MississippiCAN Program Summary

Revised November, 2012

Introduction

Program Goals

The implementation of Mississippi Coordinated Access Network (MississippiCAN), a Coordinated Care Program for Mississippi Medicaid beneficiaries, will address the following goals:

- **Improve access to needed medical services -** This goal will be accomplished by connecting the targeted beneficiaries with a medical home, increasing access to providers and improving beneficiaries' use of primary and preventive care services.
- **Improve quality of care –** This goal will be accomplished by providing systems and supportive services, including disease state management and other programs that will allow beneficiaries to take increased responsibility for their health care.
- **Improve efficiencies and cost effectiveness** – This goal will be accomplished by contracting with Coordinated Care Organizations (CCOs) on a full-risk capitated basis to provide comprehensive services through an efficient, cost effective system of care.

Section A: Program Description

Part I: Program Overview

A. Federal Authority

After completion of the actuarially sound capitated rates (calculated by Milliman), Mississippi received federal approval in the form of a State Plan Amendment to implement a care coordination program for targeted beneficiaries. The Program was implemented on January 1, 2011.

B. Program Geographic Areas

MississippiCAN includes all 82 counties in the state of Mississippi for eligible beneficiaries.

C. Target Population

Upon implementation the target population of MississippiCAN was comprised of five categories of eligibility. Targeted, high cost Medicaid beneficiaries are defined as those individuals in a category of eligibility that has been determined by claims where beneficiaries in categories of eligibility with an above average per member per month cost and more than 1,200 member months, excluding those persons in an institution, dual eligible and waiver members. For the purposes of this program upon implementation, the targeted, high cost beneficiaries included:

Targeted Population

- SSI
- Disabled Child at Home,
- Working Disabled,
- Department of Human Services Foster Care, and
- Breast/Cervical Group

Persons in an institution such as a nursing facility, ICF/MR or PRTF; dual eligible (Medicare and Medicaid); and waiver members are excluded from the program regardless of the category of eligibility.

During the 2012 Legislative Session, House Bill 421 was passed which authorized certain changes to the program. These included the following:

- Increased from 15% to 45% the percentage of Medicaid beneficiaries who can be enrolled in coordinated care program
- Ensures that the medical decisions of hospital physicians or staff regarding patients admitted to a hospital cannot be overridden by the program
- Mandates that the program may not have a prior authorization process for prescription drugs that is more stringent than the prior authorization process used by Division of Medicaid
- Requires the program to maintain a preferred drug list that is no more stringent than the mandatory preferred drug list established by Division of Medicaid
- Ensures that beneficiaries with hemophilia have access to the federally funded hemophilia treatment centers as part of the Medicaid coordinated care network of providers
- Allowed for certain categories of eligibility to be mandatory enrolled in the program.

D. <u>Voluntary Enrollment</u>

The enrollment into MississippiCAN of the targeted populations upon implementation was voluntary. Targeted beneficiaries were provided information about the program with their program options. Beneficiaries could then enroll in the plan of their choice. If they did not enroll within 30 days from the date of notification, they were auto-enrolled by the Division of Medicaid (DOM). If they did not opt out of the program within 90 days of enrollment, they remained in until the next annual open enrollment period.

All beneficiaries had the ability to choose the CCO of their choice. Enrolled beneficiaries had an open enrollment period during the 90 days following their initial enrollment in a CCO during which they can enroll in a different CCO "without cause," and have an open enrollment period annually.

Eligibility criteria for MississippiCAN is the same as the eligibility criteria for Mississippi Medicaid. The CCOs do not have the ability to directly market to the targeted beneficiaries. DOM is responsible for the process to provide information about choice of CCOs and enroll the beneficiaries into their chosen CCO. DOM staff and the Medicaid Fiscal Agent work together to accomplish these tasks. Upon implementation no separate enrollment broker was procured.

The enrollment process ensures that beneficiaries had an informed choice, resulting in the process being cost efficient and timely, and the process was acceptable to advocates, providers and beneficiaries.

Mandatory Enrollment vs. Voluntary (Optional) Enrollment

With changes authorized by House 421, DOM included additional categories of eligibility, enrollment is mandatory for certain categories of eligibility, and mental health services were added to the program to be provided and reimbursed by the CCOs.

New categories of eligible for the program, effective December 1, 2012, include the following:

- DHS Foster Children (Adoption Assistance)
- Family/Children-TANF
- Children only age 0-1 (who are eligible in category 087, which includes children up to age 6)
- Children only age 0-1 (who are eligible in category 091, which includes children up to age 19)
- Pregnant Women and Infants

Mandatory Populations

SSI	Ages 19-65
Working Disabled	Ages 19-65
Breast and Cervical Cancer	Ages 19-65
Pregnant Women and Infants	Ages 0-1 and 8-65
Family/Children TANF	Ages 0-1 and 19-65
Children in category of eligibility 087	Ages 0-1
Children in category of eligibility 091	Ages 0-1

Voluntary (Optional) Population

SSI-Ages	Ages 0-19
Disabled Child Living at Home	Ages 0-19
DHS Foster Care Children	Ages 0-19
DHS Foster Care Children (Adoption Assistance)	Ages 0-19

E. Member s' Rights and Protections

Members' rights and protections will be required, including the right to:

- receive needed information about the program;
- be treated with respect, dignity and privacy;
- receive information on available treatment options; participate in health care decisions;
- request copies of medical records; and
- be furnished services with an adequate delivery network, timely access, coordination and continuity of care, and other specified standards.

Members' protections will also be provided through access standards, care coordination requirements, quality management programs, and detailed grievance and appeals procedures.

F. Coordinated Care Organizations

To meet goals of choice for beneficiaries, financial stability of the program and administrative ease, DOM selected two CCOs to administer the program:

- Magnolia Health Plan
- UnitedHealthcare Community Plan

CCOs serve the entire state and provide, at a minimum, the comprehensive package of Mississippi Medicaid services (excluding inpatient hospital services and non-emergency transportation) to all populations.

CCOs receive a prepaid monthly capitated payment and provide services through a full-risk arrangement.

Part II: Major Program Elements

A. Benefits

A comprehensive package of services is provided by the CCOs that includes, at a minimum, the current Mississippi Medicaid benefits which must be medically necessary. CCOs are not responsible for inpatient hospital services. Non-emergency transportation will continue to be provided by DOM's current contractor.

The CCOs must encourage beneficiaries to have a wellness physical exam annually. This will ensure that the CCO has a baseline of enrollee's health status, allowing CCOs to measure change and coordinate care appropriately by developing a health and wellness plan and by identifying interventions to improve outcomes.

B. Administrative Services

CCOs are required to operate both member and provider call centers. The member call center is available to members 24 hours a day, seven days a week. The provider call center operates during normal providers' business hours.

CCOs are responsible for processing claims. DOM established minimum standards for financial and administrative accuracy and for timeliness of processing; these standards are no less than the standards currently in place for the Medicaid fee-for-service program. CCOs are required to submit complete encounter data to DOM that meets federal requirements and allows DOM to monitor the program. CCOs that do not meet standards are penalized.

C. Provider Network

The "provider network" is the panel of health service providers with which the CCO contracts for the provision of covered services to beneficiaries. All CCO-contracted providers must also be enrolled in the Mississippi Medicaid program. CCOs are required to recruit a provider network that includes all types of Medicaid providers, and the full range of medical specialties necessary to provide the covered benefits, including contracts with out-of-state providers for medically necessary services. In establishing its provider network, CCOs are required to contract with FQHCs and RHCs. Access standards for the provider network require the CCOs to ensure that for primary care services, members travel no more than 60 minutes or 60 miles in the rural regions, and 30 minutes or 30 miles in the urban regions.

As access to non-hospital based emergency care is an issue of concern, CCOs are required to include non-hospital urgent and emergent care providers in their networks.

CCOs are required to reimburse providers in their network at a rate no less than the current Medicaid rate for each service.

D. Care Management

The CCOs are expected to participate as partners, with providers and beneficiaries, in arranging the delivery of health care services that improve health status in a cost-effective way. DOM expects CCOs to connect beneficiaries to a medical home and implement comprehensive care management programs for the populations. Care management includes a method to coordinate services with behavioral health providers, social services agencies, and out-of-state providers to improve care and quality outcomes.

CCOs are required to have a disease management program that focuses on diseases that are chronic or very high cost, including but not limited to diabetes, asthma, hypertension, obesity, congestive heart disease, organ transplants, and improved birth outcomes.

The CCO's are expected to have a comprehensive health education program that will support the disease management programs.

The CCOs have a comprehensive utilization management program to ensure the medical necessity of all services provided.

E. Quality Assurance

CCO quality assurance programs assess actual performance to ensure that beneficiaries are receiving medically appropriate care on a timely basis that results in positive or improved outcomes. Complaint resolutions and grievance processes are components of an effectively integrated quality assurance program and, therefore, are included.

CCO quality assurance programs identify opportunities for improved quality, and initiate programs that achieve improvements by using evidence-based medicine and practice guidelines. These activities include, using data to establish baselines, measure performance, identify performance improvement opportunities, and create member and provider profiles.

CCOs are committed to supporting the use of electronic medical records in provider offices to promote efficient coordinated care that will ultimately result in improved outcomes.

Section B: Contract Compliance and Monitoring

Contract Compliance and Monitoring

A critical component of MississippiCAN is contract compliance and monitoring to ensure that the goals of the program are being met. DOM assesses the performance of the selected CCOs throughout the contract period.

DOM completed readiness reviews of CCOs prior to implementation of MississippiCAN, and prior to the planned expansion of the program. This included evaluation of all CCO program components, including technology, administrative services, and medical management.

DOM conducts audits of the performance of the CCOs against contract requirements. The audits include all aspects of the program that are over and above the waiver requirements and financial expectations. DOM closely monitors the financial performance of contractors. DOM requires the CCOs to submit quarterly and annual reports that allow DOM to assess CCO claims reserves and overall financial soundness. DOM requires quarterly reports on claims processing and encounter submission. DOM may impose penalties for failure to meet established standards. If DOM establishes that a CCO is not compliant with any of the above monitoring activities, the CCO will be required to provide corrective action plans to ensure that the goals of the program will be met.