



What is a Medicaid Coordinated Care Organization?

Medicaid Coordinated Care Organizations (CCOs) provide comprehensive, coordinated healthcare services to improve quality and outcomes for Medicaid recipients, including those receiving SSI. CCOs work with state governments to improve healthcare outcomes, quality of care, establish health care provider relationships and control costs. CCOs partner with physicians, hospitals and other providers to make certain that each participant gets the right care, in the right setting, at the right time. These companies encourage preventive care such as check-ups and screenings, promote healthy pregnancies through education and incentive programs, manage prescription drug benefits and provide disease management programs—resulting in better care, better use of state resources and budget predictability. Switching from fee-for-service (FFS) to care management is a proven approach. More than 30 states have already successfully adopted this strategy and other states continue to follow this trend as they look for opportunities to improve care while reducing costs.

Supplemental Security Income (SSI)

SSI is a federal Medicaid program that provides healthcare services for the aged, people who are blind and those with disabilities. Nationally, the elderly and disabled comprise only 24% of total Medicaid enrollees, but account for 70% of total Medicaid expenditures.¹ An SSI enrollee typically has a chronic medical and/or behavioral illness, is economically disadvantaged and requires intense care coordination for multiple co-morbidities. Coordinated Care Organizations can play a pivotal role in assisting the primary care physician in coordinating these multiple complex needs.

Foster Care

The U.S. Children's Bureau estimates around 800,000 children are served in the foster care system each year. The Urban Institute found that States disburse approximately \$10 billion annually in federal and state funds to meet the needs of children placed in foster care. Coordinating services and health information for this population has unique challenges. Keeping track of medical history including medical conditions, doctor visits, immunizations, and prescription drug history is complicated by the temporary nature of care situations. In addition, one study by the Urban Institute suggests that as many as 80 percent of children involved with child welfare agencies have conditions which require mental health services. States are turning to Medicaid managed care solutions to help coordinate the unique medical, behavioral and social services for these children.

Breast and Cervical Cancer

This population is eligible for Medicaid as a result of a diagnosis of breast or cervical cancer. Women in this eligibility category are typically receiving active treatment for their diagnosis. Coordinated Care Organizations are able to assist these women by ensuring treatment plans are implemented in a timely manner so that the member receives the greatest health benefit. Since education on appropriate follow up can be difficult for members to absorb and understand while receiving cancer treatment, the CCO will work with the member during and immediately following treatment to ensure awareness of follow-up requirements such as repeat exams for early identification of reoccurrence. The CCO also will work to schedule follow-up appointments in advance; develop a transition plan; and prepare the member for maneuvering the health care system after loss of eligibility.

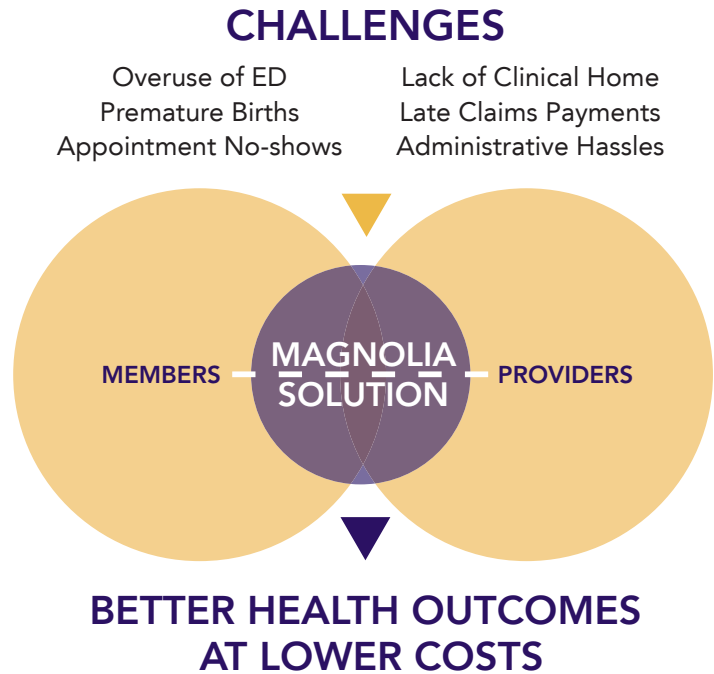
¹Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on 2005 MSIS data

**For more information about Magnolia Health Plan or
the changes in Medicaid, please visit www.magnoliahealthplan.com.**

The Value Magnolia Brings

Magnolia Health Plan (Magnolia) is a long-term solution to help the state of Mississippi enhance care for Medicaid recipients while most effectively managing Medicaid funds. A physician-driven, Mississippi-based Medicaid CCO, Magnolia is backed by its parent company, Centene Corporation (www.centene.com). Centene has 25 years of experience in Medicaid and other government-funded programs such as SSI and long-term care.

Magnolia understands that providers face unique challenges with Medicaid members. Through our partnerships with hospitals, physicians and other healthcare providers, we provide solutions for better health outcomes at lower costs.



Magnolia Solution	Outcomes
<p>MEMBER COMPLIANCE</p> <ul style="list-style-type: none"> • Focus on effective case management and treatment coordination to manage chronic and complex conditions • Educate members on the importance of preventive care, including making and keeping appointments for regular check-ups and screenings • MemberConnections[®]: Program that promotes preventive health practices and connects members to both quality healthcare and community social services • Start Smart for Your Baby[®]: Education program for pregnant members and new moms that offers incentives for keeping their doctors' appointments • NurseWise[®]: A 24-hour, toll-free phone line staffed by registered nurses that can answer medical questions and help members decide whether their condition is an emergency 	<p>Helps ensure members keep appointments and are more compliant with treatments</p> <p>Encourages the clinical home concept and strengthens a member-provider relationship</p> <p>Encourages members to use clinical home instead of the Emergency Department for non-emergent conditions</p> <p>Positions providers as a central point to coordinate member care in a timely manner</p>
<p>PHYSICIAN PARTNERSHIPS</p> <ul style="list-style-type: none"> • Education of physicians and office staff through orientations, office visits, ongoing training and physician participation in advisory board • Minimal referral requirements and limited prior authorizations • Electronic and web-based claims submission • Central claims processing facility and medical review unit 	<p>Reduces administrative hassle so that physician offices can focus on what they do best—providing quality healthcare to members</p>
<p>BOOTS ON THE GROUND</p> <ul style="list-style-type: none"> • Local Provider Relations and Medical Management staff support • Local call centers 	<p>Timely and accurate claims payments with the average clean claims processed in just seven to eight days</p>