Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Mississippi enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization [MCOs], primary care case managers [PCCMs], and/or PCCM entities) 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 require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on state wideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).

This authority may ***not*** 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 described in 42 CFR 438.50(d).

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date. All applicable assurances should be checked, even when the compliance date is in the future. **Please see Appendix A of this document for compliance dates for various sections of 42 CFR 438.**

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
noted 42 CFR 438.2
42 CFR 438.6
42 CFR 438.50(b)(1)-(2)

B. Managed Care Delivery System.
The State will contract with the entity(ies) below and reimburse them as under each entity type.

1. ☒ MCO
   - ☒ Capitation
   - ☒ The state assures that all applicable requirements of 42 CFR 438.6, regarding special contract provisions related to payment, will be met.

2. ☐ PCCM (individual practitioners)
   a. ☐ Case management fee
   b. ☐ Other (please explain below)

3. ☐ PCCM entity
   a. ☐ Case management fee
   b. ☐ Shared savings, incentive payments, and/or financial rewards (see 42 CFR 438.310(c)(2))

Citation	Condition or Requirement

c. ☐ Other(please explain below)

If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as in 42 CFR 438.2), in addition to PCCM services:

- ☐ Provision of intensive telephonic case management
- ☐ Provision of face-to-face case management
- ☐ Operation of a nurse triage advice line
- ☐ Development of enrollee care plans.
- ☐ Execution of contracts with fee-for-service (FFS) providers in the FFS program
- ☐ Oversight responsibilities for the activities of FFS providers in the FFS program
- ☐ Provision of payments to FFS providers on behalf of the State.
- ☐ Provision of enrollee outreach and education activities.
- ☐ Operation of a customer service call center.
- ☐ Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement.
- ☐ Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.
- ☐ Coordination with behavioral health systems/providers.
- ☐ Coordination with long-term services and supports systems/providers.
- ☐ Other (please describe): _____

42 CFR 438.50(b)(4) C. Public Process.

Describe the public process including tribal consultation, if applicable, utilized for both the design of the managed care program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan managed care program has been implemented. *(Example: public meeting, advisory groups.)*
If the program will include long term services and supports (LTSS), please indicate how the views of stakeholders have been, and will continue to be, solicited and addressed during the design, implementation, and oversight of the program, including plans for a member advisory committee (42 CFR 438.70 and 438.110)

The MississippiCAN program was authorized in 2010, with an effective date of 1/1/2011, through State legislation in accordance with Miss. Code Ann. 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 State's website seeking comments/revisions/input.

The State 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 State 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.

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. Every procurement for managed care services subject to this SPA has been posted publicly on the State's website.

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.

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 State's website.

Citation	Condition or Requirement

D. 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)
met. 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

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 (including for PCCM entities) 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 beneficiaries to receive their benefits through managed care entities will be met.

1932(a)(1)(A)
42 CFR 431.51
1905(a)(4)(C)
42 CFR 438.10(g)(2)(vii)

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.

1932(a)(1)(A)

5. ☒ The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).

1932(a)(1)(A)
of 42 CFR 438
1903(m)

6. ☒ The state assures that all applicable managed care requirements 42 CFR Part 438 for MCOs, PCCMs, and PCCM entities will be met.

1932(a)(1)(A)

42 CFR 438.4
42 CFR 438.5
42 CFR 438.7
42 CFR 438.8
42 CFR 438.74
42 CFR 438.50(c)(6)

7. ☒ The state assures that all applicable requirements of 42 CFR 438.4, 438.5, 438.7, 438.8, and 438.74 for payments under any risk contracts will be met.

1932(a)(1)(A)

8. ☐ The state assures that all applicable requirements of 42 CFR 447.362 for

Citation	Condition or Requirement

42 CFR 447.362
42 CFR 438.50(c)(6)

payments under any non-risk contracts will be met.

45 CFR 75.326

9. ☒–The state assures that all applicable requirements of 45 CFR 75.326 for procurement of contracts will be met.

42 CFR 438.66

10. Assurances regarding state monitoring requirements:
☒The state assures that all applicable requirements of 42 CFR 438.66(a), (b), and (c), regarding a monitoring system and using data to improve the performance of its managed care program, will be met.
☒The state assures that all applicable requirements of 42 CFR 438.66(d), regarding readiness assessment, will be met.
☒The state assures that all applicable requirements of 42 CFR 438.66(e), regarding reporting to CMS about the managed care program, will be met.

1932(a)(1)(A)
1932(a)(2)

E. Populations and Geographic Area

1. **Included Populations.** Please check which eligibility groups are included, if they are enrolled on a **Mandatory (M)** or **Voluntary (V)** basis (as defined in 42 CFR 438.54(b)) or **Excluded (E),** and the geographic scope of enrollment.
Under the **Geographic Area** column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions. Also, if type of enrollment varies by geographic area (for example, mandatory in some areas and voluntary in other areas), please note specifics in the **Geographic Area** column.
Under the **Notes** column, please note any additional relevant details about the population or enrollment.

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
A. Mandatory Eligibility Groups (Eligibility Groups to which a state must provide Medicaid coverage)						
• **Family/Adult**						
1. Parents and Other Caretaker Relatives	§435.110	X				
2. Pregnant Women	§435.116	X				
3. Children Under Age 19 (Inclusive of Deemed Newborns under §435.117)	§435.118	X				
4. Former Foster Care Youth (up to age 26)	§435.150			X		
5. Adult Group (Non-pregnant individuals age 19-64 not eligible for Medicare with income no more than 133% FPL)	§435.119				N/A	

Citation Condition or Requirement

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
6. Transitional Medical Assistance (Includes adults and children, if not eligible under §435.116, §435.118, or §435.119)	1902(a)(52), 1902(e)(1), 1925, and 1931(c)(2) of SSA	X				
7. Extended Medicaid Due to Spousal Support Collections	§435.115			X		FFS
• **Age d/Blind/Disabled Individuals**						
8. Individuals Receiving SSI age 19 and over only (See E.2. below regarding age <19)	§435.120	X				
9. Aged and Disabled Individuals in 209(b) States	§435.121					N/A
10. Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA Increase since April, 1977	§435.135			X		FFS
11. Disabled Widows and Widowers Ineligible for SSI due to an increase of OASDI	§435.137			X		FFS
12. Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	§435.138			X		FFS
13. Working Disabled under 1619(b)	1619(b), 1902(a)(10)(A)(i)(II), and 1905(q) of SSA	X				
14. Disabled Adult Children	1634(c) of SSA			X		FFS
B. Optional Eligibility Groups						
• **Family/Adult**						
1. Optional Parents and Other Caretaker Relatives	§435.220					N/A
2. Optional Targeted Low-Income Children	§435.229					N/A
3. Independent Foster Care Adolescents Under Age 21	§435.226					N/A
4. Individuals Under Age 65 with Income Over 133%	§435.218					N/A
5. Optional Reasonable Classifications of Children Under Age 21	§435.222					N/A
6. Individuals Electing COBRA Continuation Coverage	1902(a)(10)(F) of SSA					N/A
• **Age d/Blind/Disabled Individuals**						
7. Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash	§435.210 and §435.230					N/A

Citation Condition or Requirement

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
8. Individuals eligible for Cash except for Institutionalized Status	§435.211					N/A
9. Individuals Receiving Home and Community-Based Waiver Services Under Institutional Rules	§435.217			X		FFS
10. Optional State Supplement Recipients - 1634 and SSI Criteria States – with 1616 Agreements	§435.232					N/A
11. Optional State Supplemental Recipients- 209(b) States and SSI criteria States without 1616 Agreements	§435.234					N/A
12. Institutionalized Individuals Eligible under a Special Income Level	§435.236					N/A
13. Individuals Participating in a PACE Program under Institutional Rules	1934 of the SSA					N/A
14. Individuals Receiving Hospice Care	1902(a)(10)(A)(ii)(VII) and 1905(o) of the SSA					N/A
15. Poverty Level Aged or Disabled	1902(a)(10)(A)(ii)(X) and 1902(m)(1) of the SSA					N/A
16. Work Incentive Group	1902(a)(10)(A)(ii)(XIII) of the SSA					N/A
17. Ticket to Work Basic Group	1902(a)(10)(A)(ii)(XV) of the SSA					N/A
18. Ticket to Work Medically Improved Group	1902(a)(10)(A)(ii)(XVI) of the SSA					N/A
19. Family Opportunity Act Children with Disabilities	1902(a)(10)(A)(ii)(XIX) of the SSA					N/A
20. Individuals Eligible for State Plan Home and Community-Based Services	§435.219					N/A
• **Partial Benefits**						
21. Family Planning Services	§435.214			X		FFS-Waiver population
22. Individuals with Tuberculosis	§435.215					N/A
23. Individuals Needing Treatment for Breast or Cervical Cancer (under age 65)	§435.213	X				
C. Medically Needy						
1. Medically Needy Pregnant Women	§435.301(b)(1)(i) and (iv)					N/A
2. Medically Needy Children under Age 18	§435.301(b)(1)(ii)					N/A

Citation Condition or Requirement

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
3. Medically Needy Children Age 18 through 20	§435.308					N/A
4. Medically Needy Parents and Other Caretaker Relatives	§435.310					N/A
5. Medically Needy Aged	§435.320					N/A
6. Medically Needy Blind	§435.322					N/A
7. Medically Needy Disabled	§435.324					N/A
8. Medically Needy Aged, Blind and Disabled in 209(b) States	§435.330					N/A

2. **Voluntary Only or Excluded Populations.** Under this managed care authority, some populations cannot be subject to mandatory enrollment in an MCO, PCCM, or PCCM entity (per 42 CFR 438.50(d)). Some such populations are Eligibility Groups separate from those listed above in E.1., while others (such as American Indians/Alaskan Natives) can be part of multiple Eligibility Groups identified in E.1. above.

Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
Medicare Savings Program – Qualified Medicare Beneficiaries, Qualified Disabled Working Individuals, Specified Low Income Medicare Beneficiaries, and/or Qualifying Individuals	1902(a)(10)(E), 1905(p), 1905(s) of the SSA		X		
"Dual Eligibles" not described under Medicare Savings Program - Medicaid beneficiaries enrolled in an eligibility group other than one of the Medicare Savings Program groups who are also eligible for Medicare			X		
American Indian/Alaskan Native — Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes	§438.14	X		Statewide	
Children Receiving SSI who are Under Age 19 - Children under 19 years of age who are eligible for SSI under title XVI	§435.120	X		Statewide	
Qualified Disabled Children Under Age 19 - Certain children under 19 living at home, who are	§435.225 1902(e)(3) of the SSA	X		Statewide	

Citation Condition or Requirement

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
disabled and would be eligible if they were living in a medical institution.					
Title IV-E Children - Children receiving foster care, adoption assistance, or kinship guardianship assistance under title IV-E *	§435.145	X		Statewide	
Non-Title IV-E Adoption Assistance Under Age 21 *	§435.227	X		Statewide	
Children with Special Health Care Needs - 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.					N/A

* = Note – Individuals in these two Eligibility Groups who are age 19 and 20 can have mandatory enrollment in managed care, while those under age 19 cannot have mandatory enrollment. Use the Notes column to indicate if you plan to mandatorily enroll 19 and 20 year olds in these Eligibility Groups.

3. **(Optional) Other Exceptions:** The following populations (which can be part of various Eligibility Groups) can be subject to mandatory enrollment in managed care, but states may elect to make exceptions for these or other individuals.

Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

Population	Voluntary	Excluded	Notes
Other Insurance--Medicaid beneficiaries who have other health insurance		X	
Reside in Nursing Facility or ICF/IID-- Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).		X	
Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program		X	
Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program		X	

Citation | Condition or Requirement

Population	Voluntary	Excluded	Notes
Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).		X	
Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.		X	
Other (Please define): Participants in the 1915(i) State Plan Community Support Program (CSP)		X	

1932(a)(4)
42 CFR 438.54

F. Enrollment Process.

Based on whether mandatory and/or voluntary enrollment are applicable to your program (see E. Populations and Geographic Area and definitions in 42 CFR 438.54(b)), please complete the below:

1. For **voluntary** enrollment: (see 42 CFR 438.54(c))
   a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(c)(3).

   Information is provided through the enrollment packets that describe how the Member may disenroll from managed care and how tribal members may opt-in to managed care. Information will additionally be provided in the Member Handbook and on the State's website.

   States with voluntary enrollment must have an enrollment choice period or passive enrollment. Please indicate which will apply to the managed care program:

   b. ☐ If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(c)(1)(i) and 42 CFR 438.54(c)(2)(i), during which individuals who are subject to voluntary enrollment may make an active choice to enroll in the managed care program, or will otherwise continue to receive covered services through the fee-for-service delivery system.
      i. Please indicate the length of the enrollment choice period: _____

c. ☒ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(c)(1)(ii) and 438.54(c)(2)(ii), for individuals who are subject to voluntary enrollment.

i. If so, please describe the algorithm used for passive enrollment and how the algorithm and the state's provision of information meets all of the requirements of 42 CFR 438.54(c)(4),(5),(6),(7), and (8).

Passive Member managed care enrollment allows the State to enroll potential members through auto-assignment and simultaneously provides a period of ninety (90) days for the enrollee 1) to change the MCO passively assigned to a different MCO, or 2) to maintain enrollment in the MCO passively assigned, or 3) to return to Medicaid Fee-for-Service, if the member is included in the voluntary population. 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 MCO which has a contract with the enrollee's primary care physician.

Tribal members are not passively enrolled with managed care but may opt-in at any time.

The use of claims data and MCO relationships for other family members is designed to preserve existing provider-recipient relationships.

ii. Please indicate how long the enrollee will have to disenroll from the plan and return to the fee-for- service delivery system:
90 days. See also F.1.c.i., above.

Citation	Condition or Requirement

2. For **mandatory** enrollment: (see 42 CFR 438.54(d))
   a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(d)(3).

      During the Medicaid application process and annually thereafter, Medicaid members are given information about the MCOs in operation in the State. Members are informed of their ability to select an MCO, and if one is not selected during the application process, the State will automatically enroll them in one of the MCOs.

   b. ☐ If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(d)(2)(i), during which individuals who are subject to mandatory enrollment may make an active choice to selecta managed care plan, or will otherwise be enrolled in a plan
      selected by the State's default enrollment process.
      i. Please indicate the length of the enrollment choice period:

         _____

   c. ☐ If applicable, please check here to indicate that the state uses a **default** enrollment process, as described in 42 CFR 438.54(d)(5), for individuals who are subject to mandatory enrollment.
      i. If so, please describe the algorithm used for default enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (5), (7), and (8).

   d. ☒ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(d)(2), for individuals who are subject to mandatory enrollment.
      i. If so, please describe the algorithm used for passive enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (6), (7), and (8).
         Passive Member managed care enrollment allows the State to enroll potential members through auto-assignment and simultaneously provides a period of ninety (90) days for the enrollee 1) to change the MCO passively assigned to a different MCO, or 2) to maintain enrollment in the MCO passively assigned. 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 MCO which has a contract with the enrollee's primary care physician.

         The use of claims data and MCO relationships for other family

members is designed to present exiting provider-recipient relationships.

1932(a)(4)
42 CFR 438.54

3. State assurances on the enrollment process.

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

42 CFR 438.52

a. ☒ The state assures that, per the choice requirements in 42 CFR 438.52:

i. Medicaid beneficiaries with mandatory enrollment in an MCO will have a choice of at least two MCOs unless the area is considered rural as defined in 42 CFR 438.52(b)(3);

ii. Medicaid beneficiaries with mandatory enrollment in a primary care case management system will have a choice of at least two primary care case managers employed by or contracted with the State;

iii. Medicaid beneficiaries with mandatory enrollment in a PCCM entity may be limited to a single PCCM entity and will have a choice of at least two PCCMs employed by or contracted with the PCCM entity.

Citation	Condition or Requirement

1932(a)(4)
42 CFR 438.56

G. Disenrollment.

1. The state will ☒ / will not ☐ limit disenrollment for managed care.

2. The disenrollment limitation will apply for 12 months (up to 12 months).

3. ☒ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56.

4. Describe the state's process for notifying the Medicaid beneficiaries of their right to disenroll without cause during the 90 days following the date of their initial enrollment into the MCO, PCCM, or PCCM entity. *(Examples: state generated correspondence, enrollment packets, etc.)*
Medicaid beneficiaries assigned to a MCO receive state-generated correspondence informing them that they may disenroll without cause during the first ninety (90) days of initial enrollment. MCO enrollment packets also provide information regarding disenrollment without cause during ninety (90) days of the initial enrollment date.

5. Describe any additional circumstances of "cause" for disenrollment (if any).
   - 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 MCO, or
   - There is a lack of access to providers experienced in dealing with the beneficiary's health care needs.
   - Tribal members may choose to disenroll at any time.

H. Information Requirements for Beneficiaries

1932(a)(5)(c)
42 CFR 438.50

☒ The state assures that its state plan program is in compliance with 42 CFR 438.10 for information requirements specific to MCOs, PCCMs, and PCCM entity

Citation | Condition or Requirement

42 CFR 438.10 programs operated under section 1932(a)(1)(A)(i) state plan amendments.

1932(a)(5)(D)(b) I. List all benefits for which the MCO is responsible.
1903(m)
1905(t)(3)

Complete the chart below to indicate every State Plan-Approved services that will be delivered by the MCO, and where each of those services is described in the state's Medicaid State Plan. For "other practitioner services", list each provider type separately. For rehabilitative services, habilitative services, EPSDT services and 1915(i), (j) and (k) services list each program separately by its own list of services. Add additional rows as necessary.

In the first column of the chart below, enter the name of each State Plan-Approved service delivered by the MCO. In the second – fourth column of the chart, enter a State Plan citation providing the Attachment number, Page number, and Item number, respectively.

State Plan-Approved Service Delivered by the MCO	Medicaid State Plan Citation		
	Attachment#	Page #	Item #
Telehealth Services	3.1-A	Introductory Page 1	1-7
Inpatient Hospital	3.1-A	1, see also Exhibits 1 and 1a	1
Outpatient Hospital	3.1-A	1, see also Exhibit 2	2.a.
Rural Health Clinic Services	3.1-A	1, see also Exhibit 2b (pages 1-5)	2.b
Federally Qualified Health Centers	3.1-A	1, see also Exhibit 2c (pages 1 – 4)	2.c
Other laboratory and x-ray	3.1-A	1, see also Exhibit 3	3
EPSDT	3.1-A	2, see also 3.1-A Exhibit 4.b, pages 1.01 and 1-5	4.b.
Autism Spectrum Disorder (ASD) Services	3.1-A	Exhibit 4b, page 6	
Prescribed Pediatric Extended Care (PPEC) Services	3.1-A	Exhibit 4b,	

		page 7	
Private Duty Nursing (PDN) Services and Personal Care Services (PCS)	3.1-A	Exhibit 4b, page 8	
Mississippi Youth Programs Around the Clock (MYPAC)	3.1-A	Exhibit 4b, page 9	
Face-to-Face Tobacco Cessation Counseling Services for pregnant women	3.1-A	2, see also Exhibit 4.d	4.d
Physicians' services	3.1-A	2, see also exhibit 5	5.~~a~~
Medical and surgical services furnished by a dentist	3.1-A	2, see also Exhibit 5.b	5.b
Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law	3.1-A	2	6
Podiatrists' services	3.1-A	2, see also Exhibit 6a	6.a
Chiropractor's services	3.1-A	2, see also Exhibit 6c	6.c
Other practitioners' services		See also Exhibit 6d, pages 1-3	6.d
Nurse Practitioner Services	3.1-A	Exhibit 6d, page 1	
Physician Assistant Services	3.1-A	Exhibit 6d, page 1	
Psychologists, LCSWs, LPCs and LMFTs	3.1-A	Exhibit 6d, page 1	
Licensed Pharmacist Services	3.1-A	Exhibit 6d, page 1-3	
Home health services	3.1-A	3, see also Exhibit 7, page 1	7
Clinic services	3.1-A	4, see also Exhibit 9	9
Dental services	3.1-A	4, see also Exhibit 10, page 1	10
Physical therapy	3.1-A	4, see also Exhibit 11	1
Occupational therapy	3.1-A	4, see also Exhibit 11	2
Speech-Language Pathology	3.1-A	4, see also Exhibit 11	3
Prescribed drugs	3.1-A	5, see also Exhibit 12.a, page 1-2	12.a

Dentures	3.1-A	5, see also Exhibit 12.b, page 1	12.b
Prosthetic devices	3.1-A	5, see also Exhibit 12.c	12.c
Eyeglasses	3.1-A	5, see also Exhibit 12.d	12.d
Diagnostic services	3.1-A	5, see also Exhibit 13.a	13.a
Screening services	3.1-A	6, see also Exhibit 13.b	13.b
Preventative services	3.1-A	6, see also Exhibit 13.c, page 1	13.c
Rehabilitative services	3.1-A	6, see also Exhibit 13.d, page 1-17	13.d
Crisis Response Services	3.1-A	Exhibit 13d, page 4	2
Crisis Residential Services	3.1-A	Exhibit 13d, page 5	3
Community Support Services	3.1-A	Exhibit 13d, page 6	4
Acute Partial Hospitalization Services	3.1-A	Exhibit 13d, page 11	15
Psychosocial Rehabilitation Services	3.1-A	Exhibit 13d, page 12	16
Program of Assertive Community Treatment (PACT) Services	3.1-A	Exhibit 13d, page 13, page 17	17
Intensive Community Outreach and Recovery (ICORT) Services	3.1-A	Exhibit 13d, page 14	18
Peer Support Services	3.1-A	Exhibit 13d, page 15	19
Intensive Outpatient Psychiatric Services	3.1-A	Exhibit 13d, page 16	17
Inpatient psychiatric facility services for individuals under 22~~1~~ years of age	3.1-A	7, see also Exhibit 16	16
Nurse-midwife services	3.1-A	7, see also Exhibit 17	17
Hospice care	3.1-A	7, see also Exhibit 18, page 1-2	18
Extended services for pregnant women	3.1-A	Page 20a and	

		20b	
Transportation	3.1-A	9, see also Exhibit 24.a, page 1 -2	24.a
Care and services provided in Christian Science sanitoria	3.1-A	9, see also Exhibit 24.c	24.c
Nursing facility services for patients under 21 years of age	3.1-A	9, see also Exhibit 24.d	24.d
Coverage of Routine Patient Cost in Qualifying Clinical Trials	3.1-A	12	30
Organ Transplants	3.1-E	1	
Family Planning services and Supplies for Individuals of Child-Bearing Age	3.1-A	Exhibit 26	1

1932(a)(5)(D)(b)(4) and 42 CFR 438.228

J. ☒ The state assures that each MCO has established an internal grievance appeal system for enrollees.

Citation	Condition or Requirement

1932(a)(5)(D)(b)(5)
42 CFR 438.62
42 CFR 438.68
42 CFR 438.206
42 CFR 438.207
42 CFR 438.208

K. Services, including capacity, network adequacy, coordination, and continuity

☒ The state assures that all applicable requirements of 42 CFR 438.62, regarding continued service to enrollees, will be met.

☒ The state assures that all applicable requirements of 42 CFR 438.68, regarding network adequacy standards, will be met.

☒ The state assures that all applicable requirements of 42 CFR 438.206, regarding availability of services, will be met.

☒ The state assures that all applicable requirements of 42 CFR 438.207, regarding assurances of adequate capacity and services, will be met.

☒ The state assures that all applicable requirements of 42 CFR 438.208, regarding coordination and continuity of care, will be met.

1932(c)(1)(A)
42 CFR 438.330
42 CFR 438.340

L. ☒ The state assures that all applicable requirements of 42 CFR 438.330 and 438.340, regarding a quality assessment and performance improvement program and State quality strategy, will be met.

1932(c)(2)(A)
42 CFR 438.350
42 CFR 438.354
42 CFR 438.364

M. ☒ The state assures that all applicable requirements of 42 CFR 438.350, 438.354, and 438.364 regarding an annual external independent review conducted by a qualified independent entity, will be met.

1932 (a)(1)(A)(ii)

N. Selective Contracting Under a 1932 State Plan Option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

Citation	Condition or Requirement

1. The state will ☒/will not ☐ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. ☒ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)* The State based this decision upon actuarial analysis and the needs of the Members and the State.

4. ☐ The selective contracting provision in not applicable to this state plan.

Citation | Condition or Requirement

Appendix A: Compliance Dates (from Supplementary Information in 81 FR 27497, published 5/6/2016)

States must comply with all provisions in effect as of the issuance of this preprint. Additionally, the following compliance dates apply:

Compliance Dates	Sections
For rating periods for Medicaid managed care contracts Beginning before July 1, 2017, States will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in 42 CFR parts 430 to 481, edition revised as of October 1, 2015. **States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2017.**	§§ 438.3(h), 438.3(m), 438.3(q) through(u), 438.4(b)(7), 438.4(b)(8), 438.5(b) through(f), 438.6(b)(3), 438.6(c) and (d), 438.7(b), 438.7(c)(1) and (2), 438.8, 438.9, 438.10, 438.14, 438.56(d)(2)(iv), 438.66(a) through (d), 438.70, 438.74, 438.110, 438.208, 438.210, 438.230, 438.242, 438.330, 438.332, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424, 438.602(a), 438.602(c) through(h), 438.604, 438.606, 438.608(a), and 438.608(c) and (d)
For rating periods for Medicaid managed care contracts beginning before July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015. **States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2018.**	§§ 438.4(b)(3), 438.4(b)(4), 438.7(c)(3), 438.62, 438.68, 438.71, 438.206, 438.207, 438.602(b), 438.608(b), and 438.818
States must be in compliance with the requirements at § 438.4(b)(9) no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2019.	§ 438.4(b)(9)
States must be in compliance with the requirements at § 438.66(e) no later than the rating period for Medicaid managed care contracts starting on or after the date of the publication of CMS guidance.	§ 438.66(e)
States must be in compliance with § 438.334 no later than 3 years from the date of a final notice published in the Federal Register.	§ 438.334
Until July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as	§§ 438.340, 438.350, 438.354, 438.356, 438.358, 438.360, 438.362, and 438.364

Citation | Condition or Requirement

Compliance Dates	Sections
they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.	
States must begin conducting the EQR-related activity described in § 438.358(b)(1)(iv) (relating to the mandatory EQR-related activity of validation of network adequacy) **no later than one year from the issuance of the associated EQR protocol.**	§ 438.358(b)(1)(iv)
States may begin conducting the EQR-related activity described in § 438.358(c)(6) (relating to the optional EQR-related activity of plan rating) **no earlier than the issuance of the associated EQR protocol.**	§ 438.358(c)(6)

State: Mississippi

Citation	Condition or Requirement

1932(a)(1)(A) A. Section 1932(a)(1)(A) of the Social Security Act.

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 ***not*** 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).

B. General Description of the Program and Public Process.

1932(a)(1)(B)(i) 1. The State will contract with an
1932(a)(1)(B)(ii)
42 CFR § 438.50(b)(1) X i. MCO

____ ii. PCCM (including capitated PCCMs that qualify as PAHPs)

____ iii. Both

42 CFR § 438.50(b)(2) 2. The payment method to the contracting entity will be:
42 CFR § 438.50(b)(3)

____ i. fee for service;

X ii. capitation;

____iii. a case management fee;

____iv. a bonus/incentive payment;

____ v. a supplemental payment, or

____vi. other. (Please provide a description below).

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 process in compliance with applicable state and federal rules, regulations, and law.

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.

Citation	Condition or Requirement

- 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.

1905(t)
42 CFR § 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive case management fee, if certain conditions are met.

If applicable to this state plan, place a check mark to affirm the state has met ***all*** 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)).

____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.

__X__ vii. Not applicable to this 1932 state plan amendment.

42 CFR § 438.50(b)(4)

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. *(Example: public meeting, advisory groups.)*

Citation	Condition or Requirement
	The MississippiCAN program was authorized in 2010, with an effective date of 1/1/2011, through State legislation in accordance with Miss. Code Ann. 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. 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. 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. 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. 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.
1932(a)(1)(A)	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.

Citation Condition or Requirement

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, and
- Locked in any Medicaid waiver program.

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.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR § 438.50(e)(1)

1. X 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(e)(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)

3. X The state assures that all the applicable requirements of section 1932

Citation		Condition or Requirement
42 CFR § 438.50(e)(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. X	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(e)(4) 1903(m)	5. X	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(e)(6)	6. X	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(e)(6)	7. ____	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. X	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.

- 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

Citation | Condition or Requirement

administered by the MS State Dept. of Health.

- 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 postpartum period following the month of delivery, miscarriage or other termination of pregnancy.

- 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.

- Parents and Caretaker Relatives with Dependent Children under age 18.
  As a condition of eligibility, the parent or caretaker relative must cooperate with child support enforcement requirements for each eligible child deprived due to a parent's continued absence from the home.

- Children age 1 up to 6
  Children age 1 up to 6 whose family income does not exceed 143% of FPL.

- Children age 6 up to 19
  Children age 6 up to 19 whose family income does not exceed 107% of FPL.

- 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.

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR § 438.50.

Use a check mark to affirm whether there is voluntary enrollment of any of the following mandatory exempt groups.

1932(a)(2)(B)
42 CFR § 438.50(d)(1)

i. ____Recipients who are also eligible for Medicare.

If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee for service.)*

Citation	Condition or Requirement
1932(a)(2)(C) 42 CFR § 438.50(d)(2)	ii. X 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. X 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. X 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. X 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. X 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. ___ 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.

Citation		Condition or Requirement
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)* 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 Medicaid Eligibility Determination System (MEDS). 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 Medicaid Eligibility Determination System (MEDS). 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 Medicaid Eligibility Determination System (MEDS). 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 Medicaid Eligibility Determination System (MEDS).
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. *(Example: self-identification)* 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

Citation	Condition or Requirement
42 CFR § 438.50(d)	mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)* i. Recipients also eligible for Medicare. The State identifies these individuals based on the Medicare indicator in the Medicaid Eligibility Determination System (MEDS). 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. The State identifies these individuals using information in the Medicaid Eligibility Determination System (MEDS) and through self identification.
42 CFR § 438.50(2)	F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment Refer to B.5.
42 CFR § 438.50(2)	G. List all other eligible groups who will be permitted to enroll on a voluntary basis • 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

Citation | Condition or Requirement

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

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

Describe how the state's default enrollment process will preserve:

i. The existing provider-recipient relationship (as defined in H.1.i).

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.

The use of claims data and CCO relationships for other family members is designed to preserve existing provider-recipient relationships.

ii. The relationship with providers that have traditionally served Medicaid recipients (as defined in H.1.ii).

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:

- 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.

Citation Condition or Requirement

- 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.

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.

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). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

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:

- 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.

Auto-assignment is a hierarchy process, but in no case will auto-assignment exceed the capacity of the CCO's provider network.

The use of claims data and CCO relationships for other family members is designed to preserve existing provider-recipient relationships.

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.

Citation		Condition or Requirement
1932(a)(4) 42 CFR § 438.50	3.	As part of the state's discussion on the default enrollment process, include the following information:

i. The state will X / will not ____ use a lock-in for managed care.

ii. The time frame for recipients to choose a health plan before being auto-assigned will be 30 days.

iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

Medicaid beneficiaries auto enrolled receive State generated correspondence informing of the assigned CCO.

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. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

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.

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

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.

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

Citation Condition or Requirement

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.

1932(a)(4) I. State assurances on the enrollment process
42 CFR § 438.50

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. X 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.

2. X 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).

3. ____ The state plan program applies the rural exception to choice requirements of 42 CFR § 438.52(a) for MCOs and PCCMs.

X This provision is not applicable to this 1932 State Plan Amendment.

4. ____ 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.)

X This provision is not applicable to this 1932 State Plan Amendment.

5. X 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.

___This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4) J. Disenrollment
42 CFR § 438.50

1. The state will X /will not___ use lock-in for managed care.

2. The lock-in will apply for up to twelve (12) months.

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)
CFR § 438.50
42 CFR § 438.10

X 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.

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

Excluded services include:

- Long-term care services, including nursing facility and ICF/IID,
- Any waiver services, and
-

Citation Condition or Requirement

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

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will _X_ /will not_____ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. _X_ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

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.

4. ____ The selective contracting provision is not applicable to this state plan.

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Mississippi enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization [MCOs], primary care case managers [PCCMs], and/or PCCM entities) 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 require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on state wideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).

This authority may ***not*** 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 described in 42 CFR 438.50(d).

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date. All applicable assurances should be checked, even when the compliance date is in the future. **Please see Appendix A of this document for compliance dates for various sections of 42 CFR 438.**

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
noted 42 CFR 438.2
42 CFR 438.6
42 CFR 438.50(b)(1)-(2)

B. Managed Care Delivery System.
The State will contract with the entity(ies) below and reimburse them as under each entity type.

1. ☒ MCO
   - ☒ Capitation
   - ☒ The state assures that all applicable requirements of 42 CFR 438.6, regarding special contract provisions related to payment, will be met.

2. ☐ PCCM (individual practitioners)
   a. ☐ Case management fee
   b. ☐ Other (please explain below)

3. ☐ PCCM entity
   a. ☐ Case management fee
   b. ☐ Shared savings, incentive payments, and/or financial rewards (see 42 CFR 438.310(c)(2))

Citation	Condition or Requirement

c. ☐ Other(please explain below)

If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as in 42 CFR 438.2), in addition to PCCM services:

- ☐ Provision of intensive telephonic case management
- ☐ Provision of face-to-face case management
- ☐ Operation of a nurse triage advice line
- ☐ Development of enrollee care plans.
- ☐ Execution of contracts with fee-for-service (FFS) providers in the FFS program
- ☐ Oversight responsibilities for the activities of FFS providers in the FFS program
- ☐ Provision of payments to FFS providers on behalf of the State.
- ☐ Provision of enrollee outreach and education activities.
- ☐ Operation of a customer service call center.
- ☐ Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement.
- ☐ Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.
- ☐ Coordination with behavioral health systems/providers.
- ☐ Coordination with long-term services and supports systems/providers.
- ☐ Other (please describe): _____

42 CFR 438.50(b)(4) C. Public Process.

Describe the public process including tribal consultation, if applicable, utilized for both the design of the managed care program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan managed care program has been implemented. *(Example: public meeting, advisory groups.)*
If the program will include long term services and supports (LTSS), please indicate how the views of stakeholders have been, and will continue to be, solicited and addressed during the design, implementation, and oversight of the program, including plans for a member advisory committee (42 CFR 438.70 and 438.110)

The MississippiCAN program was authorized in 2010, with an effective date of 1/1/2011, through State legislation in accordance with Miss. Code Ann. 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 State's website seeking comments/revisions/input.

The State 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 State 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.

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. Every procurement for managed care services subject to this SPA has been posted publicly on the State's website.

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.

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 State's website.

Citation	Condition or Requirement
	D. 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) met. 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
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 (including for PCCM entities) 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 beneficiaries to receive their benefits through managed care entities will be met.
1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C) 42 CFR 438.10(g)(2)(vii)	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.
1932(a)(1)(A)	5. ☒ The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).
1932(a)(1)(A) of 42 CFR 438 1903(m)	6. ☒ The state assures that all applicable managed care requirements 42 CFR Part 438 for MCOs, PCCMs, and PCCM entities will be met.
1932(a)(1)(A) 42 CFR 438.4 42 CFR 438.5 42 CFR 438.7 42 CFR 438.8 42 CFR 438.74 42 CFR 438.50(c)(6)	7. ☒ The state assures that all applicable requirements of 42 CFR 438.4, 438.5, 438.7, 438.8, and 438.74 for payments under any risk contracts will be met.
1932(a)(1)(A)	8. ☐ The state assures that all applicable requirements of 42 CFR 447.362 for

Citation	Condition or Requirement

42 CFR 447.362
42 CFR 438.50(c)(6)

payments under any non-risk contracts will be met.

45 CFR 75.326

9. ☒ – The state assures that all applicable requirements of 45 CFR 75.326 for procurement of contracts will be met.

42 CFR 438.66

10. Assurances regarding state monitoring requirements:
☒ The state assures that all applicable requirements of 42 CFR 438.66(a), (b), and (c), regarding a monitoring system and using data to improve the performance of its managed care program, will be met.
☒ The state assures that all applicable requirements of 42 CFR 438.66(d), regarding readiness assessment, will be met.
☒ The state assures that all applicable requirements of 42 CFR 438.66(e), regarding reporting to CMS about the managed care program, will be met.

1932(a)(1)(A)
1932(a)(2)

E. Populations and Geographic Area

1. **Included Populations.** Please check which eligibility groups are included, if they are enrolled on a **Mandatory (M)** or **Voluntary (V)** basis (as defined in 42 CFR 438.54(b)) or **Excluded (E),** and the geographic scope of enrollment.
Under the **Geographic Area** column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions. Also, if type of enrollment varies by geographic area (for example, mandatory in some areas and voluntary in other areas), please note specifics in the **Geographic Area** column.
Under the **Notes** column, please note any additional relevant details about the population or enrollment.

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
A. Mandatory Eligibility Groups (Eligibility Groups to which a state must provide Medicaid coverage)						
• **Family/Adult**						
1. Parents and Other Caretaker Relatives	§435.110	X				
2. Pregnant Women	§435.116	X				
3. Children Under Age 19 (Inclusive of Deemed Newborns under §435.117)	§435.118	X				
4. Former Foster Care Youth (up to age 26)	§435.150			X		
5. Adult Group (Non-pregnant individuals age 19-64 not eligible for Medicare with income no more than 133% FPL)	§435.119				N/A	

Citation | Condition or Requirement

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
6. Transitional Medical Assistance (Includes adults and children, if not eligible under §435.116, §435.118, or §435.119)	1902(a)(52), 1902(e)(1), 1925, and 1931(c)(2) of SSA	X				
7. Extended Medicaid Due to Spousal Support Collections	§435.115			X		FFS
• **Age d/Blind/Disabled Individuals**						
8. Individuals Receiving SSI age 19 and over only (See E.2. below regarding age <19)	§435.120	X				
9. Aged and Disabled Individuals in 209(b) States	§435.121					N/A
10. Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA Increase since April, 1977	§435.135			X		FFS
11. Disabled Widows and Widowers Ineligible for SSI due to an increase of OASDI	§435.137			X		FFS
12. Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	§435.138			X		FFS
13. Working Disabled under 1619(b)	1619(b), 1902(a)(10)(A)(i)(II), and 1905(q) of SSA	X				
14. Disabled Adult Children	1634(c) of SSA			X		FFS
B. Optional Eligibility Groups						
• **Family/Adult**						
1. Optional Parents and Other Caretaker Relatives	§435.220					N/A
2. Optional Targeted Low-Income Children	§435.229					N/A
3. Independent Foster Care Adolescents Under Age 21	§435.226					N/A
4. Individuals Under Age 65 with Income Over 133%	§435.218					N/A
5. Optional Reasonable Classifications of Children Under Age 21	§435.222					N/A
6. Individuals Electing COBRA Continuation Coverage	1902(a)(10)(F) of SSA					N/A
• **Age d/Blind/Disabled Individuals**						
7. Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash	§435.210 and §435.230					N/A

Citation Condition or Requirement

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
8. Individuals eligible for Cash except for Institutionalized Status	§435.211					N/A
9. Individuals Receiving Home and Community-Based Waiver Services Under Institutional Rules	§435.217			X		FFS
10. Optional State Supplement Recipients - 1634 and SSI Criteria States – with 1616 Agreements	§435.232					N/A
11. Optional State Supplemental Recipients- 209(b) States and SSI criteria States without 1616 Agreements	§435.234					N/A
12. Institutionalized Individuals Eligible under a Special Income Level	§435.236					N/A
13. Individuals Participating in a PACE Program under Institutional Rules	1934 of the SSA					N/A
14. Individuals Receiving Hospice Care	1902(a)(10)(A)(ii)(VII) and 1905(o) of the SSA					N/A
15. Poverty Level Aged or Disabled	1902(a)(10)(A)(ii)(X) and 1902(m)(1) of the SSA					N/A
16. Work Incentive Group	1902(a)(10)(A)(ii)(XIII) of the SSA					N/A
17. Ticket to Work Basic Group	1902(a)(10)(A)(ii)(XV) of the SSA					N/A
18. Ticket to Work Medically Improved Group	1902(a)(10)(A)(ii)(XVI) of the SSA					N/A
19. Family Opportunity Act Children with Disabilities	1902(a)(10)(A)(ii)(XIX) of the SSA					N/A
20. Individuals Eligible for State Plan Home and Community-Based Services	§435.219					N/A
• **Partial Benefits**						
21. Family Planning Services	§435.214			X		FFS-Waiver population
22. Individuals with Tuberculosis	§435.215					N/A
23. Individuals Needing Treatment for Breast or Cervical Cancer (under age 65)	§435.213	X				
C. Medically Needy						
1. Medically Needy Pregnant Women	§435.301(b)(1)(i) and (iv)					N/A
2. Medically Needy Children under Age 18	§435.301(b)(1)(ii)					N/A

Citation Condition or Requirement

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
3. Medically Needy Children Age 18 through 20	§435.308					N/A
4. Medically Needy Parents and Other Caretaker Relatives	§435.310					N/A
5. Medically Needy Aged	§435.320					N/A
6. Medically Needy Blind	§435.322					N/A
7. Medically Needy Disabled	§435.324					N/A
8. Medically Needy Aged, Blind and Disabled in 209(b) States	§435.330					N/A

2. **Voluntary Only or Excluded Populations.** Under this managed care authority, some populations cannot be subject to mandatory enrollment in an MCO, PCCM, or PCCM entity (per 42 CFR 438.50(d)). Some such populations are Eligibility Groups separate from those listed above in E.1., while others (such as American Indians/Alaskan Natives) can be part of multiple Eligibility Groups identified in E.1. above.

Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
Medicare Savings Program – Qualified Medicare Beneficiaries, Qualified Disabled Working Individuals, Specified Low Income Medicare Beneficiaries, and/or Qualifying Individuals	1902(a)(10)(E), 1905(p), 1905(s) of the SSA		X		
"Dual Eligibles" not described under Medicare Savings Program - Medicaid beneficiaries enrolled in an eligibility group other than one of the Medicare Savings Program groups who are also eligible for Medicare			X		
American Indian/Alaskan Native — Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes	§438.14	X		Statewide	
Children Receiving SSI who are Under Age 19 - Children under 19 years of age who are eligible for SSI under title XVI	§435.120	X		Statewide	
Qualified Disabled Children Under Age 19 - Certain children under 19 living at home, who are	§435.225 1902(e)(3) of the SSA	X		Statewide	

Citation Condition or Requirement

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
disabled and would be eligible if they were living in a medical institution.					
Title IV-E Children - Children receiving foster care, adoption assistance, or kinship guardianship assistance under title IV-E *	§435.145	X		Statewide	
Non-Title IV-E Adoption Assistance Under Age 21 *	§435.227	X		Statewide	
Children with Special Health Care Needs - 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.					N/A

* = Note – Individuals in these two Eligibility Groups who are age 19 and 20 can have mandatory enrollment in managed care, while those under age 19 cannot have mandatory enrollment. Use the Notes column to indicate if you plan to mandatorily enroll 19 and 20 year olds in these Eligibility Groups.

3. **(Optional) Other Exceptions:** The following populations (which can be part of various Eligibility Groups) can be subject to mandatory enrollment in managed care, but states may elect to make exceptions for these or other individuals.

Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

Population	Voluntary	Excluded	Notes
Other Insurance--Medicaid beneficiaries who have other health insurance		X	
Reside in Nursing Facility or ICF/IID-- Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).		X	
Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program		X	
Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program		X	

Citation | Condition or Requirement

Population	Voluntary	Excluded	Notes
Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).		X	
Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.		X	
Other (Please define): Participants in the 1915(i) State Plan Community Support Program (CSP)		X	

1932(a)(4)
42 CFR 438.54

F. Enrollment Process.

Based on whether mandatory and/or voluntary enrollment are applicable to your program (see E. Populations and Geographic Area and definitions in 42 CFR 438.54(b)), please complete the below:

1. For **voluntary** enrollment: (see 42 CFR 438.54(c))
   a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(c)(3).

      Information is provided through the enrollment packets that describe how the Member may disenroll from managed care and how tribal members may opt-in to managed care. Information will additionally be provided in the Member Handbook and on the State's website.

      States with voluntary enrollment must have an enrollment choice period or passive enrollment. Please indicate which will apply to the managed care program:

   b. ☐ If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(c)(1)(i) and 42 CFR 438.54(c)(2)(i), during which individuals who are subject to voluntary enrollment may make an active choice to enroll in the managed care program, or will otherwise continue to receive covered services through the fee-for-service delivery system.
      i. Please indicate the length of the enrollment choice period: _____

c. ☒ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(c)(1)(ii) and 438.54(c)(2)(ii), for individuals who are subject to voluntary enrollment.

i. If so, please describe the algorithm used for passive enrollment and how the algorithm and the state's provision of information meets all of the requirements of 42 CFR 438.54(c)(4),(5),(6),(7), and (8).

Passive Member managed care enrollment allows the State to enroll potential members through auto-assignment and simultaneously provides a period of ninety (90) days for the enrollee 1) to change the MCO passively assigned to a different MCO, or 2) to maintain enrollment in the MCO passively assigned, or 3) to return to Medicaid Fee-for-Service, if the member is included in the voluntary population. 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 MCO which has a contract with the enrollee's primary care physician.

Tribal members are not passively enrolled with managed care but may opt-in at any time.

The use of claims data and MCO relationships for other family members is designed to preserve existing provider-recipient relationships.

ii. Please indicate how long the enrollee will have to disenroll from the plan and return to the fee-for- service delivery system:
90 days. See also F.1.c.i., above.

Citation	Condition or Requirement

2. For **mandatory** enrollment: (see 42 CFR 438.54(d))
   a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(d)(3).

      During the Medicaid application process and annually thereafter, Medicaid members are given information about the MCOs in operation in the State. Members are informed of their ability to select an MCO, and if one is not selected during the application process, the State will automatically enroll them in one of the MCOs.

   b. ☐ If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(d)(2)(i), during which individuals who are subject to mandatory enrollment may make an active choice to selecta managed care plan, or will otherwise be enrolled in a plan
      selected by the State's default enrollment process.
      i. Please indicate the length of the enrollment choice period:

         _____

   c. ☐ If applicable, please check here to indicate that the state uses a **default** enrollment process, as described in 42 CFR 438.54(d)(5), for individuals who are subject to mandatory enrollment.
      i. If so, please describe the algorithm used for default enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (5), (7), and (8).

   d. ☒ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(d)(2), for individuals who are subject to mandatory enrollment.
      i. If so, please describe the algorithm used for passive enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (6), (7), and (8).
         Passive Member managed care enrollment allows the State to enroll potential members through auto-assignment and simultaneously provides a period of ninety (90) days for the enrollee 1) to change the MCO passively assigned to a different MCO, or 2) to maintain enrollment in the MCO passively assigned. 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 MCO which has a contract with the enrollee's primary care physician.

         The use of claims data and MCO relationships for other family

members is designed to present existing provider-recipient relationships.

1932(a)(4)
42 CFR 438.54

3. State assurances on the enrollment process.

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

a. ☒ The state assures that, per the choice requirements in 42 CFR 438.52:

42 CFR 438.52

i. Medicaid beneficiaries with mandatory enrollment in an MCO will have a choice of at least two MCOs unless the area is considered rural as defined in 42 CFR 438.52(b)(3);

ii. Medicaid beneficiaries with mandatory enrollment in a primary care case management system will have a choice of at least two primary care case managers employed by or contracted with the State;

iii. Medicaid beneficiaries with mandatory enrollment in a PCCM entity may be limited to a single PCCM entity and will have a choice of at least two PCCMs employed by or contracted with the PCCM entity.

Citation	Condition or Requirement

1932(a)(4)
42 CFR 438.56

G. Disenrollment.

1. The state will☒/ will not☐ limit disenrollment for managed care.

2. The disenrollment limitation will apply for 12 months (up to 12 months).

3. ☒The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56.

4. Describe the state's process for notifying the Medicaid beneficiaries of their right to disenroll without cause during the 90 days following the date of their initial enrollment into the MCO, PCCM, or PCCM entity. *(Examples: state generated correspondence, enrollment packets, etc.)*
Medicaid beneficiaries assigned to a MCO receive state-generated correspondence informing them that they may disenroll without cause during the first ninety (90) days of initial enrollment. MCO enrollment packets also provide information regarding disenrollment without cause during ninety (90) days of the initial enrollment date.

5. Describe any additional circumstances of "cause" for disenrollment (if any).
   - 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 MCO, or
   - There is a lack of access to providers experienced in dealing with the beneficiary's health care needs.
   - Tribal members may choose to disenroll at any time.

H. Information Requirements for Beneficiaries

1932(a)(5)(c)
42 CFR 438.50

☒The state assures that its state plan program is in compliance with 42 CFR 438.10 for information requirements specific to MCOs, PCCMs, and PCCM entity

Citation | Condition or Requirement

42 CFR 438.10 programs operated under section 1932(a)(1)(A)(i) state plan amendments.

1932(a)(5)(D)(b) I. List all benefits for which the MCO is responsible.
1903(m)
1905(t)(3)

Complete the chart below to indicate every State Plan-Approved services that will be delivered by the MCO, and where each of those services is described in the state's Medicaid State Plan. For "other practitioner services", list each provider type separately. For rehabilitative services, habilitative services, EPSDT services and 1915(i), (j) and (k) services list each program separately by its own list of services. Add additional rows as necessary.

In the first column of the chart below, enter the name of each State Plan-Approved service delivered by the MCO. In the second – fourth column of the chart, enter a State Plan citation providing the Attachment number, Page number, and Item number, respectively.

State Plan-Approved Service Delivered by the MCO	Medicaid State Plan Citation		
	Attachment#	Page #	Item #
Telehealth Services	3.1-A	Introductory Page 1	1-7
Inpatient Hospital	3.1-A	1, see also Exhibits 1 and 1a	1
Outpatient Hospital	3.1-A	1, see also Exhibit 2	2.a.
Rural Health Clinic Services	3.1-A	1, see also Exhibit 2b (pages 1-5)	2.b
Federally Qualified Health Centers	3.1-A	1, see also Exhibit 2c (pages 1 – 4)	2.c
Other laboratory and x-ray	3.1-A	1, see also Exhibit 3	3
EPSDT	3.1-A	2, see also 3.1-A Exhibit 4.b, pages 1.01 and 1-5	4.b.
Autism Spectrum Disorder (ASD) Services	3.1-A	Exhibit 4b, page 6	
Prescribed Pediatric Extended Care (PPEC) Services	3.1-A	Exhibit 4b,	

		page 7	
Private Duty Nursing (PDN) Services and Personal Care Services (PCS)	3.1-A	Exhibit 4b, page 8	
Mississippi Youth Programs Around the Clock (MYPAC)	3.1-A	Exhibit 4b, page 9	
Face-to-Face Tobacco Cessation Counseling Services for pregnant women	3.1-A	2, see also Exhibit 4.d	4.d
Physicians' services	3.1-A	2, see also exhibit 5~~.a~~	5.
Medical and surgical services furnished by a dentist	3.1-A	2, see also Exhibit 5.b	5.b
Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law	3.1-A	2	6
Podiatrists' services	3.1-A	2, see also Exhibit 6a	6.a
Chiropractor's services	3.1-A	2, see also Exhibit 6c	6.c
Other practitioners' services		See also Exhibit 6d, pages 1-3	6.d
Nurse Practitioner Services	3.1-A	Exhibit 6d, page 1	
Physician Assistant Services	3.1-A	Exhibit 6d, page 1	
Psychologists, LCSWs, LPCs and LMFTs	3.1-A	Exhibit 6d, page 1	
Licensed Pharmacist Services	3.1-A	Exhibit 6d, page 1-3	
Home health services	3.1-A	3, see also Exhibit 7, page 1	7
Clinic services	3.1-A	4, see also Exhibit 9	9
Dental services	3.1-A	4, see also Exhibit 10, page 1	10
Physical therapy	3.1-A	4, see also Exhibit 11	1
Occupational therapy	3.1-A	4, see also Exhibit 11	2
Speech-Language Pathology	3.1-A	4, see also Exhibit 11	3
Prescribed drugs	3.1-A	5, see also Exhibit 12.a, page 1-2	12.a

Dentures	3.1-A	5, see also Exhibit 12.b, page 1	12.b
Prosthetic devices	3.1-A	5, see also Exhibit 12.c	12.c
Eyeglasses	3.1-A	5, see also Exhibit 12.d	12.d
Diagnostic services	3.1-A	5, see also Exhibit 13.a	13.a
Screening services	3.1-A	6, see also Exhibit 13.b	13.b
Preventative services	3.1-A	6, see also Exhibit 13.c, page 1	13.c
Rehabilitative services	3.1-A	6, see also Exhibit 13.~~b~~d, page 1-17	13.d
Crisis Response Services	3.1-A	Exhibit 13d, page 4	2
Crisis Residential Services	3.1-A	Exhibit 13d, page 5	3
Community Support Services	3.1-A	Exhibit 13d, page 6	4
Acute Partial Hospitalization Services	3.1-A	Exhibit 13d, page 11	15
Psychosocial Rehabilitation Services	3.1-A	Exhibit 13d, page 12	16
Program of Assertive Community Treatment (PACT) Services	3.1-A	Exhibit 13d, page 13, page 17	17
Intensive Community Outreach and Recovery (ICORT) Services	3.1-A	Exhibit 13d, page 14	18
Peer Support Services	3.1-A	Exhibit 13d, page 15	19
Intensive Outpatient Psychiatric Services	3.1-A	Exhibit 13d, page 16	17
Inpatient psychiatric facility services for individuals under 21 years of age	3.1-A	7, see also Exhibit 16	16
Nurse-midwife services	3.1-A	7, see also Exhibit 17	17
Hospice care	3.1-A	7, see also Exhibit 18, page 1-2	18
Extended services for pregnant women	3.1-A	Page 20a and	

		20b	
Transportation	3.1-A	9, see also Exhibit 24.a, page 1 -2	24.a
Care and services provided in Christian Science sanitoria	3.1-A	9, see also Exhibit 24.c	24.c
Nursing facility services for patients under 21 years of age	3.1-A	9, see also Exhibit 24.d	24.d
Coverage of Routine Patient Cost in Qualifying Clinical Trials	3.1-A	12	30
Organ Transplants	3.1-E	1	
Family Planning services and Supplies for Individuals of Child-Bearing Age	3.1-A	Exhibit 26	1

1932(a)(5)(D)(b)(4) and 42 CFR 438.228

J. ☒ The state assures that each MCO has established an internal grievance appeal system for enrollees.

Citation	Condition or Requirement
1932(a)(5)(D)(b)(5) 42 CFR 438.62 42 CFR 438.68 42 CFR 438.206 42 CFR 438.207 42 CFR 438.208	K. Services, including capacity, network adequacy, coordination, and continuity ☒ The state assures that all applicable requirements of 42 CFR 438.62, regarding continued service to enrollees, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.68, regarding network adequacy standards, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.206, regarding availability of services, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.207, regarding assurances of adequate capacity and services, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.208, regarding coordination and continuity of care, will be met.
1932(c)(1)(A) 42 CFR 438.330 42 CFR 438.340	L. ☒ The state assures that all applicable requirements of 42 CFR 438.330 and 438.340, regarding a quality assessment and performance improvement program and State quality strategy, will be met.
1932(c)(2)(A) 42 CFR 438.350 42 CFR 438.354 42 CFR 438.364	M. ☒ The state assures that all applicable requirements of 42 CFR 438.350, 438.354, and 438.364 regarding an annual external independent review conducted by a qualified independent entity, will be met.
1932 (a)(1)(A)(ii)	N. Selective Contracting Under a 1932 State Plan Option To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

Citation	Condition or Requirement

1. The state will ☒/will not ☐ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. ☒ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)* The State based this decision upon actuarial analysis and the needs of the Members and the State.

4. ☐ The selective contracting provision in not applicable to this state plan.

Citation | Condition or Requirement

Appendix A: Compliance Dates (from Supplementary Information in 81 FR 27497, published 5/6/2016)

States must comply with all provisions in effect as of the issuance of this preprint. Additionally, the following compliance dates apply:

Compliance Dates	Sections
For rating periods for Medicaid managed care contracts Beginning before July 1, 2017, States will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in 42 CFR parts 430 to 481, edition revised as of October 1, 2015. **States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2017.**	§§ 438.3(h), 438.3(m), 438.3(q) through(u), 438.4(b)(7), 438.4(b)(8), 438.5(b) through(f), 438.6(b)(3), 438.6(c) and (d), 438.7(b), 438.7(c)(1) and (2), 438.8, 438.9, 438.10, 438.14, 438.56(d)(2)(iv), 438.66(a) through (d), 438.70, 438.74, 438.110, 438.208, 438.210, 438.230, 438.242, 438.330, 438.332, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424, 438.602(a), 438.602(c) through(h), 438.604, 438.606, 438.608(a), and 438.608(c) and (d)
For rating periods for Medicaid managed care contracts beginning before July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015. **States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2018.**	§§ 438.4(b)(3), 438.4(b)(4), 438.7(c)(3), 438.62, 438.68, 438.71, 438.206, 438.207, 438.602(b), 438.608(b), and 438.818
States must be in compliance with the requirements at § 438.4(b)(9) no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2019.	§ 438.4(b)(9)
States must be in compliance with the requirements at § 438.66(e) no later than the rating period for Medicaid managed care contracts starting on or after the date of the publication of CMS guidance.	§ 438.66(e)
States must be in compliance with § 438.334 no later than 3 years from the date of a final notice published in the Federal Register.	§ 438.334
Until July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as	§§ 438.340, 438.350, 438.354, 438.356, 438.358, 438.360, 438.362, and 438.364

Citation | Condition or Requirement

Compliance Dates	Sections
they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.	
States must begin conducting the EQR-related activity described in § 438.358(b)(1)(iv) (relating to the mandatory EQR-related activity of validation of network adequacy) **no later than one year from the issuance of the associated EQR protocol.**	§ 438.358(b)(1)(iv)
States may begin conducting the EQR-related activity described in § 438.358(c)(6) (relating to the optional EQR-related activity of plan rating) **no earlier than the issuance of the associated EQR protocol.**	§ 438.358(c)(6)

According to the Paperwork Reduction Act of1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0933. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

CMS-10120