MISSISSIPPI DIVISION OF MEDICAID

MississippiCAN Program Summary

Revised March 1, 2010

Introduction

Program Goals

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

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

Section A: Program Description

Part I: Program Overview

A. Federal Authority

Upon completion of the actuarially sound capitated rates (calculated by Milliman), Mississippi will seek federal approval in the form of a State Plan Amendment to implement a care coordination program for targeted beneficiaries.

B. Program Geographic Areas

MississippiCAN will be implemented in all 82 counties in the state of Mississippi for all eligible beneficiaries.

C. Target Population

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

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

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

D. Voluntary Enrollment

The enrollment into MississippiCAN of the targeted populations will be voluntary. Targeted beneficiaries will be provided information about the program with their program options. Beneficiaries will then enroll in the plan of their choice. If they don't enroll within 30 days, they will be auto-enrolled by the Division of Medicaid (DOM). If they do not opt out of the program within 90 days of enrollment, they remain in until the next annual open enrollment period.

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

Eligibility criteria for MississippiCAN will be the same as the eligibility criteria for Mississippi Medicaid.

The CCOs will not have the ability to directly market to the targeted beneficiaries. DOM will be responsible for creating a process to provide information about choice of CCOs and enroll the beneficiaries into their chosen CCO. DOM staff and the Medicaid Fiscal Agent will work together to accomplish these tasks. No separate enrollment broker will be procured.

The enrollment process will ensure that beneficiaries have informed choice, the process is cost efficient and timely, and the process is acceptable to advocates, providers and beneficiaries.

E. Members' Rights and Protections

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

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

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

F. Coordinated Care Organizations

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

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

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

Part II: Major Program Elements

A. Benefits

A comprehensive package of services will be provided by the CCOs that include, at a minimum, the current Mississippi Medicaid benefits. CCOs will not be responsible for inpatient hospital services and behavioral health services. However, psychotropic medications will be provided by CCOs because many of these medications are prescribed by primary care physicians. Non-emergency transportation will continue to be provided by DOM's current contractor.

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

B. Administrative Services

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

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

C. Provider Network

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

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

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

D. Care Management

The CCOs are expected to participate as partners with providers and beneficiaries in arranging for the delivery of health care services that improve health status in a cost effective way. DOM expects CCOs to connect beneficiaries to a medical home and implement comprehensive care management programs for the targeted populations. Care management will include a method to coordinate services with

behavioral health providers, social services agencies and out-of-state providers to improve care and quality outcomes.

CCOs will be required to develop disease state management programs that focus on diseases that are chronic or very high cost including but not limited to diabetes, asthma, hypertension, obesity, congestive heart disease, hemophilia, organ transplants, and improved birth outcomes.

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

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

E. Quality Assurance

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

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

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

Section B: Contract Compliance and Monitoring

Contract Compliance and Monitoring

A critical component of MississippiCAN is contract compliance and monitoring to ensure that the goals of the program are being met. DOM will assess the performance of the selected CCOs prior to and after implementation.

DOM will complete readiness reviews of CCOs prior to implementation of MississippiCAN. This includes evaluation of all CCO program components including IT, administrative services and medical management.

DOM will audit the performance of the CCOs against contract requirements. The audit will include all aspects of the program that are over and above the waiver requirements and financial expectations. DOM will closely monitor the financial performance of contractors. DOM will require CCOs to submit quarterly and annual reports that will allow DOM to assess CCO claims reserves and overall financial soundness. DOM will require quarterly reports on claims processing and encounter submission. DOM will impose penalties for failure to meet established standards. When DOM establishes that a CCO is out of compliance with any of the above monitoring activities, the CCO will be required to provide corrective action plans to ensure that the goals of the program will be met.