PUBLIC NOTICE

Under the provisions of Section 438.50(b)(4), Title 42, Code of Federal Regulations, public notice is hereby given to the submission of a Mississippi Medicaid State Plan Amendment (SPA). Effective December 1, 2015, the Mississippi Division of Medicaid, in the Office of the Governor, will implement changes to the Mississippi Coordinated Access Network (MSCAN) to comply with Miss. Code Ann. § 43-13-117(A)(18)(b)-(c), our Transmittal # 15-010.

1. SPA 15-010 MSCAN is being submitted to remove inpatient hospital services from the excluded list of MSCAN services to comply with Miss. Code Ann. § 43-13-117(A)(18)(b)-(c), effective December 1, 2015.

2. The proposed SPA is estimated to result in increased Medicaid expenditures of approximately $2.21 million in state dollars and $6.46 million in federal dollars for a total of $8.67 million for FFY16, and $8.45 million in state dollars and $24.70 million in federal dollars for a total of $33.15 million for FF17. This estimate does not incorporate funds that will be returned to the State or federal government as a result of the Mississippi premium tax or Federal Health Insurer Fee (HIF).

3. Senate Bill 2588, passed in the 2015 Legislative Session, authorized the Division of Medicaid to implement these changes to MSCAN.

4. A copy of the proposed SPA will be available in each county health department office and in the Department of Human Services office in Issaquena County for review.

5. Written comments will be received by the Division of Medicaid, Office of the Governor, Office of Policy, Walter Sillers Building, Suite 1000, 550 High Street, Jackson, Mississippi 39201, or Margaret.Wilson@medicaid.ms.gov for thirty (30) days from the date of publication of this notice. Comments will be available for public review at the above address and on the Division of Medicaid's website at www.medicaid.ms.gov.

6. A public hearing on this SPA will not be held.

David J. Dzielak, Ph.D.
Executive Director
Division of Medicaid
Office of the Governor

August 31, 2015

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 not responsible for inpatient hospital services.~~ 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.

Citation	Condition or Requirement

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).

A beneficiary may request to disenroll from the CCO "with cause" if:

- 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.

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:

- ~~Inpatient hospital services.~~

- Long term care services, including nursing facility, ICF/IID, and PRTF.

- Any waiver services.

- Hemophilia services.

Citation	Condition or Requirement

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