

Frequently Asked Questions about the MississippiCAN Program

This document is intended to provide information to beneficiaries, providers, legislators and other interested stakeholders.

1. Who is eligible for MississippiCAN?

Only Medicaid beneficiaries in the eligibility groups listed below can enroll in the MississippiCAN program.

Category of Eligibility (COE)	COE	AGE
SSI- Supplemental Security Income	001	0-65
DHS- Foster Care Children –IV-E	003	0-19
Disabled Child Living at Home	019	0-19
Working Disabled	025	19-65
DHS- Foster Care Children-CWS	026	0-19
Breast and Cervical Cancer	027	19-65
Newborns (below 185% FPL)	071	0-1
Children (<age6) (<133% FPL)	072	1-5
Children (<age19) (<100% FPL)	073	6-19
Quasi-CHIP (100%-133% FPL) (previously qualified for CHIP)	074	6-19
Parents and Caretakers (TANF)	075	19-65

2. Is it mandatory for beneficiaries to enroll in the MississippiCAN program?

Yes, for some. Enrollment in MississippiCAN is mandatory for the following populations:

Mandatory Populations		
Category of Eligibility (COE)	COE	AGE
SSI- Supplemental Security Income	001	19-65
Working Disabled	025	19-65
Breast and Cervical Cancer	027	19-65
Newborns (below 185% FPL)	071	0-1
Children (<age6) (<133% FPL)	072	1-5
Children (<age19) (<100% FPL)	073	6-19
Quasi-CHIP (100%-133% FPL) (previously qualified for CHIP)	074	6-19
Parents and Caretakers (TANF)	075	19-65

3. Can beneficiaries opt out of the MississippiCAN program?

Only certain beneficiaries can opt out of the MississippiCAN program. Enrollment in MississippiCAN is optional for the following populations:

Optional Populations		
Category of Eligibility (COE)	COE	AGE
SSI- Supplemental Security Income	001	0-19
DHS- Foster Care Children –IV-E	003	0-19
Disabled Child Living at Home	019	0-19
DHS- Foster Care Children-CWS	026	0-19

4. What consumer protections are included in the MississippiCAN program?

Members' rights and protections are 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.

5. How will it be ensured that beneficiaries who are blind or those with low literacy or limited English proficiency obtain information necessary to choose a plan?

Enrollment information and materials have been developed to ensure all beneficiaries, including those with special needs, are fully informed of their choice of plans.

6. Will beneficiaries have freedom of choice in determining the best CCO for their needs?

Yes.

7. Will beneficiaries be allowed to select their primary care provider (PCP) and specialist within a CCO?

Each beneficiary will be allowed to choose their PCP from the CCO network to the extent possible, reasonable and appropriate. If the beneficiary does not choose an available PCP, the CCO may assign the beneficiary a PCP.

8. Can a beneficiary change PCPs?

Yes. The beneficiary should call Member Services of the CCO with which they are enrolled.

9. Can a beneficiary change CCOs?

Yes, a beneficiary can change CCOs one time within 90 days of his or her initial enrollment. Also, a beneficiary can change CCOs one time during the open enrollment period (October – December each year). Changes made during open enrollment are effective on January 1.

10. Will MississippiCAN replace a beneficiary's Medicaid?

No. The MississippiCAN program is part of the Mississippi Medicaid program. It is not a replacement.

11. Can a beneficiary enrolled in the MississippiCAN program continue to receive care from a provider who does not participate in any of the plans?

Yes, but the member may be responsible for payment. A beneficiary enrolled in the MississippiCAN program should seek treatment from a provider in the CCO network. The CCOs are not required to reimburse out of network providers the same fee as is reimbursed to Mississippi Medicaid Fee for Service (FFS) providers.

12. What if a beneficiary's doctor does not accept MississippiCAN (Magnolia or United)?

If a beneficiary's practitioner does not accept Magnolia or UnitedHealthcare, the beneficiary should contact the CCO with whom they are enrolled and let them know. Providers are not required to join but are encouraged to participate in the MississippiCAN program to ensure access for beneficiaries. Providers who do not join the CCO networks will need prior authorization from the CCO for payment of services provided to a beneficiary enrolled in MississippiCAN.

13. If a patient is enrolled in a plan, but the provider is not contracted with their plan, can the patient switch CCOs?

The first ninety (90) days following enrollment will be an open enrollment period during which members can enroll once with a different CCO without cause.

14. If a patient does not choose a plan during open enrollment, will one be chosen for them?

If the beneficiary does not respond to the open enrollment letter within 30 days after date of letter, then a plan will be chosen for them. They will be notified and have 90 days to switch plans.

15. Will prescription drugs be one of the benefits offered by the CCOs?

Yes.

16. If a beneficiary enrolls with a CCO, how will he or she get a ride to medical appointments if needed?

Both MississippiCAN CCOs will provide non-emergency transportation to MississippiCAN beneficiaries beginning July 1, 2014. A beneficiary can contact their CCO or call 1-866-331-6004 to make arrangements for a ride.

17. Will beneficiaries get an identification card from the CCO when they enroll?

Yes. Beneficiaries enrolled in a CCO will have an identification card from the CCO and a Medicaid identification card. It will be necessary to keep both cards and to show both cards when seeing a provider.

18. If a CCO does not authorize a covered service, will regular Medicaid pay for the CCO covered service?

No. If a beneficiary is enrolled in MississippiCAN, Medicaid only pays for inpatient hospital services.

19. What if a beneficiary has a problem with the CCO?

Beneficiaries should contact their assigned CCO (Magnolia Health Plan 1-866-912-6285; UnitedHealthcare 1-877-743-8731) to resolve any problem. If the problem is not resolved the member may contact the Bureau of Coordinated Care at 601-359-3789.

20. What is the appeal process?

A member or provider may file an appeal within thirty (30) calendar days of receiving a notice of adverse action from the CCO.

21. What is a state fair hearing process?

Any adverse action or appeal that is not resolved wholly in favor of the member by the CCO may be appealed to the Division for a state fair hearing within thirty (30) calendar days of the final decision by the CCO.

22. Will beneficiaries who are enrolled in the MississippiCAN program be responsible for co-pays?

No. There are no copayments for MississippiCAN members for services provided by the CCOs.

23. Can a CCO disenroll a beneficiary because their care is costing too much?

No. A CCO cannot disenroll a beneficiary because of an adverse change in the beneficiary's health status or because of the beneficiary's utilization of medical services.

24. Will beneficiaries be allowed to disenroll from a plan if required specialized services are not available?

Various "for cause" reasons for disenrollment will be allowed, such as: providers that do not (for religious or moral reasons) offer needed services; not all related services are available in the plan's network; or the plan lacks providers experienced in dealing with the enrollee's health care needs.

25. If a beneficiary is admitted to a nursing facility while enrolled in the MississippiCAN program, will the CCO be responsible for reimbursement?

No. Long term care is not covered by MississippiCAN. Upon admission to a nursing facility, a beneficiary is dis-enrolled from the CCO and is no longer eligible for the MississippiCAN program.

26. If a mother who is enrolled in MississippiCAN delivers a child, is that child automatically enrolled in the CCO?

Yes. Newborns born to a Medicaid mother who is currently enrolled in MississippiCAN will automatically be placed in the same CCO as the mother.

27. Will all Medicaid services be provided by the MississippiCAN program?

No. Inpatient hospital services will continue to be provided through traditional Medicaid. All other services will be provided by the MississippiCAN program through the beneficiary's CCO.

28. Will CCOs have lower reimbursement than Medicaid?

In accordance with State law, CCOs cannot reimburse providers in their networks at a rate lower than Medicaid fee-for-service rates. CCOs may reimburse out of network providers at a lesser rate.

29. How will a provider know if a beneficiary is in the MississippiCAN program?

Providers should always verify Medicaid eligibility of beneficiaries prior to providing services to receive payment.

30. Can providers contract with more than one CCO?

Yes. Providers are encouraged to contract with both CCOs to ensure access for beneficiaries.

31. Why do current Medicaid providers have to go through credentialing with each CCO?

This is a federal requirement as outlined in 42 CFR 438.214.

32. Do contracted providers have to get prior authorization from the CCOs?

Some services require prior authorization, even if provided by a network provider. Providers should visit the CCOs website or contact the CCO directly for a list of services requiring prior authorization.

33. Can a provider who has not previously been enrolled as a Medicaid provider treat a beneficiary enrolled in a CCO?

No. All providers in the CCO network must be Medicaid providers.

34. How will a provider receive certification for an inpatient hospital stay for a beneficiary enrolled in the MississippiCAN program?

The provider will continue to receive inpatient hospital certification as usual from the Division of Medicaid's UM/QIO contractor,

35. Do the CCOs use the same Preferred Drug List (PDL) as the Division of Medicaid?

Currently each CCO has its own PDL. However, effective October 1, 2014, the Division of Medicaid and the CCOs will implement a uniform PDL.

36. Is there a charge for "no shows" for appointments?

No, providers are not allowed to charge a beneficiary, Medicaid or the CCOs for a no show appointment.

37. Are beneficiaries who have third party insurance eligible for MississippiCAN?

Yes. As with Medicaid, the provider must file with the third party insurance first.

38. How do physicians file services for OBGYN patients who deliver as inpatient?

Providers should contact the member's CCO to determine this procedure.

39. What is the difference between dis-enrolling and switching plans?

Dis-enrolling means the member has chosen not to participate in MississippiCAN program. Switching plans means the member chose to enroll with another CCO.

40. Can prior authorizations be submitted through the web portal?

Providers should check with each CCO for prior authorization processes.

41. Is there a list reflecting which procedures require precertification?

Each CCO has its own list. Providers should contact the CCO for this list or visit the CCOs website.

42. What incentives are in place for providers to accept MississippiCAN?

Both CCOs have provider incentive programs. Providers should refer to CCO websites for information on these incentives.

43. How long after Medicare is obtained, is a MississippiCAN beneficiary disenrolled?

Beneficiaries are disenrolled from MississippiCAN as soon as the Division of Medicaid is notified by Social Security Administration or Medicare and our files are updated.

44. Will pregnant women on Medicaid in the COE 088 be able to see a dentist?

Medicaid and the CCOs will only cover pregnancy related services for this category of eligibility.

45. Are timely filing requirements of CCOs the same as Medicaid? If not, what are your requirements for timely filing?

No, the current timely filing limit for CCOs is ninety (90) days. Effective 7/1/14 the timely filing limit for the CCOs will be 180 days. Providers are encouraged to file claims after services have been completed.

46. What does DOM recommend when no local providers in specialty areas accept the plans?

Please contact the beneficiary's CCO for assistance in locating a specialist and working with the specialists for payment.

47. How can beneficiaries locate providers who accept the plans?

This information can be obtained by contacting the provider or the CCO.

48. Who should providers contact if payments from the CCOs are less than those received from Medicaid?

Please contact the CCO for assistance. If the issue is not resolved contact the Division of Medicaid's Bureau of Coordinated Care.

49. If a patient shows a Medicaid and UHC or MHP card, which card should providers file under?

Providers should always check eligibility before providing services. For all services except inpatient facility charges, providers should file with the CCO

(UHC or MHP) card. Inpatient hospital services should be filed using the Medicaid card.

50. What referral opportunities do providers have for sub-specialty referrals when there are no local MississippiCAN providers in GI, hematology, oncology, etc.?

The beneficiary needs to be referred to a specialist that is within the beneficiary's CCO if possible and enrolled in case management. Please contact the beneficiary's CCO for assistance in locating a provider.

51. Will the CCO web portals allow providers to file claims for automatic payment and adjustments?

Yes.

52. What are the physician inpatient hospital visit limits for MHP and UHC?

There are no limits on inpatient hospital visits for MHP, UHC or Division of Medicaid effective 10/1/12.

53. Will physicians who join a CCOs provider network be forced to take new patients?

No. CCOs may not require that physicians see new patients.

54. Will MississippiCAN pay for fluoride treatments in primary care physician offices?

Please contact the beneficiary's CCO for coverage of fluoride treatments.

55. Will maternity still be billed on a per visit basis with the plans, or will it change to the global maternity package?

Maternity services are billed on a per visit basis. Providers should contact the member's CCO for additional information.

56. Please define non emergent transportation? Does this include non-emergent transportation to the hospital?

Non-Emergency transportation shall be provided to members who require transportation to and from Medicaid covered non-emergency services. Non-emergency ambulance transport is included when criteria in Division of Medicaid Administrative Code is met.

57. What is the procedure to change providers name on the card?

The beneficiary must contact the CCO to change the PCP name on their card.