 1932(a)(5)<br>42 CFR 438.50<br>42 CFR 438.10 | <input checked="" type="checkbox"/> 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)<br>1905(t)                     | L. List all services that are excluded for each model (MCO & PCCM)<br><br>Excluded services include: <ul style="list-style-type: none"><li>▪ Inpatient hospital services.</li><li>▪ Non-emergency transportation which will continue to be provided via the existing broker program.</li><li>• Long term care services, including nursing facility, ICF-MR, and PRTF.</li><li>• Any waiver services.</li></ul><br>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<br><br>To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.   |

TN No. 2012-013  
Supersedes  
TN No. 10-004

Received Date 10/24/12  
Approval Date 01/22/13  
Effective Date 12/01/2012

State: Mississippi

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| Citation | Condition or Requirement   |
|----------|--|
|          | <ol style="list-style-type: none"><li data-bbox="532 499 1443 558">1. The state will <u>X</u> /will not _____ intentionally limit the number of entities it contracts under a 1932 state plan option.</li><li data-bbox="532 621 1443 680">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><li data-bbox="532 716 1443 800">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>)<br/><br/>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. Because the program is limited to no more than forty-five (45) percent of the Mississippi Medicaid population, 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.</li><li data-bbox="532 1016 1443 1047">4. _____ The selective contracting provision is not applicable to this state plan.</li></ol> |

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