MississippiCAN
Quality Strategy – Draft

Quality Strategy Overview

DOM Mission Statement

The overarching mission of the Mississippi Division of Medicaid (DOM) is to ensure access to health services for the Medicaid eligible population in the most cost efficient and comprehensive manner possible and to continually pursue strategies for optimizing the accessibility and quality of health care.

This Quality Strategy outlines an approach that focuses on working closely with beneficiaries, providers, the Coordinated Care Organizations (CCOs), advocates, and other stakeholders to develop strategic goals and action plans to achieve substantial improvement in quality. The Quality Strategy serves as a roadmap to monitor and implement quality improvement; it is a "living" document with periodic updates expected because of feedback on the effectiveness of the program.

We believe that healthcare should be *safe, effective, patient-centered, timely, efficient, and equitable*. In developing a healthcare strategy for the Mississippi Coordinated Access Network (MississippiCAN), we recognize that quality encompasses both outcomes and value. MississippiCAN is committed to maximizing the quality and quantity of beneficiaries' lives, thus relies on the responsible delivery of data driven and fiscally sound healthcare services. Our future quality strategies will outline initiatives to reduce illness, and to pursue the improvement of health and functioning of MississippiCAN beneficiaries. We will undertake data driven and evidence-based decision making, engage in transparency of reporting to encourage informed decision making by patients, families, and stakeholders, and encourage the implementation of best practices.

We believe *effective communication* is one of the cornerstones of support for this mission. DOM has developed collaborative, open relationships with each of the CCOs. For example, DOM meets regularly with each of the CCOs to discuss program implementation and ongoing operational issues and in many cases has been able to anticipate and resolve potential problems proactively before they have a negative impact on the program. The

CCOs and DOM jointly conducted twenty-four (24) beneficiary meetings during the summer of 2011. The benefits of jointly conducting these meetings were twofold, presenting a "united front" and a cohesive message to beneficiaries and allowing the CCOs and DOM to spend time together, further solidifying their collegial relationship. This open dialogue and collaboration with the CCOs has enabled DOM to realize a smooth implementation of the new MississippiCAN program and has helped DOM establish a strong working relationship with the CCOs. "Starting off on the right foot" has been particularly important because DOM has not had an active managed care program since 1999, and managed care is still relatively new to Mississippi.

Good communication with providers is equally important. Providers need education about how the MississippiCAN program works, and how they can best collaborate with the CCOs and DOM to provide services to MississippiCAN beneficiaries. The CCOs and DOM have also dealt forthrightly and directly with providers, addressing their concerns and dispelling myths about managed care. Provider education has been particularly important to help ensure that MississippiCAN beneficiaries are able to maintain their existing providers, thus supporting coordination of care and maximizing the number of providers contracting to provide MississippiCAN services. Statewide provider workshops were conducted immediately following implementation of the MississippiCAN program and are planned again in early November in conjunction with open enrollment. Both the CCO quality improvement committees and the DOM Leadership Team and Quality Task Force include provider representation.

Similarly, *member education* is one of the basic tenets of the MississippiCAN program. The program's strong emphasis on disease management requires that high-risk, high-cost beneficiaries receive education about managing their conditions and taking responsibility for their own health. To close the communication loop, both the CCOs and DOM include beneficiaries on their respective quality improvement committees, sending the clear message to beneficiaries that their input is valuable and is used to help make improvements to the MississippiCAN program.

Providing appropriate *access and availability of care* is particularly important to high-risk, high-cost MississippiCAN beneficiaries. Toward that end, DOM has established rigorous requirements for access to primary care physicians in an effort to encourage beneficiaries to use their medical home as an alternative to inappropriate emergency room care - or no care at all. The MississippiCAN performance measures, selected by DOM, focus on preventive care and management of those chronic diseases that are most prevalent in the MississippiCAN population.

DOM strongly believes that *managed care leads to improved health outcomes*, and that adhering to managed care principles creates an environment where it is possible to make decisions about the program and about patient care that are *fiscally responsible* but also in the best interests of beneficiaries. This translates to providing the most appropriate service, at the right time and in the most appropriate location. DOM will monitor to ensure that patient interventions are based on the most up-to-date industry best practices and clinical practice guidelines. Continuing to communicate with the CCOs, providers, beneficiaries, advocates, and others is key to the success of DOM's mission.

Finally, DOM strongly believes that *continuous quality improvement* is key to the ongoing success of the MississippiCAN program. While the DOM team's Quality Improvement Registered Nurse is the business owner of quality initiatives for the program, DOM has made it clear that everyone on the DOM team and everyone on each of the CCO teams are responsible for maintaining and improving quality. DOM has provided and will continue to provide ongoing training to its own staff around issues related to quality and monitoring, and the CCOs' respective Quality Managers meet regularly with the DOM Quality Improvement Team to collaborate on quality initiatives.

DOM will prioritize future interventions and updates to the Quality Strategy based on prevalence, cost, morbidity, and the ability to implement meaningful interventions.

Goals, Values and Guiding Principles

Goals

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

- **Improve access to needed medical services –** The MississippiCAN program will accomplish this goal 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 –** The MississippiCAN program will accomplish this goal 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** – The MississippiCAN program will accomplish this goal by contracting with CCOs on a full-risk capitated basis to provide comprehensive services through an efficient, cost effective system of care.

Guiding Values and Principles

- Every MississippiCAN beneficiary has a right to receive quality, accessible care

- The DOM is committed to achieving program excellence via a continuous quality improvement process

- The DOM will establish and maintain high standards for quality of care, access to care and quality of service, and monitor to those standards

- The MississippiCAN program supports beneficiaries taking responsibility for their own health care through use of preventive care and education

- Managed care is a cost-effective approach that promotes improved health outcomes

- Public review, input and feedback on Quality Strategy activities is key to community acceptance and helps insure that program services are appropriate to

address the needs of the MississippiCAN beneficiaries, thus contributing to the success of the program

Quality Strategy Development

The DOM team, in consultation with the CCOs, has developed this initial Quality Strategy for the MississippiCAN program. The DOM has also contracted with a healthcare consulting firm, Navigant, Inc. (NCI), with experience assisting other states in the development of their quality infrastructure, and developing and monitoring their Quality Strategies. To create the initial Quality Strategy, DOM relied on program descriptions and proposals received from the CCOs. In addition, CCO staff (notably, the Quality Directors, Health Services Directors and Medical Directors) provided feedback to DOM regarding the development of the Quality Strategy. Many of the staff involved in the creation of the Quality Strategy will also participate in the MississippiCAN Leadership Team and Quality Task Force that will provide oversight of the implementation and ongoing monitoring of the Quality Strategy of the MississippiCAN program.

In subsequent years, DOM plans to involve providers, beneficiaries, advocates and other stakeholders in revisions to the MississippiCAN Quality Strategy via the MississippiCAN Leadership Team and Quality Task Force (see further discussion regarding these committees in Table 1). Currently, DOM is preparing a Request for Proposals (RFP) for its initial External Quality Review (EQR) to begin in 2012; the selected External Quality Review Organization (EQRO) will also play a key role in ongoing monitoring of the Quality Strategy and the MississippiCAN program.

External Quality Review Organization (EQRO)

The DOM envisions a significant role for its EQRO, which will include participation in the MississippiCAN Leadership Team and the Quality Task Force. In addition, DOM will require its EQRO to conduct performance improvement projects in addition to those conducted by the CCOs, and to assist DOM in conducting studies on quality that focus on a particular aspect of clinical or nonclinical services that align with DOM's priorities. The EQRO's initial report will help guide revisions to the initial Quality Strategy, and DOM is

deliberately seeking to contract with an EQRO with experience working with programs with high-risk beneficiaries, similar to those beneficiaries in the MississippiCAN program, to fully take advantage of the EQRO's expertise and experience in quality improvement. This experience will offer increased value and an ability to leverage lessons learned.

Participant Input

In addition to seeking input from the CCOs and DOM staff, DOM will also aggressively solicit input from provider and consumer members of its MississippiCAN Leadership Team and Quality Task Force. These individuals will bring important perspective to the quality improvement process since they actively participate in and thus have first-hand knowledge of the program. In August-September 2011, DOM and the CCOs participated in a series of meetings with beneficiaries to help prepare them for the upcoming open enrollment process, but also to solicit feedback from them about their satisfaction with the MississippiCAN program and their suggestions for improvement. The DOM is considering conducting these beneficiary meetings on an annual basis and using these meetings as a forum to solicit input regarding the Quality Strategy from a broader group of beneficiaries.

In addition to enrollee participation in each of DOM's quality committees, each of the CCOs also include enrollee representatives in their respective internal quality improvement committees.

Public Input

DOM will publish the draft Quality Strategy on its website to provide an opportunity to other stakeholders to offer their feedback about the draft strategy. Based on recommendations from its Leadership Team and Quality Task Force, DOM may also consider using focus groups to provide feedback on the program. In addition, DOM could consider using a Web-based mailbox where beneficiaries could send emails with input and suggestions, or conducting various public meetings.

Quality Management Strategy Implementation

DOM has delegated quality oversight responsibilities for the MississippiCAN program to the MississippiCAN Quality Leadership Team (the Leadership Team) and MississippiCAN Quality Task Force (the Task Force). As noted in Figure 1 below, the Task Force reports to the Leadership Team, who in turn reports to DOM.

MississippiCAN Quality Leadership Team

The Leadership Team serves as an advisory board for the MississippiCAN program, providing feedback to DOM leadership. Membership is comprised of executives who are decision makers within their own organizations, including DOM supervisors and CCO Directors. Network providers and MississippiCAN beneficiaries also serve on the committee. DOM or the Leadership Team itself may from time to time invite other participants to the Leadership Team on a permanent or ad hoc basis. For example, should the Leadership Team have a need to discuss integration of behavioral health and physical health services, DOM could invite behavioral health practitioners or representatives of behavioral health advocacy groups to join the Leadership Team.

One of the first tasks of the MississippiCAN Quality Leadership Team will be to collaborate with DOM to clarify their role and to draft bylaws for the Leadership Team. Although the Leadership Team will provide oversight of the Task Force and make recommendations to DOM regarding direction for the MississippiCAN program, DOM ultimately makes final program decisions. However, the Leadership Team brings expertise, experience and strategic vision that DOM will thoughtfully consider, especially as DOM seeks to implement the MississippiCAN Quality Strategy.

Simultaneously, the Leadership Team will assist DOM with a second related and equally important task – to develop the Quality Strategy. It is likely that DOM will present the initial Quality Strategy document for Leadership Team review and feedback, and that DOM will incorporate Leadership Team revisions in the Quality Strategy.

Initially, the Leadership Team will meet more frequently as it works through clarification of its role and begins to address MississippiCAN issues. Ultimately, it is likely that the Leadership Team will meet on a bi-monthly or quarterly basis, depending upon the agenda items.

Quality Task Force

There is substantial overlap between the Task Force and the Leadership Team, i.e., at a minimum, the CCO Quality Managers and DOM supervisory staff will sit on both committees. Initially, the DOM Care Coordination Bureau Director and/or Division Director will chair each of the committee meetings, with the intent of shifting leadership responsibility to a DOM contracted medical director who will share leadership responsibility with the medical directors of the CCOs.

Additional membership includes subject matter experts and additional stakeholders designated by DOM. The CCOs will alternate recording minutes of each Task Force meeting, and will submit the minutes of each meeting to DOM for approval. Once DOM has approved the minutes, the responsible CCO will submit the minutes to members of the Task Force for review and approval, and then to the Leadership Team.

One of the first tasks of the MississippiCAN Quality Task Force will also be to collaborate with DOM to clarify their role and to draft bylaws for the Task Force. At the same time, the Task Force will assist in the development and implementation of the MississippiCAN Quality Strategy. Using their expertise, the Task Force will provide feedback to the MississippiCAN Leadership Team and DOM on the appropriateness and quality of care and services provided, will assist DOM in establishing standards and guidelines for provisions of care and will review monitoring and evaluation reports. Additionally, the Task Force will support DOM in establishing priorities, designing and implementing quality monitoring, and analyzing findings from the discovery review processes.

DOM may develop additional workgroups to address specific areas. These workgroups will also report to DOM and the MississippiCAN Leadership Team.

Review of Quality Strategy

For the first calendar year of the MississippiCAN program, the Leadership Team will review the Quality Strategy at a minimum on a quarterly basis. In year two and in subsequent years, the Leadership Team will review and revise the Quality Strategy at a minimum on a semi-annual basis. The Leadership Team will be responsible for submitting its written recommendations for modifications to the Quality Strategy to DOM, which will review those recommendations and make a decision as to whether to proceed with changes to the Quality Strategy. If changes are required, DOM will submit these proposed changes in writing to CMS for review and approval.

Table 1 below provides an overview of the membership and roles and responsibilities of each of the planned quality committees.

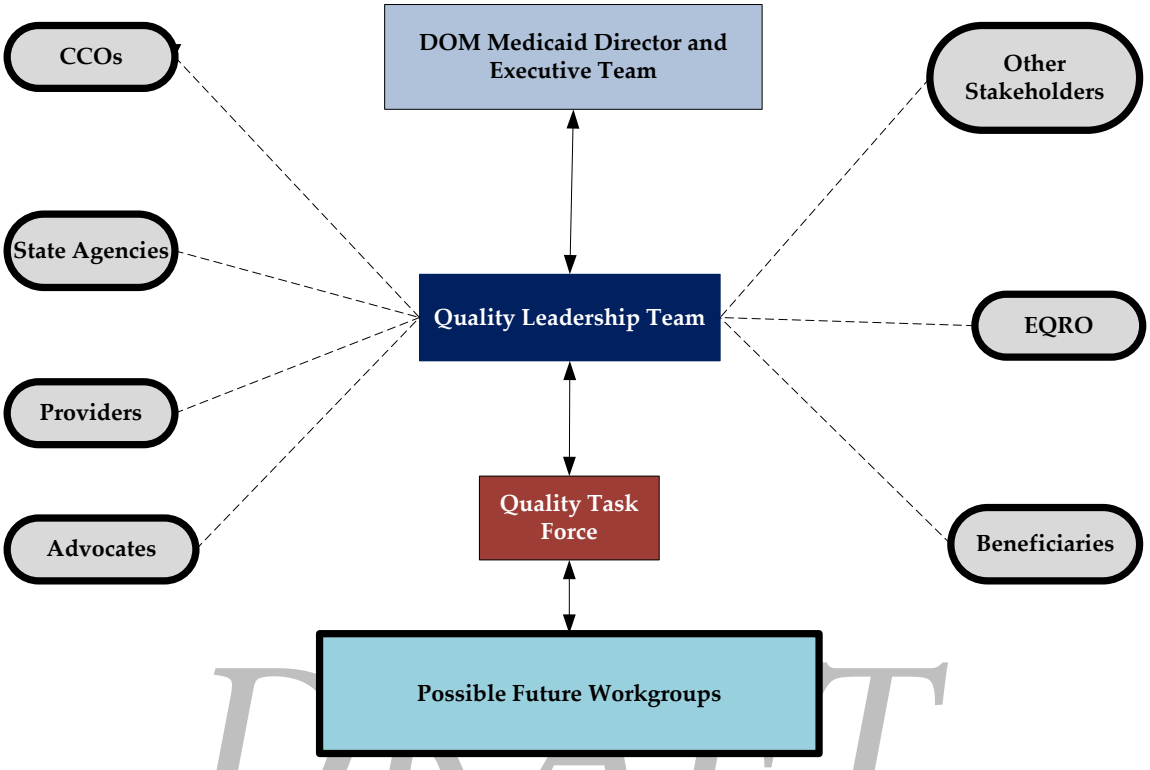
Table 1: Composition of Planned MississippiCAN Quality Committees

Quality Committee	Membership	Roles and Responsibilities
MississippiCAN Quality Leadership Team	• Medicaid, CCO and Community-based Leadership • At a minimum, DOM supervisory staff and Quality Manager • Medical Directors of each of the CCOs • Other CCO Executives, as designated by DOM • At least two network providers from each CCO who are actively involved in providing services to MississippiCAN beneficiaries • At least two beneficiaries enrolled in each CCO who are actively involved in receiving MississippiCAN services • Other stakeholders and representatives	• Acts as the advisory board of the MississippiCAN quality program, providing feedback to DOM leadership • Approves and provides oversight of Quality Strategy development, implementation and evaluation • Provides oversight of MississippiCAN Quality Task Force • Serves as a public forum for exchange of best practices and solicitation of feedback from MississippiCAN stakeholders • Publishes results and findings related to the MississippiCAN

Quality Committee	Membership	Roles and Responsibilities
	from community advocacy groups, community agencies and academia, as designated by DOM • MississippiCAN External Quality Review Organization representative (optional) • Initially chaired by DOM Care Coordination Bureau Director and/or Division Director	program
MississippiCAN Quality Task Force	• DOM leadership and other representatives • Representatives from MississippiCAN CCOs, including the Quality Managers and Health Services Managers • Subject matter experts, as designated by DOM • Other stakeholders, as designated by DOM • MississippiCAN External Quality Review Organization representative (optional) • Initially chaired by DOM Care Coordination Bureau Director and/or Division Director	• Supports development and implementation of the MississippiCAN Quality Strategy • Provides feedback on the appropriateness and quality of care and services provided to MississippiCAN beneficiaries to the MississippiCAN Leadership Committee and DOM • Assists DOM in establishing standards and guidelines for provision of care • Assists DOM by reviewing monitoring and evaluation reports, as designated by DOM • Provides forum for sharing best practices • Provides support and feedback to DOM for the: – establishment of priorities – identification, design, and implementation of quality

Quality Committee	Membership	Roles and Responsibilities
		reporting and monitoring – review of findings from discovery processes – development of remediation strategies • Conducts data analysis, identifies potential quality improvement strategies and makes recommendations to the MississippiCAN Leadership Team and DOM • Establishes additional workgroups to address specific topics, with DOM and MississippiCAN Leadership Team approval • Reports to DOM and the MississippiCAN Leadership Team

Figure 1: Quality Management Structure



History of MississippiCAN

On February 2, 2009, the DOM released a Request for Proposals (RFP) requesting offers from responsible contractors to provide services to implement the MississippiCAN, a coordinated care program for Mississippi Medicaid beneficiaries. The original deadline for submission of proposals was March 16, 2009. The DOM received proposals from five (5) coordinated care organizations. The initial program design included mandatory enrollment of pregnant women and infants up to age one.

During the Second Extraordinary Session of the 2009 Mississippi Legislature, House Bill 71 included technical amendments regarding revisions to the MississippiCAN project. In particular, this bill described certain requirements for the program. The DOM met all requirements as outlined in Table 2 below.

Table 2: Technical Amendments to the MississippiCAN Project and MississippiCAN Actions

Requirement	Action
Prohibits implementation of any coordinated care program until January 1, 2010	Implementation date set for July 1, 2010, but due to delay with Centers for Medicare and Medicaid Services (CMS), implementation was January 1, 2011.
Limits participation to no more than fifteen (15) percent of the Medicaid population	Enrollment is limited to no more than fifteen (15) percent of the Mississippi Medicaid population with the ability to opt out of the program and return to the fee-for-service program. These categories of eligibility selected as eligible for the program represent no more than fifteen (15) percent, or approximately 90,000 beneficiaries, of the Mississippi Medicaid population. This number is based on the fact that the monthly average of Medicaid beneficiaries in State fiscal year 2010 was 615,497 and fifteen (15) percent is 92,325.
Requires that all beneficiaries have a window of at least thirty (30) days to disenroll from the MississippiCAN program on an annual basis	All beneficiaries will have the ability to select the CCO of their choice. The DOM sends enrollment packets to persons who may elect to participate in this program. The beneficiary has thirty (30) days to select a plan or opt out of the program. Enrollees who fail to make a voluntary CCO selection within thirty (30) days will be 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 that has a contract

Requirement	Action
	with the enrollee's primary care physician where possible. • Determine if a family member is assigned to a CCO and assign the enrollee to that CCO. • If not, assign the enrollee to an open panel closest to the enrollee's home. If multiple CCOs meet this standard, auto-assignment will occur using a random process. The use of claims data and CCO relationships for other family members preserve existing provider-recipient relationships. CCO provider networks for Medicaid beneficiaries are limited to Medicaid-participating providers. This will ensure beneficiaries a relationship with providers who have traditionally served Medicaid beneficiaries. For those beneficiaries for whom it is not possible to determine any prior patient/provider relationship, the State will randomly assign beneficiaries to ensure equitable enrollment among the plans. If the plans have equitable distribution, then a round robin methodology will be used to ensure maintenance of an equitable distribution. State-generated correspondence informing Medicaid beneficiaries of their auto assignment to a CCO in the MississippiCAN program will inform beneficiaries that they may disenroll or opt out without cause within ninety (90) days of their enrollment date or select an alternative CCO. Enrolled beneficiaries will have an open enrollment period

Requirement	Action
	at least once every twelve (12) months after the initial date with the option to opt out or select another CCO during this period. Various "for cause" reasons for disenrollment at other times will incorporate federal requirements, 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.
Requires that payments made by the care coordination plans shall be considered regular Medicaid payments for the purposes of calculating Medicare UPL and DSH payments	Federal regulations do not allow CCO payments to providers for inpatient hospital services to be included in the upper payment limit (UPL) payments. Therefore, inpatient hospital services are carved out of the program and paid based on the per diem rate by the DOM. Federal regulations do not limit managed care payments in the calculations for the disproportionate share (DSH) program. Therefore, hospitals will need to report their managed care charges and payments on the DSH survey as the managed care payments in excess or below cost will be included in their facility specific DSH limit calculations. Since the DOM's reimbursement does not have a gap in the Medicare payment and Medicaid payment for outpatient hospital services there is no outpatient UPL and there will be no impact from the managed care program.
Requires care coordination plans to reimburse providers at rates no lower than those for beneficiaries not participating in the program	The contract between the DOM and the CCOs assures reimbursement paid by the CCOs is no lower than the current Medicaid rate. DOM will be monitoring this as well.

Requirement	Action
	All services will be reimbursed by the CCO with the exception of the following excluded services: • Behavioral health services; however, psychotropic medications will be provided by CCOs because many of these medications are prescribed by primary care physicians • Inpatient hospital services • Non-emergency transportation; the existing broker will continue providing this service • Long-term care services, including nursing facility, ICF-MR, PRTF and home- and community-based waiver services
Restricts care coordination plans from requiring its members to utilize a pharmacy that ships, mails or delivers drugs or devices	The contract between the DOM and the CCOs restricts CCOs from requiring its membership to utilize a pharmacy that ships, mails, or delivers drugs or devices.
Provides for a comprehensive performance evaluation by PEER to determine cost savings, quality of care and access to care	DOM has provided PEER with all information requested.

Because of program design changes required by House Bill 71, the DOM released an amended RFP on August 19, 2009, with the deadline for submission of amended proposals on September 14, 2009. The DOM received amended proposals from the same five (5) CCOs, which had originally submitted proposals. To support the goals of offering choice for beneficiaries, ensuring financial stability of the program and ease of program administration, the DOM awarded contracts to two CCOs to administer a care coordination program. These CCOs are Magnolia Health Plan and UnitedHealthcare.

In September 2010, the DOM submitted a State Plan Amendment to CMS to secure the federal authority for implementation of the care coordination program for targeted Medicaid beneficiaries. CMS approved the State Plan Amendment.

The DOM developed a detailed plan for implementation of the coordinated care program, including assessing the current Medicaid Management Information System (MMIS) to determine specific modifications and/or enhancements necessary for operation of this new program. The updates to the MMIS were completed before the program became operational.

For two weeks in November 2010, DOM staff conducted desk audits and on-site readiness reviews of all proposed program components including information systems, administrative services and medical management to ensure that the CCOs were prepared to administer the program prior to enrollment of beneficiaries.

The DOM contracted with the CCOs using a full-risk arrangement that pays each CCO a prepaid monthly capitation rate to cover all the services included in the CCO contract. Cost-effective and actuarially sound rates have been developed according to all applicable CMS rules and regulations.

In general, the capitation rates were developed using fee-for-service data for the eligible populations from State fiscal years 2008 and 2009 and the following adjustments:

- Utilization trend
- Unit cost trend
- Medicaid program changes
- Incurred but not reported claims and third party recoveries
- Coordinated cost savings
- CCO administrative allowance

On January 1, 2011, the DOM implemented MississippiCAN, a statewide coordinated care program for targeted high-cost Mississippi Medicaid beneficiaries. Targeted, high-cost Medicaid beneficiaries include individuals in a category of eligibility that has been

determined by claims review to have an above average per member per month cost and annually more than 1,200 member months in the category. Mississippi Medicaid beneficiaries who are eligible to enroll in the MississippiCAN program are limited to individuals eligible for Medicaid through the following eligibility categories:

- Supplemental Security Income (SSI) - Beneficiaries who are low income and age 65 or older, blind, or disabled (birth to age 65) who are receiving SSI cash assistance or who are "deemed" to be cash recipients.

- Disabled Child Living at Home - Beneficiaries who are disabled and under the age of 18 qualify based on income under 300 percent of the SSI limit (nursing facility limit) and who meet the level of care requirement for nursing facility/intermediate care facility for the mentally retarded placement. Income and resource criteria are the same as for long-term care rules. Parental income and resources are not considered.

- Working disabled - Beneficiaries who are any age and disabled and work and have earnings under 250 percent of Federal Poverty Level (FPL), or unearned income under 135 percent of FPL with a resource limit of $24,000 single/$26,000 family. A premium is required in certain cases.

- Department of Human Services Foster Care and Adoption Assistance Children - Beneficiaries up to age 21, if in the custody of the Mississippi Department of Human Services and in a licensed foster home, with eligibility based on income/resources of the child and resources not to exceed $10,000.

- Breast/Cervical Cancer Group - Female beneficiaries under age 65 with no other insurance and who were screened and diagnosed with breast or cervical cancer under the screening program of the Center for Disease Control (CDC) that is administered by the Mississippi State Department of Health (MSDH). The income limit is 250 percent of FPL.

Regardless of the category of eligibility, persons in an institution such as a nursing facility, intermediate care facility for the mentally retarded or psychiatric residential treatment facility, dual eligibles and waiver members are not included in the program.

The MississippiCAN program addresses the following goals:

- **Improve access to needed medical services** – The MississippiCAN program will accomplish this goal 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** – The MississippiCAN program will accomplish this goal 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** – The MississippiCAN program will accomplish this goal by contracting with the CCOs on a full-risk capitated basis to provide comprehensive services through an efficient, cost effective system of care.

Magnolia Health Plan and UnitedHealthcare provide a comprehensive package of services that must include, at a minimum, the current Mississippi Medicaid benefits. Each CCO provides some benefits not available through the Medicaid fee-for-service program, i.e., nurse advice lines, unlimited doctor visits, additional prescriptions, etc. CCOs are not responsible for inpatient hospital or behavioral health services. Although CCOs are not responsible for behavioral health services, they are responsible for coverage of psychotropic medications in their pharmacy benefits because primary care physicians prescribe many of these medications. The current contractor of the DOM continues to provide non-emergency transportation.

The CCOs may not directly market to the targeted beneficiaries. The DOM has created an enrollment packet to provide information about choice of CCOs and acts as an enrollment

broker, enrolling beneficiaries into their chosen CCO. Additionally, the DOM provides education to providers and beneficiaries by conducting annual statewide workshops.

A critical component of MississippiCAN is contract compliance and monitoring to ensure that the goals of the program are being met. The DOM will continually assess the performance of the contracted CCOs against contract requirements.

The DOM will ensure that the MississippiCAN program conforms to State Plan requirements as listed below.

- Program Impact – choice, marketing, enrollment/disenrollment, program integrity, information to beneficiaries, and grievance systems
- Access – timely access, PCP/specialist capacity, and coordination and continuity of care
- Quality – coverage and authorization, provider selection, and quality of care

Rationale for Managed Care

By targeting high-cost, high-risk beneficiaries, DOM is attempting to better predict and manage costs by focusing on those beneficiaries who represent the greatest challenge and greatest expense to the State. In addition, by contracting with CCOs, the goal of DOM is to improve quality of care and access to care for these beneficiaries. The CCOs will provide comprehensive care management and disease management for beneficiaries that were not eligible for such services previously.

Goals and Objectives

The MississippiCAN program goal is to provide quality care to a targeted population through increased access and appropriate and timely utilization of health care services.

Targeted, high cost Medicaid beneficiaries include individuals in a category of eligibility determined by claims review to have an above average per member per month cost and more than 1,200 member months in the category. Therefore, the targeted, high cost

Medicaid beneficiaries covered in this program are beneficiaries in the following eligibility groups:

- SSI recipients
- Disabled child at home
- Working disabled
- Department of Human Services Foster Care
- Breast/cervical group

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

The program's focus on management of care for beneficiaries with high-risk, high-cost diseases is a key component of the program, and supports the program goals of improving access and quality of care. The DOM has prioritized several clinical areas that are representative of the high-risk, high-cost diagnoses of this population. The clinical areas are:

- Obesity
- Hypertension
- Diabetes
- Asthma
- Congestive Heart Disease
- Hemophilia
- Organ Transplants

The DOM contractually requires each of the CCOs to conduct at least four (4) Focused Studies during the first year of their MississippiCAN contracts, with obesity being a required topic for one of the Focused Studies. Each of the CCOs chose diabetes, asthma and congestive heart disease as topics for the remaining three (3) required Focused Studies.

Results of the Focused Studies are due to DOM in July 2012, but the CCOs have already implemented several quality improvement strategies to address these clinical priorities. For example, the CCOs identified beneficiaries with asthma, diabetes and congestive heart disease, and currently send reminder cards to educate these enrollees about necessary screenings and follow-up care.

The following specific goals provide more detail regarding the program's overarching goal of providing quality care to MississippiCAN beneficiaries:

Goal 1: Improve access to needed medical services - The MississippiCAN program will accomplish this goal by connecting the targeted beneficiaries with a medical home, increasing access to providers and improving beneficiaries' use of primary and preventive care services.

DOM chose performance measures based on its stated priorities for MississippiCAN beneficiaries:

- Obesity
- Hypertension
- Diabetes
- Asthma
- Congestive Heart Disease
- Hemophilia
- Organ Transplants

Contract Year One Objectives: At a minimum, as contractually required by DOM, the CCOs will collect baseline data for their members for the following performance measures during calendar year 2011:

- Adults' access to preventative/ambulatory health services

- Children and adolescents' access to primary care practitioners
- Call abandonment
- Call answer timeliness
- Annual dental visits
- Prenatal care

The CCOs submit quarterly GeoAccess reports that crosswalk the home location of each enrollee to available PCPs. The target for the first year of the program is that 100 percent of members will have this access.

In addition, as access to non-hospital based emergency care is an issue of concern, DOM requires CCOs to include non-hospital urgent and emergent care providers in their networks.

Goal 2: Improve quality of care – The MississippiCAN program will accomplish this goal 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.

Objectives: At a minimum, as contractually required by DOM, the CCOs will collect baseline data for the following performance measures during calendar year 2011:

- BMI (Body Mass Index) for adults
- BMI weight assessment for nutrition and physical activity counseling for children and adolescents
- Use of appropriate medications for people with asthma

In addition, for the measures listed in Appendix B that are based on Healthcare Effectiveness Data and Information Set (HEDIS) and have available HEDIS benchmarks, DOM has set a calendar year 2011 target of a rate at or exceeding the 50th percentile

benchmark as compared to HEDIS Medicaid benchmarks for calendar year 2009 (HEDIS 2010). Appendix B lists the relevant targets for all performance measures.

However, DOM realizes that although it wants the CCOs to strive to improve program performance and health outcomes during calendar year 2011, with a few exceptions it is likely that the CCOs will not have an opportunity to favorably affect rates during the first calendar year of the program. In addition, given the high-risk, high-cost nature of the MississippiCAN population, it is equally likely that the rates for this population may fall below the NCQA HEDIS industry benchmarks, which are calculated based on a Medicaid population whose characteristics differ from those of the MississippiCAN population. Therefore, DOM will review and may revise the calendar year 2011 targets, depending upon the findings of baseline data collection for calendar year 2011, due to DOM in March 2012. DOM is also considering collecting its own baseline data based on claims for calendar year 2010, for inpatient utilization, ER visits and adult access to preventive/ambulatory health services.

Once the CCOs have collected and reported their calendar year 2011 data, DOM will annually review baseline data and subsequent annual rates and will revise targets. In consultation with the MississippiCAN Leadership Team and the Quality Task Force, DOM will on an annual basis:

- Review performance measures for relevance to the MississippiCAN program
- Add or modify relevant performance measures
- Delete performance measures that may no longer be a MississippiCAN priority
- Review and revise performance targets based on industry benchmarks, CCO performance, MississippiCAN priorities, etc. For example, for measures where baseline rates exceed the 50th percentile, DOM may increase the target to the 75th percentile.
- Consider establishing targets for improved performance. For example, if the baseline rate for a particular measure is consistently below the 50th percentile but

there is significant improvement in the rate, consider financial bonuses based on percent improvement.

- Consider assigning performance incentives and/or sanctions to certain performance measures

Goal 3: Improve efficiencies and cost effectiveness – DOM will accomplish this goal by contracting with CCOs on a full-risk capitated basis to provide comprehensive services through an efficient, cost effective system of care. DOM does not anticipate cost savings in the first year of the program. However, following the first year of the program, DOM will evaluate cost of care for MississippiCAN beneficiaries, especially for emergency room visits and inpatient care, services that MississippiCAN beneficiaries tend to over-utilize. DOM and the CCOs will use the results of this assessment to help determine if the strategies for addressing over-utilization of emergency room services and inpatient care are effective, and will allow the CCOs to consider alternative approaches to managing this utilization.

In Section 14.2 of DOM's contract with the CCOs, DOM has set cost savings targets for inpatient care. DOM expects the CCO to achieve the target savings amount for each category of member eligibility and its corresponding target savings category. The target savings goal is ten (10) percent for the first year of the program. Upon demand by the DOM, the CCO will remit payment to the DOM for the difference between actual savings realized by the CCO and the target program savings amounts.

Assessment – Quality and Appropriateness of Care

There is a well-defined monitoring infrastructure to provide oversight of the MississippiCAN program. As part of the oversight process, the DOM has identified certain performance measures (see Appendix B) and contract requirements (see Appendix A) that reflect the clinical and operational priorities of the MississippiCAN program. DOM staff receives and reviews regular reports (i.e., monthly, quarterly, semi-annually or annually, depending on the measure) from each of the CCOs regarding each of these performance measures. DOM staff then collectively discusses the reports and identifies trends and outliers, both positive and negative. On a regular monthly basis, DOM conducts meetings

with each of the CCOs to discuss these findings and address issues and concerns noted from the review.

During the CCO readiness reviews, DOM required the CCOs to demonstrate their ability to meet compliance requirements for each standard in anticipation of assuming enrollment of MississippiCAN beneficiaries. DOM developed an Issues Log to track those issues for which the CCOs were not fully compliant at the time of the readiness review. Following the successful completion of the readiness review, DOM maintained the Log to track non-compliant findings identified during the course of routine program monitoring. Depending on the nature, priority and timeliness of the issue, and its impact on program integrity, DOM discusses these issues with the CCOs on a regular basis, until the issue has been satisfactorily resolved.

On an ongoing basis, each DOM staff member is assigned to monitor certain contract standards for each of the CCOs. Depending upon the nature and priority of the standard, DOM monitors review the standards on a monthly, quarterly or annual basis. These standards are listed in Appendix A. The DOM monitor assigns a rating of "compliant" or "non-compliant" for each of these standards. For non-compliant standards, the DOM monitor discusses with the CCO a remediation strategy that addresses the contract non-compliance or deficiency area. The CCO then has an opportunity to implement this remediation strategy. If the deficiency or non-compliant issue cannot be resolved via this process, the CCO is required to present a Corrective Action Plan (CAP). The DOM monitor tracks and monitors the CCO's adherence to this CAP until the problem is resolved.

The DOM monitoring team also identifies high priority, high risk issues and communicates those to the Quality Task Force and MississippiCAN Leadership Team. On an ongoing basis, these two committees advise DOM about how best to proceed to ensure that MississippiCAN beneficiaries continue to receive the care that they need.

Finally, the use of sanctions is a last resort. The CCO contracts itemize parameters as to when and how sanctions are applied. The DOM believes that through open and frequent communication with the CCOs and collegial attitudes on the part of both DOM and the

CCOs, issues can be resolved quickly to avoid a negative impact on the program and members. The bottom line: the CCOs and DOM share a common goal – to improve health outcomes for MississippiCAN beneficiaries.

Procedures for Race, Ethnicity, Primary Language, and Data Collection

The CCOs must make written information available in English, Spanish and other prevalent non-English languages identified by DOM, upon the beneficiary's request. In addition, the CCO must identify additional languages that are prevalent among the CCO's membership and provide oral translation services to members.

Data collection

Data regarding race and primary language are currently available in the MississippiCAN system. Caseworkers processing enrollments for MississippiCAN beneficiaries solicit and enter this data at the time of the beneficiary's enrollment. DOM updates this information daily and provides this information directly to the CCOs on a daily basis via the 834 enrollment report.

Communication with CCOs

The monthly enrollment report in the form of a data file includes client enrollment/disenrollment information. The CCO receives the file electronically on or before the first day of each enrollment month. It includes newly enrolled clients, clients enrolled last month who continue to be enrolled, clients who transferred into the plan, and clients who are no longer enrolled with the plan. To facilitate care delivery appropriate to client needs, the enrollment file also includes race/ethnicity, primary language spoken, and selective health information. To maintain compliance with CFR 438.204(b)(2)), DOM expects the CCOs to use information on race/ethnicity and language to support member services, develop member materials, provide interpretive services, identify staff training needs and determine the need for and availability of providers with non-English speaking capacity.

Clinical Guidelines

DOM requires that each of the CCOs' Quality Management Programs conduct quality of care studies, health service delivery studies and other monitoring activities using objective, measurable and current standards for service delivery, quality indicators, or pre-established practice guidelines. These guidelines shall be based on reasonable scientific evidence, reasonable medical evidence, reviewed by providers in the Plan who can recommend adoption of clinical practice guidelines to the CCO, updated annually and communicated to those whose performance will be measured against the standards. The CCOs must provide clinical guidelines to physicians and other MississippiCAN providers as appropriate. Clinicians shall analyze clinical issues arising related to the guidelines through monitoring and evaluation activities and recommend corrective action needed to improve services. The CCOs must have a plan for reviewing the guidelines at least every two (2) years and updating the guidelines as appropriate.

On an annual basis, DOM requires the CCOs to measure provider performance against at least two (2) of the clinical guidelines and provide to DOM a copy of the results of the study.

External Quality Review

The DOM will procure an independent External Quality Review Organization (EQRO) to evaluate the Federal and State regulatory requirements and performance standards, as they apply to the CCOs, in accordance with 42 CFR 438 Subpart E. Based upon the definitions in 42 CFR 438.320, the EQR report will include timeliness, outcomes and accessibility assessments for the services covered under the CCO contracts.

Currently, DOM is developing an RFP for its External Quality Review Organization (EQRO). The EQRO will adhere to the federally mandated scope of the annual EQR and may perform a number of additional tasks, particularly in years subsequent to the initial implementation of the program.

The mandatory tasks include:

1. Validation of performance improvement projects required by the State to comply with requirements set forth in 438.240(b)(1) that were underway during the preceding 12 months.

The MississippiCAN CCOs collected baseline data during calendar year 2011 and will conduct four (4) Focused Studies during calendar year 2012, with topics to be determined based on the analysis of baseline data and DOM priorities. In the first year of this contract, the EQRO will validate the data collection methodologies used by the CCOs and will review and comment on the development of the Focused Studies. Findings from the Focused Studies are due to DOM no later than July 1, 2012. In subsequent years, the EQRO will validate the Performance Improvement Projects (PIPs).

The CMS protocol describes the following three (3) activities that the Contractor shall undertake in validating Focused Studies/PIPs for MississippiCAN:

a. Assess the CCO's methodology for conducting the Focused Study/PIP

b. Verify actual Focused Study/PIP study findings

c. Evaluate overall validity and reliability of study results

2. Validation of performance measures reported (as required by the State) during the preceding 12 months to comply with requirements set forth in 438.240(b)(2).

The CMS protocol addresses the following three (3) activities that the Contractor shall undertake in validating performance measures for MississippiCAN:

a. Review the data management processes of the CCO

b. For those performance measures based on HEDIS, evaluate algorithmic compliance (the translation of captured data into actual statistics) with specifications with HEDIS Technical Specifications. For other performance measures, DOM will provide specifications for data collection (see Appendix A for a list of performance measures and their related specifications). The

CCOs will submit audited HEDIS rates and rates for other performance measures to DOM no later than June 15, 2012.

c. Verify performance measures to confirm that the reported results are based on accurate source information

3. A review, conducted within the previous three-year period, to determine the CCO's compliance with standards [except with respect to standards under 438.240(b)(1) and (2), for the conduct of performance improvement projects and calculation of performance measures respectively] established by the State to comply with the requirements of 438.204(g).

The EQRO will review CCOs' compliance with State's standards for access to care, structure and operations, and quality measurement and improvement. These standards are listed in Appendix A.

The Contractor must follow CMS's most current Monitoring Medicaid Managed Care Organization (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al.

The Contractor shall validate CCO compliance annually. The Contractor shall perform the following seven (7)activities that comprise this protocol:

a. Planning for compliance monitoring activities

b. Obtaining background information from DOM

c. Documenting review

d. Conducting interviews

e. Collecting any other accessory information (e.g., from site visits)

f. Analyzing and compiling findings

g. Reporting results to DOM

In addition to the federally mandated activities, the Contractor shall perform the following activities:

1. Participate in the State's Quality Leadership Team and Quality Task Force.

   These committees are comprised of DOM representatives, CCO representatives (including CCO Quality Manager, Medical Director, and others), providers, beneficiaries, advocates and other stakeholders. Together these committees are responsible for advising DOM regarding the development of and compliance with the MississippiCAN Quality Strategy, and for conducting ongoing monitoring of the performance of the MississippiCAN program.

   The Contractor shall participate in regularly scheduled meetings of the MississippiCAN Quality Leadership Team and Quality Task Force. Upon DOM request, the Contractor will prepare and present information and consult to these committees.

2. Validate consumer and provider surveys on quality of care.

   The Contractor must follow CMS's most current Administering or Validating Surveys protocol. The protocol specifies the following seven activities that the Contractor must undertake to assess the methodological soundness of a given survey:

   a. Review survey purpose(s) and objective(s)

   b. Review intended survey audience(s)

   c. Assess the reliability and validity of the survey instrument

   d. Assess the sampling plan

   e. Assess the adequacy of the response rate

   f. Review survey data analysis and findings/conclusions

   g. Document evaluation of survey

The DOM is also considering requesting the EQRO participate in the following activities in years following the initial implementation year:

a) Conduct performance improvement projects in addition to those conducted by the CCOs and validated by the EQRO.

b) Conduct quality studies that focus on a particular aspect of clinical or non-clinical services (i.e., hospital readmissions, emergency room admissions, etc.)

The EQRO will use the EQR protocols developed by CMS to perform the mandatory activities required of EQROs as described in 42 CFR 438.352 and 438.358 to evaluate the quality and appropriateness of care and services, synthesize results compared to standards and develop recommendations based on the findings. The protocols developed by CMS used to complete these activities include:

- Data to be gathered
- Data sources
- Activities to ensure accuracy, validity and reliability of data
- Proposed data analysis and interpretation methods
- Documents and/or tools necessary to implement the protocol

To complete these activities, the EQRO will conduct medical chart reviews, provider surveys and CCO case management file reviews, per the CMS protocols. Using these findings, the EQRO will produce a technical report describing the conclusions regarding quality, timeliness, and access to care furnished by the CCO and recommendations for improving the quality of health care by the CCO. This report is a requirement of CMS as noted in 42 CFR 438.364.

The DOM reviews and provides feedback to the EQR regarding the technical report and results. Using the results and data compiled by the EQR, DOM is able to identify opportunities for process and system improvements and Performance Improvement

Projects. As appropriate, and in addition to DOM's regular monitoring of the CCOs, CCO compliance with federal and State requirements is also monitored using the EQR reports.

The State will ensure that the EQRO has sufficient information for the review from the mandatory and optional EQR-related activities described in the regulation as mentioned in 42 CFR 438.350. This information will be obtained through methods consistent with established protocols, include the elements described in the EQR Results Section, and results will be made available as specified in the regulation.

If a CCO is non-compliant during any aspect of the EQR process, development of a CAP is required to address areas of noncompliance including a time line for achieving compliance. DOM may request the EQR to provide technical assistance regarding compliance review report findings and effectiveness of CAPs. CCOs submit CAPs to DOM for review and approval prior to implementation. DOM monitors progress of these corrective actions through several mechanisms that may include internal meetings with the CCO, on-site CCO audits and review of CCO reports. As per federal requirements, the EQRO reviews CCO CAPs for effectiveness as part of the annual compliance review.

Performance Measures and Performance Improvements

The DOM, in conjunction with input from the Leadership Team, Quality Task Force, the CCOs and other stakeholders, has identified a set of performance measures and focused topics for required performance improvement projects (PIPs). These State-mandated measures and projects address a range of priority issues for the MississippiCAN population. The State identifies the measures through a process of data analysis and evaluation of trends and costs within the MississippiCAN population. See Appendix A for a list of the Performance Measures.

Final selection and approval of performance measures, focused topics and PIPs is the responsibility of DOM, with significant input from the Leadership Team, the Quality Task Force and the CCOs. State specific performance measures are reported by the CCOs and results are reviewed monthly, quarterly or annually by DOM, depending on the priority of the performance measure. The Leadership Team and Quality Task Force review validation

results of the PIPs on an annual basis in conjunction with the EQRO compliance report results, and more frequently as designated by DOM.

State-Specific Mandatory Performance Reporting

A goal of the State is to have accurate data that clearly reflects the performance of the CCOs in managing the delivery of healthcare to their MississippiCAN beneficiaries. Currently, the State requires annual, biannual, quarterly and monthly reports for a number of performance metric results. The CCO submits the results in a State-mandated format using State-specific definitions, and required timeframes for calculation and reporting. At a minimum, on a monthly basis DOM staff meets with each of the CCOs to discuss findings from these reports, to identify any deficiencies and to develop or monitor action plans addressing these deficiencies. These reports include:

MississippiCAN Performance Improvement Projects

CMS requires PIPs as an essential component of a CCO's Quality Improvement Program. The purpose of a PIP is to identify, assess and monitor improvement in processes or outcomes of care.

Because the CCOs will not have calendar year 2011 baseline data until early 2012 to identify which PIPs would be most important to implement, DOM has mandated each CCO conduct four (4)Focused Studies in calendar year 2011. The Focused Study is the first step in identifying an appropriate PIP; the purpose of a Focused Study is to collect data that will be used to develop PIPs that are relevant to DOM's priorities. In subsequent years, DOM will require each CCO to conduct a least two (2)PIPs annually.

In year one of the CCO contract, DOM gave the CCOs the option of selecting Focused Study topics based on any one of the seven top priority disease conditions as designated by DOM. Whenever possible, DOM encourages CCOs to utilize HEDIS specifications when appropriate. The CCOs selected the following disease conditions for their Focused Studies for calendar year 2011:

- Obesity

- Diabetes
- Asthma – children
- Congestive heart failure

Upon completion of the Focused Studies, the CCOs will review Focused Study findings, claims data and HEDIS data, and other sources of data and develop goals based upon evidence-based guidelines.

State Standards

In an effort to provide adequate access to care for the MississippiCAN populations, all standards for access to care, structure and operations, and quality measurement and improvement (listed in Appendix A and throughout the Quality Strategy document) were incorporated in the CCO contract/RFP, which is in accordance with Federal Regulations. The following is a summary of some of the general contract requirements/standards.

Access to Care Standards

The CCOs are contractually required to:

- Provide an adequate network that meets the standards dictated by DOM
- Identify network gaps and recruit providers
- Conduct access and availability audits and report results to DOM
- Implement a comprehensive care management program for all beneficiaries
- Maintain disease management programs that focus on chronic or high-cost diseases
- Ensure that all covered services are available to beneficiaries, including case management and continuity of medical care

- Provide a system of utilization review and conduct initial and continuing authorizations of services

For additional detail on contract standards related to access to care, see Appendix A.

Structure and Operations

The CCOs are contractually required to:

- Provide all enrollment notices, informational materials and instructional materials relating to beneficiaries in a comprehensive form
- Maintain enrollee education programs
- Provide an enrollee identification card, enrollee information packet and enrollee handbook to each enrollee no later than 14 days after notice of enrollee's enrollment
- Maintain a grievance/appeals system and inform beneficiaries of their right to file a grievance and appeal, and the processes for doing so
- Maintain a reporting system for all grievances and appeals, and submit regular reports to DOM
- Provide for enrollee continuous open enrollment
- Follow DOM-mandated policies and procedures outlining the process for submission of encounter claims
- Maintain systems for collecting and reporting data
- Maintain HIPAA and all other relevant confidentiality requirements

For additional detail on contract standards related to structure and operations, see Appendix A.

Quality Assessment and Performance Improvement

The CCOs are contractually required to:

- Implement a Quality Management System and Quality Improvement Program
- Annually measure provider performance
- Conduct an annual enrollee satisfaction survey
- Conduct Focused Studies and Performance Improvement Projects
- Provide a system of utilization review
- Participate in DOM quality committees

For additional detail on contract standards related to Quality Assessment and Performance Improvement, see Appendix A.

Monitoring Mechanisms – State Monitoring and Evaluation

The DOM monitoring staff monitors compliance with reporting requirements and reviews selected measures and metrics to ensure that CCOs are operating in the most efficient and effective manner consistent with Federal and State requirements, and are providing appropriate patient care and services. The scope of DOM's monitoring includes reviewing evidence of ongoing improvement efforts and resulting outcomes. On an ongoing basis, DOM provides feedback to the CCO should results indicate non-compliance or sub-standard performance. In addition, the DOM monitoring staff strives to maintain a collegial relationship with the CCOs, evaluating and providing feedback regarding identified opportunities for improvement, including analysis of trends, brainstorming interventions for improvement, addressing systemic barriers to quality improvement or requesting additional data. Re-measurement occurs in the appropriate period following new implementations.

Mechanisms

As required by CFR 438.204(b) (3), Mississippi DOM regularly monitors and evaluates CCO compliance with the contract standards. DOM requires that the CCO develops and implements a quality plan that is consistent with the Quality Strategy and approved by the Leadership Team and Quality Task Force. In addition to regular ongoing monitoring, other monitoring methods include:

Member Satisfaction Survey

DOM requires each of the CCOs to administer the CAHPS survey, an assessment of consumer satisfaction with the health plan and health plan services, on an annual basis. The CCOs contract with independent CAHPS survey organizations, accredited by the National Committee for Quality Assurance (NCQA) to administer the survey. The CAHPS survey organizations administer the survey annually to a statistically valid random sample of clients who are enrolled in the MississippiCAN program at the time of the survey. The standardized survey tool includes questions designed to assess specific dimensions of client satisfaction with providers, services, delivery, and quality, including but not limited to:

- Overall satisfaction with CCO services, delivery and quality
- Enrollee satisfaction with the accessibility and availability of services
- Enrollee satisfaction with quality of care offered by the CCO's providers

For calendar year 2011, DOM requires the CCOs to conduct only the basic CAHPS survey, but DOM will consider expanding the scope of the survey to include program-specific custom questions in subsequent years.

Provider Satisfaction Survey

DOM requires each CCO to conduct an annual Provider Satisfaction Survey. DOM approves the survey questions and methodology; the Leadership Team, the Quality Task Force and DOM review the results of the survey. Provider responses to the survey

questions assist the CCOs in identifying areas for improvement and developing action plans.

Grievance and Appeals Logs and Reports

For each of the CCOs, DOM staff reviews grievance and appeals logs and reports on a regular monthly basis. DOM staff meets with representatives of each of the CCOs to discuss specific grievances and appeals, to identify trends, to address resolution, to identify barriers to improvement, and to assess quality and utilization of care and services. Results from ongoing analysis are applied to evaluation of compliance with quality expectations. The CCOs also submit a regular monthly Management Report that summarizes grievances and appeals by category. The CCOs are also required to submit this summary report to the Leadership Team and Quality Task Force for their review and analysis.

HEDIS and Other Performance Measure Results

For calendar year 2011, the CCOs are collecting baseline data and calculating baseline rates for the performance measures identified in Appendix B. Many of these performance measures are based on HEDIS, and for those measures not based on HEDIS, DOM has provided technical specifications regarding how the CCOs must collect and report data and rates. In subsequent years, DOM will require the CCOs to meet specific performance targets for each of these performance measures.

CCO Reporting

As previously described, the State conducts monthly, quarterly, bi-annual and annual review of numerical data and narrative reports that describe clinical and quality related information on health services and outcomes.

MCO Performance Improvement Projects (PIPs)

In the first year of the MississippiCAN program, the CCOs will each conduct Focused Studies chosen from among a short list of DOM clinical priorities. In subsequent years, the CCOs will conduct PIPs, which will be approved by the Leadership Team and the Quality

Task Force. The EQRO will review the results of each of these PIPs, and will analyze the findings, compare the actual results to expected outcomes, and advise DOM and the CCOs whether to continue or adjust the focus of the PIPs, based on these results.

In addition, the CCOs suggest that the following tools and information be used to continue monitoring the programs:

- Annual Evaluation of the Quality Improvement Program
- HEDIS data
- CAHPS findings
- Pursing and obtaining NCQA accreditation
- Analysis of baseline performance measurements
- Review of GeoAccess reports
- Claim data reports
- Review of policies and procedures
- Review of grievance, appeal and complaint reports
- ESPDT data
- Evaluation of data collection and medical record systems
- Assessment of clinical care standards
- Review of practice guidelines

Health Information Technology

At the cornerstone of many quality initiatives, is the reliance on data. The need for real-time, point of care data that provides clinicians with improved clinical support based on individual health history and population-based analyses will allow providers and programs to improve quality outcomes for patients and Medicaid beneficiaries more efficiently than ever before. The emerging trends for some of the key tenets of Mississippi's Medicaid program - Medical Home Models, patient-centered healthcare, patient incentive programs, payment transformation - all require improvements to health information technology. Improvements at the micro level include adoption and use of Electronic Health Records (EHRs) and the ability to exchange data captured via the EHRs. Improvements at the macro

level including transformations to MMIS systems via ICD-10 conversion, Medicaid Information Technology Architecture (MITA) compliance, development of Health Information Exchanges and Health Benefit Exchanges to offer gateways for critical and life-saving data exchanges.

Knowing this, Mississippi has embarked on several strategies to improve the health information technology infrastructure with the goal of improving the quality of healthcare for all residents of Mississippi. Some of these efforts include:

- Broadband Initiatives
- State Department of Health, Health Data Registry
- Mississippi Health Information Network (MS-HIN)
- Medicaid Electronic Health Records System and ePrescribing System (MEHRS/eScript)
- Recent procurement for an MMIS overhaul
- Collaboration with Federally Qualified Health Centers and Regional Extension Centers

Broadband Initiatives

The State of Mississippi has had a public mandate to improve access to broadband technology since 2003 when the Mississippi Broadband Technology Development Act was passed (Miss. Code Ann. § 57-87-1 et. seq.). The Mississippi Broadband Task Force was founded in 2004 to promote citizen use of the Internet with a plan and broadband strategy. Since that time, the State has been moving forward with planning and implementation of improved access to broadband services. Over $77 million in grant funding was awarded to the Office of the Governor through federal broadband stimulus programs. The funding is used to expand broadband access and adoption in communities across the State of Mississippi. Specifically, the State is participating in the national broadband mapping and planning initiative through the Broadband Technology Opportunities Program (BTOP) administered by the Department of Commerce (DOC).

The broadband infrastructure provides the communication support to some of the most rural and underserved areas of Mississippi. Bringing technology to these areas also opens the door for introducing telehealth efforts and allows rural health providers an opportunity to transmit and connect with other health information exchanges. These technologies pave the way for improved access to care and improvements in the care provided.

State Department of Health, Health Data Registry (HDR)

The HDR is designed to improve data quality and efficiency of collection, as well as improve the ease of submission of vital health data, immunizations and disease surveillance. Access to an electronic HDR accessible at the point of care and that is updated in real-time will allow DOM and Medicaid providers a greater opportunity to improve Early and Periodic Screening, Diagnosis and Treatment (EPSDT) measures, track and report disease information.

Currently, the CCOs are working with the State Department of Health to streamline their ability to retrieve data regarding immunizations from the registry, so that the CCOs can effectively reach out on behalf of children and adolescents who are in need of immunizations.

Mississippi Health Information Network (MS-HIN)

DOM participated in the Mississippi Statewide Health Information Network (MS-HIN) Strategic Operational Plan for the State of Mississippi (SOP) effort as a member of the Technical Infrastructure and Finance Domain Groups. The Statewide Health Information Exchange (HIE) SOP was submitted to the Office of the National Coordinator (ONC) in September 2010, and was approved in late February 2011. MS-HIN is operational with the original Mississippi Coastal Health Information Exchange (MSCHIE) pilot group and is planning to roll out the first component, DIRECT messaging, in late October 2011. The Mississippi HIN Board is in the process of developing the sustainability model for the network and will launch a marketing initiative once it is approved.

Medicaid sponsored EHR, MEHRS/eScript

DOM has launched and is actively using the MEHRS/eScript system. The MEHRS/eScript system, powered by Shared Health, offers providers an EHR that could aid them in meeting the Meaningful Use criteria. The smart analytics and predictive modeling enables improvement of care for Medicaid beneficiaries, while concurrently managing and reducing the cost of care.

MEHRS/eScript launched in June 2010 supporting over 775,000 beneficiaries and has attained community adoption exceeding 2,000 providers and 1,200 clinical and staff users. The adoption of this product for practices with and without an existing EHR has exceeded DOM's goals and expectations.

The future versions of the MEHRS/eScript product will incorporate additional standards-based transactions, transactions for clinical data, EHR certification for the product, and integration opportunities for workflow and data integration with providers' practice management and other vendor EMR/EHR systems.

The MEHRS/eScript solution is currently in Phase 3, and DOM will now offer participating providers the following functionality during this phase:

- Certified EHR – Certified by one of three ONC certification bodies
- Population management and predictive modeling tools and reporting
- Strategically selected and prioritized Mississippi communities for connectivity
- Deployment of community clinical outreach programs for identified Mississippi
- communities
- Workflow and data interoperability with the Statewide HIE (MS-HIN)
- Incorporation of lab and radiology reports into the clinical data offering
- Workflow and data interoperability with requested practice management and EHR systems through Continuity of Care Document (CCD) exchange or through customized data interfaces and single sign-on patient-in-context interfaces
- Data exchange with the State Department of Health for the Immunization Registry and with additional State agencies.

In addition, one CCO is in the process of providing access to the Preferred Drug List through Epocrates. Epocrates is a drug database that lists preferred or non-preferred medications and any prior authorization requirements. This tool is an adjunct to e-prescribing and is an initiative that would allow providers to view prescribing information while they are seeing a beneficiary during an office visit, promoting compliance with covered services.

MMIS Overhaul and Other MMIS Initiatives

DOM has specific goals to achieve a new Medicaid Management Information System (MMIS) within the next three (3) years. With that effort, DOM will: 1) achieve greater interoperability with its providers; 2) continue to provide an EHR system with enhanced health record sharing functionality; and 3) promote adoption of EHR technology for its providers with the goal of promoting coordinated health care for its beneficiaries and better health care outcomes. The effort to promote electronic exchange of health care data for the benefit of the patient will be enhanced by the improvement of access to broadband technology for the citizens of Mississippi.

These solutions will allow our providers and our program greater opportunity to track the health of our beneficiaries, develop initiatives to better meet their needs and to render optimal health outcomes.

Currently, one CCO is educating their providers on secure web portal features and benefits when enrolling them in the pay-for-performance program. The web portal is configured to allow providers to request prior authorizations, view and file claims, and check benefits and eligibility. The secure web portal allows providers the ability to access information twenty-four hours per day. To assure continuous improvement to the web portal, the CCO's web IT team has collaborated with the University of Mississippi Medical Center in an initiative to provide critical feedback for enhancements to the web portal from the provider perspective. Continuing to adapt health information technology capabilities with provider feedback allows more enhanced usage of the programs and encourages provider usage.

In addition, DOM will work closely with our CCOs to encourage provider use of these resources and to capitalize on these benefits to comprehensively address the needs of our beneficiaries.

MMIS Challenges

DOM holds the CCOs responsible for outreach to the guardians of those children and adolescents in need of immunizations. Free clinic providers administer many immunizations without submitting a claim to DOM, limiting DOM's ability to track the number of immunizations provided. Free clinic providers may report immunizations to the State Department of Health (SDH) registry.

However, currently the process for retrieving up-to-date immunization data from the SDH registry is cumbersome. Although the number of children and adolescent beneficiaries in the MississippiCAN program is relatively small, the CCOs are challenged to identify those children and adolescents who have received immunizations so that the CCOs can target those beneficiaries still in need of immunizations. DOM supports the CCOs' efforts to work with SDH to simplify the data retrieval process and DOM will evaluate the effectiveness of these efforts by evaluating EPSDT reports and HEDIS measures related to childhood and adolescent immunizations.

Improvements and Interventions

This section describes how, based on assessment activities, DOM will attempt to improve quality of care, and specifically, what processes and tools DOM will use to improve performance in meeting the Quality Strategy's objectives. DOM will determine interventions for quality improvement based on review and analysis of baseline data, results of quality improvement activities and ongoing assessment of members' health care needs. The following is a description of the process DOM will use, along with a brief description of the various program components.

Performance Measures

The Leadership Team and Quality Task Force will assist DOM in analyzing HEDIS, CAHPS, utilization data and other performance data. Other topic-specific workgroups, as established by the Quality Task Force, will provide valuable feedback on specific clinical and operational topics. For example, one of the challenges already facing the MississippiCAN program is the inappropriate use of the emergency room. The Quality Task Force could consider forming a workgroup comprised of CCO representatives to research clinical best practices, conduct a root cause analysis to help identify reasons for inappropriate emergency room usage and to work with Mississippi hospitals to attempt to address this over-utilization problem.

Performance Improvement Projects (PIPs)

DOM pre-approves and monitors each CCO's Quality Improvement Workplan and its corresponding quality improvement initiatives, and works closely with the CCOs to help them identify appropriate PIPs that focus on DOM priorities and the needs of MississippiCAN beneficiaries. It is the hope of DOM that the quality improvement initiatives implemented by the CCOs will provide the impetus for large-scale quality improvement activities, with CCOs collaborating with each other and with other Medicaid stakeholders statewide. Toward that end, DOM mandates each of the CCOs to participate in both the Leadership Team and the Quality Task Force, with the goal of collaborating to make the best use of available resources and target systemic problems and solutions.

The CCOs are currently collecting 2011 HEDIS data and plan to align their 2012 PIPs with HEDIS measures. The CCOs plan to select their 2012 Focused Studies based on the 2011 HEDIS data. Using the HEDIS data as baseline data for the 2012 Focused Studies, the CCOs plan to conduct two two-year long longitudinal PIPs. The CCOs would like to work together on the PIPs and may consider holding committee meetings to bring more stakeholders together to accomplish the initiative and assure a consistent message to providers.

In addition to the mandatory PIPs, one CCO is conducting the following initiatives:

- Analysis of overutilization of drugs for members enrolled in hospice
- Analysis of underutilization of drugs for members identified with a sickle cell diagnosis
- Increased flu vaccine administration for members with a diagnosis of asthma and/or Chronic Obstructive Pulmonary Disease
- Increased adherence to asthma medications for children
- Achievement of an EPSDT screening rate of not less than 85 percent and 90 percent immunization rate for members under age 12 months by increasing access to EPSDT services

Input for Cross Organizational Opportunities

Representatives of other Medicaid bureaus and state agencies will participate in the Leadership Team and the Quality Task Force and workgroups. As a result of this participation, it is DOM's intention to bring a variety of stakeholders together across the table and addressing common concerns and issues in a deliberate and expedited manner. Additionally, DOM and the CCOs are working with other community resources and agencies. For example, one of the CCOs is collaborating with the State Department of Health and Department of Mental Health to educate the agencies on the MississippiCAN program and the value added benefits and services provided to beneficiaries enrolled in the program. The CCO has also initiated coordinated integrated case conferences with mental health providers to support treatment plans, promote medication compliance, coordinate discharge planning and improve follow-up with outpatient visits.

DOM plans to build on this collaborative model and involve other agency representatives to help drive additional quality improvement initiatives.

Progress Towards Goal Achievement

The CCOs have initiatives in place that align with the MississippiCAN goals to improve access and quality of care by providing comprehensive services through an efficient, cost

effective system of care. For each MississippiCAN goal, the primary initiatives that the CCOs are currently conducting to reach each goal are described as follows:

Improve access to needed medical services

- *Targeted case management* helps beneficiaries get the care and services they need. Connecting beneficiaries with a medical home and implementing comprehensive care management programs promotes coordination of services with primary care providers, behavioral health providers, social service agencies and out-of state providers.

- *Developing a comprehensive, integrated network of service providers* enables beneficiaries to receive needed services that are accessible and available.

Improve quality of care

- *Promoting and assisting beneficiaries in scheduling preventive services*, such as well visits, immunizations, and screenings, encourages beneficiaries to take responsibility for their own healthcare and supports improved health outcomes.

- *Identifying and enrolling high-risk beneficiaries with high-cost conditions such as asthma, diabetes, congestive heart failure and obesity, and providing education for those beneficiaries and their providers* regarding availability of services helps proactively address these high-cost conditions. DOM requires the CCOs 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 failure, hemophilia, and organ transplants. The CCOs are responsible for developing and maintaining enrollee education programs designed to provide the enrollee with clear, concise, and accurate information about the CCO's health plan.

- *Using nationally-accepted Clinical Practice Guidelines and providing education* to beneficiaries and providers about best practices helps to standardize the quality

of care provided to beneficiaries and ensure that beneficiaries are receiving the most appropriate services based on their condition.

Improve efficiencies and cost effectiveness

- DOM expects the CCOs 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.*
- *Conducting prior authorization reviews* helps ensure that beneficiaries are getting the right services, at the right time, in the right setting. CCOs will develop a comprehensive utilization management program to ensure the medical necessity of all services provided.
- *Implementing aggressive Emergency Room (ER) diversion and inpatient readmission avoidance efforts* and steering beneficiaries to their medical homes helps avoid costly and inappropriate emergency room usage and unnecessary inpatient readmissions.

Possible Future Interventions

As baseline data becomes available, the CCOs will continue identifying activities that are in line with MississippiCAN goals and are relevant to their programs or specific beneficiary populations. Through the implementation of Performance Improvement Projects, Focused Studies and other quality improvement initiatives, the CCOs will focus on activities that are objective, clearly defined and measurable. These activities are designed to achieve, through ongoing measurements and interventions, significant improvement over time in clinical and non-clinical areas.

Improvement projects may identify issues and test potential improvement strategies, innovative strategy or potential best practice. Performance Improvement Projects and Focused Studies may reflect the beneficiaries' age groups, disease categories, and special risk status and will include comparable local, state or national information when possible. Currently, the CCOs are collecting and analyzing data to identify potential areas where

improvements in clinical outcomes are relevant to health risks. Such data may include access and availability studies, performance on standardized clinical measures, such as HEDIS, utilization patterns, condition prevalence, member and provider grievance/complaint trends, quality of care and sentinel events, administrative data (claims and encounters), member and provider satisfaction survey results, and evidence of disparities or regional differences.

The CCOs routinely conduct beneficiary and provider outreach through multiple modalities: phone, mail, and web-based communications. One CCO is initiating a Clinical Practice Consultant program that would provide a staff person responsible for outreach to select provider practices. The program might include sponsored clinic days for specific preventative screenings.

In addition to the mandatory focused studies, the CCOs may perform focused studies on topics prevalent and significant to the population served. The clinical focus areas could include prevention and care of acute and chronic conditions, high-volume services, and high-risk services. Non-clinical focused studies may address continuity or coordination of care, appeals grievances or complaints, or access to and availability of services. As discussed in the Performance Improvement Project section of this Quality Strategy, collection and analysis of baseline data is currently occurring to narrow the focus to more specific indicators for measurement, intervention and re-evaluation. The indicators will measure changes in health status, functional status, enrollee satisfaction, or valid proxies of these outcomes. The objective of the focused studies will be to assess processes and outcomes.

The CCOs encourage NCQA accreditation and the use of nationally standardized HEDIS benchmarks for performance measurement. The plans are pursuing NCQA New Health Plan Accreditation and use evidence based clinical and non-clinical guidelines, industry standards and contractual requirements to develop performance indicators, set benchmarks and/or performance targets, and design projects and programs to optimize health outcomes and member satisfaction.

Additionally, the following interventions are in place or under development:

1. Aggressive enrollment of members into care management programs
2. Targeted case management enrollment for members with a Sickle Cell diagnosis
3. Targeted case management enrollment for members with frequent ER utilization
4. Targeted case management enrollment of pregnant members into the Start Smart for Your Baby and Healthy First Steps programs
5. Targeted transitional case management for members being discharged from the hospital or a free-standing skilled nursing facility
6. Targeted EPSDT outreach to enrollees under age 12 months to ensure compliance with the six (6) periodicity screens and the immunization schedule
7. Target disease management enrollment for the following diagnoses: diabetes, asthma, COPD, hypertension, congestive heart failure, obesity, smoking cessation, hemophilia, and organ transplantation
8. Ongoing member outreach through Welcome Calls to assist with the:
    a. Selection or change of a primary care provider (PCP)
    b. Coordination of a PCP appointment
    c. Education on MississippiCAN covered services and benefits
    d. Completion of a Health Risk Screening to identify:
        - Member risk factors
        - Special needs (cultural and linguistic)
        - Visual or hearing impairments
        - Barriers to obtaining treatment (transportation/childcare needs)

- Continuity and care coordination needs
- Educate female enrollees on the ability to directly access women's health specialists for routine and preventive health care services without a referral
- Members who may benefit from case management and disease management program enrollment and ongoing monitoring
- Members who need EPSDT services
- Members who require linkage to social, behavioral and community services
- Caregiver and personal resource issues

The CCOs will continue to develop appropriate interventions as the MississippiCAN program matures.

Pay for Performance

DOM allows the CCOs to offer non-cash incentives to their enrolled members for the purposes of rewarding compliance in securing immunizations, prenatal visits, or participating in disease management, and encourages the CCOs to use items that promote good health behavior, e.g., toothbrushes or immunization schedules.

Both CCOs include provider pay for performance initiatives in their programs, although they are at various stages in the development and implementation of their respective programs. One CCO began making payments in January based on provider compliance with HEDIS metrics; providers receive incentive payments when they submit appropriate HEDIS codes on their claims. The other CCO is collecting and analyzing baseline data, which will enable the CCO to implement a targeted pay-for-performance program based on compliance with HEDIS measures.

Quality Strategy Review and Effectiveness

DOM takes the lead on soliciting input on the Quality Strategy from a number of sources. On at least an annual basis, the Leadership Team and the Quality Task Force evaluate the effectiveness of the quality strategy and revise the strategy based upon analysis of the results. The QMS may be reviewed more frequently if significant changes occur that impact quality activities or threaten the potential effectiveness of the strategy.

Concurrent with the review of the Quality Strategy, the CCOs are conducting annual program evaluations. (For calendar year 2011, DOM required the CCOs to report on a semi-annual basis, six months after program implementation.) The end product of this evaluation is a proposed work plan consistent with the overall quality strategy and informed by the results of the CCOs' annual program evaluations. In subsequent years, the annual report of the External Quality Review will also be incorporated into the development of the work plan, and DOM will solicit input from the EQRO. In addition, the work plan will reflect input from the DOM staff, the Leadership Team and the Quality Task Force, and may reflect feedback from other sub-committees, governmental agencies, providers, beneficiaries, and advocates. These sources help DOM to determine areas of

focus for quality activities such as quality improvement measures, improvement projects and performance indicators.

As part of this review, the effectiveness of the Quality Strategy will be evaluated to determine whether potential changes to the quality strategy may be needed. Should the Leadership Team, the Quality Task Force and/or DOM determine that the change is significant enough to require additional stakeholder input, these groups may solicit additional feedback. DOM may also consider developing a sub-committee of the Quality Task Force, with the specific role of conducting ongoing review of the Quality Strategy and informing DOM of its recommendations regarding the Strategy.

The Quality Task Force, and subsequently the Leadership Team, will review and revise the Quality Strategy before it is finalized. The Leadership Team, with ultimate responsibility for approving and monitoring the Quality Strategy, may also solicit additional feedback and public input. Following DOM's approval of the Quality Strategy, DOM will discuss any amendments or major revisions to the Quality Strategy with CMS.

CCO Reporting Requirements

See Appendix C for a full list and submission schedule for all regular reports due to DOM from the CCOs. DOM is also in the process of developing additional reporting requirements, to include detailed reporting on the use of services, use of disease management services, and outreach to providers and beneficiaries. Currently, the time frames for the mandatory reports due to the State are:

Monthly Reports

CCOs must submit Monthly Management Reports to DOM by second business day of second month following reporting period, i.e., January 2011 reports were due on March 2. These reports serve as one of the primary monitoring tools for the DOM to measure CCO performance, and are the basis of discussion between DOM and the CCOs regarding CCO contract compliance.

The following reports are due from the CCOs to DOM by the fifth business day of the month following the reporting periods

- New Member Cards
- Returned Membership Cards

The following reports are due from the CCOs to DOM by the fifteenth business day of the month following the reporting periods

- Grievances and Appeals
- Complaint and Grievances Summary and Detail
- Detail Appeals Report
- Detail Enrollment Report

Quarterly Reports

The CCOs submit the Quarterly Financial Report to DOM by the fifth business day of month following reporting quarter.

Bi-annual Reports

The Semi-Annual Quality Management Evaluation (year one only) and Internal Audit reports are due on the first day of the month following reporting period.

Annual Reports

Annual Financial Reports are due on the 30th day following the last month of the reporting period. The Annual Quality Management Evaluation is due on March 1, following the reporting year.

CMS Reporting Requirements

The following is a list of reports DOM will provide to CMS on behalf of the MississippiCAN program, with a timeline for reporting Quality Strategy updates to CMS. DOM will submit quarterly reports within sixty (60) days after the close of the quarter.

- DOM will submit to CMS an annual report summarizing the first year of MississippiCAN program implementation (2011) no later than March 31, 2012.
- Beginning in the first quarter of 2012, DOM will submit quarterly reports summarizing progress toward meeting performance targets outlined in the Quality Strategy. The report will include data and results reporting as those are available, and will discuss barriers and trends.
- DOM will submit to CMS the annual 416 EPSDT report.
- Subsequent annual reports will provide a general assessment of the effectiveness of the Quality Strategy including but not limited to the following:
    - quantifiable achievements, with supporting data
    - discussion of variations from expected results
    - barriers and obstacles encountered, with proposed interventions to overcome barriers
    - how health outcomes improved as a result of Quality Strategy initiatives
    - best practices and lessons learned with proposed changes to the following years' Quality Strategy
    - proposed program or policy changes to reflect the findings of the annual program evaluation
    - a work plan outlining steps toward implementing changes

Achievements and Opportunities

By continuing to monitor the Quality Strategy, DOM and the CCOs will have the opportunity to highlight its successes and share what has been effective in improving health care quality and service. Additionally, DOM believes that learning from the challenges that the CCOs encounter and reviewing both successful and unsuccessful responses to the challenges will result in a stronger overall program that will improve the quality of care for MississippiCAN beneficiaries.

Successes and Best Practices

The CCOS have identified the following initiatives as their most successful current activities and best practices:

- Collecting and analyzing HEDIS data. Although the MississippiCAN program was implemented in January 2011, the CCOs have already begun to implement a number of quality initiatives related to improving HEDIS rates and are currently preparing for collecting and reporting HEDIS rates for calendar year 2011.
- Offering MississippiCAN beneficiaries unlimited office visits, when heretofore services were limited. This expanded benefit option encourages the beneficiary to use preventive and disease management services, with a resulting positive impact on quality of care, access to care, effectiveness of care and improved health outcomes.
- Conducting live member outreach calls to remind members of services due and offer assistance with scheduling appointments.
- Providing integrated care management programs that encompass both members' disease state management educational needs and any ongoing case management needs. The maternity care management program encompasses prenatal, postpartum and NICU outreach and care management.

- Partnering with national organizations such as Sesame Street on a campaign to promote lead screening to providers and beneficiaries.

- Offering a Clinical Practice Consultant Program that targets provider practices and provides feedback and education on medical record documentation, coding and clinical practice guidelines.

- Providing both local and regional integrated care teams and provider relations teams so that all beneficiaries and providers have access to CCO representatives regardless of geographic location. Hiring staff from within the communities in which they serve promotes enhanced care coordination because of the staff person's familiarity with the providers and facilities in the area in which the beneficiaries reside and receive services.

- Contracting with high volume hospitals such as University of Mississippi Medical Center.

Opportunities

DOM and the CCOs have identified several areas of opportunity on which to focus, especially within the first year of the program:

- *Address Inappropriate Inpatient Readmissions*: Both of the CCOs have already implemented case management interventions for reducing inpatient readmissions. DOM requires the CCOs to achieve a 10 percent savings for inpatient services within the first year of the program.

- *Reduce Inappropriate Emergency Room Utilization*: Both CCOs have implemented aggressive strategies to reduce inappropriate emergency room utilization. For example, one of the CCOs has set an internal goal of reducing emergency room visits by six (6) percent by the end of calendar year 2011.

- *Expand the MississippiCAN network*: DOM and the CCOs are working together to offer provider workshops to inform existing providers, including out-of-state

providers from border states, who may have been reluctant to join the MississippiCAN network about the benefits of the program for the providers and their patients. The workshops are one tool DOM and the CCOs are using to recruit additional providers.

- *Expand the MississippiCAN program*: DOM and the CCOs hope to enroll the maximum allowable fifteen (15) percent of Medicaid beneficiaries into the MississippiCAN program. MississippiCAN stakeholders agree that as the program matures, and as additional beneficiaries are enrolled and the provider network continues to grow, both providers and beneficiaries will come to understand and appreciate the benefits of the program. As a result, knowledge of program successes will help entice additional providers and their patients to enroll in the program.

Summary

The MississippiCAN Quality Strategy is an evolving comprehensive plan that incorporates quality assurance monitoring and ongoing quality improvement processes to coordinate, assess, and continually improve the delivery of quality care and services to MississippiCAN beneficiaries. The Quality Strategy provides a framework to communicate DOM's goals and objectives to the CCOs and other stakeholders, while focusing on strategies that consider health care cost, quality, and timely access to care.

The Quality Strategy will evolve as the program continues to grow, more data are available and DOM gathers additional feedback from stakeholders, beneficiaries, providers and State agencies. The CCOs and DOM are committed to appropriately updating the Quality Strategy as the program develops, and to using the Quality Strategy as an important tool and roadmap for continuous quality improvement.

Appendix A – Monitoring Standards

Monitoring Standards	
Administrative Requirements	
1.	CCO must operate and maintain an Accounting System that meets GAAP or can be reconciled to meet GAAP.
2.	CCO must submit to the DOM copies of all quarterly and annual filings submitted to the Department of Insurance.
3a.	CCO must acknowledge receipt of the DOM's written electronic or telephonic request within two (2) business days.
3b.	CCO shall have at a minimum key management personnel or persons with comparable qualifications.
3c.	CCO must have sufficient local and toll free lines and call distribution and monitoring system sufficient to meet the needs of enrollees and providers 24 hours/7days a week.
4.	CCO must develop and follow policies and procedures outlining the process for submission of encounter claims.
5.	CCO must demonstrate cultural competency for all written and verbal communications with enrollees and providers.
6.	CCO must annually provide a health education and prevention plan to DOM.
7.	CCO shall maintain detailed records evidencing administrative costs and expenses incurred pursuant to the contract.
8.	CCO shall not subcontract any portion of the services performed under the Contract without prior written approval of DOM.
9.	CCO must maintain a system that collects data on enrollee and provider characteristics, i.e., trimester of enrollment, tracking of appointments kept and not kept; place of services; provider type; and low birth weight as associated to age.
Member Services	
1a.	CCO must provide all enrollment notices, informational materials and instructional materials relating to enrollees in a comprehensive form.
1b.	CCO must make oral interpretation services available free of charge.

Appendix A – Monitoring Standards

Monitoring Standards	
1c.	CCO must maintain enrollee education programs designed to provide the enrollee with clear, concise and accurate information about the CCO's health plan.
2a.	CCO must provide enrollees an information packet including an ID card and member handbook listing all covered services no later than 14 days after notice of enrollee's enrollment.
2b.	CCO must submit annually a copy of the Enrollee Information Packet to DOM.
3.	Enrollees must have the opportunity to choose from at least two primary care providers (PCP) affiliated with the CCOs within 30 days.
4.	CCOs must ensure enrollees are notified of their rights and responsibilities.
5.	CCOs must maintain a grievance system.
6.	CCO must develop and maintain an Enrollee Education Program.
7.	CCO must ensure all written materials do not exceed the 6th grade level of reading comprehension.
8.	CCO must ensure proper notice is given to enrollees for all written notices.
9.	CCO must provide for a continuous open enrollment period throughout the term of the Contract.
10.	CCO must institute a mechanism and ensure access to providers for all Enrollees who do not speak English.
11.	CCO shall develop marketing materials.
12.	CCO shall develop and maintain procedures to log and resolve marketing complaints.
13.	CCO shall develop enrollee notices, grievances, and appeals procedures.
14.	CCO shall develop an Appeal Process to allow for expedited resolution.
15.	CCO shall develop, document and maintain advance directive policies that comply with 42 CFR and with State Law.
16.	CCO must prepare an Enrollee Handbook and provide Enrollee Handbook to all Enrollees.

Appendix A – Monitoring Standards

Monitoring Standards	
18.	CCO must provide all covered services within the network and have adequate provider network throughout the State.
19.	CCO must ensure that members have access to after hour coverage for emergency services.
20.	CCO must ensure that all members are able to change PCPs.
Covered Services	
1a.	CCO must make all covered services accessible to Enrollees.
1b.	CCO must provide direct access to a women's health specialist within the network.
1c.	CCO must ensure that PCPs are available on a timely basis to comply with access standards.
2.	CCO must ensure coverage for emergency services.
3.	CCO must provide coverage for post-stabilization care for services obtained within or outside the contract.
4.	CCO is financially responsible for services received outside of the plan (i.e., out-of-network providers are reimbursed at 100 percent).
5.	CCO must provide coverage for full range of EPSDT services.
6.	CCO will coordinate with DOM's Non-Emergency Transportation provider to provide services to enrollees.
7.	If the CCO elects not to provide, reimburse for or provide coverage of a counseling or referral services because of an objection on moral or religious grounds it must furnish information about the service it does not cover.
8a.	CCO is required to ensure enrollees are able to choose a PCP affiliated with the CCO based on availability.
8b.	CCOs must maintain a diverse network of providers including cultural and ethnic backgrounds.
9.	CCO is required to ensure coverage for case management and continuity of medical care for all enrollees.

Appendix A – Monitoring Standards

Monitoring Standards	
10.	CCO is required to refer enrollees for services not covered under the CCO.
11a.	For standard authorizations, CCO must provide notice within fourteen (14) calendar days following receipt of the request for services.
11b.	For expedited authorization decisions, CCO must provide decision notice no later than three (3) working days after receipt of the request for services.
11c.	CCO will provide for enrollees to have initial and continuing authorizations of services.
12.	CCO shall implement a comprehensive care management program for all enrollees.
13.	CCO shall develop disease state management programs that focus on chronic or high-cost diseases.
14.	CCO must ensure appropriate staff is available to provide access to disease management.
Provider Network Services	
1a.	CCO is required to have a provider network to provide services to all enrollees.
1b.	CCO shall not discriminate against providers with respect to the program.
1c.	CCO is required to recruit and maintain a provider network including all types of Medicaid provider and full range of medical specialties necessary to provide covered benefits. This includes out-of-state providers.
2.	CCO must ensure that primary care physician services are available, on a timely basis, to comply with the following standards: urgent care - within one day; routine sick patient care - within one week; and well care - within one month.
3.	CCO must ensure Out-of-Network providers can verify enrollee's enrollment with CCO.
4.	CCO will ensure that providers will not balance bill enrollees.
5.	CCOs must ensure all laboratory testing sites are CLIA certified.
6.	Within 30 days from the date claims are received by the CCO, the CCO shall process each claim, and for other claims notify the provider of the status of the

Appendix A – Monitoring Standards

Monitoring Standards	
	claim and if applicable, the reason a claim cannot be paid.
7.	CCO must provide all network providers information about the grievance and appeals systems at the initiation of all such contracts.
8.	CCO shall provide a mechanism for providers to appeal the denial of claims by the CCO.
9.	CCO may operate a Physician Incentive Plan.
10.	CCO must provide appropriate maintenance of medical records.
11.	CCO must have a validation process to ensure the quality, integrity, validity and completeness of data submitted by its provider.
12.	CCO must notify PCP providers of any new enrollee within five (5) business days from notice of enrollment.
13.	CCO must ensure emergency medical services are available within 30 minutes typical travel time to beneficiaries 24 hours a day, 7 days a week, either in the facilities of providers who have contracted with the CCO or through arrangements approved by DOM with other providers.
14.	CCO must contract with Federally Qualified Health Centers and Rural Health Clinics.
Reporting Requirements	
1.	CCO will coordinate and submit to DOM all of its marketing schedules.
2.	CCOs will maintain and make available to DOM, CMS, and OIG appropriate reports.
3.	CCOs will maintain a reporting system for all grievance and appeals.
4.	CCOs will disclose ownership and financial information.
5.	CCOs will submit all monthly enrollee reports.
6.	CCO must submit on a monthly basis a report listing the date and number of ID cards mailed to new enrollees and those returned within fourteen (14) days of initial enrollment.
7.	CCO must furnish to DOM at no cost, any records, documents, reports or data

Appendix A – Monitoring Standards

Monitoring Standards	
	generated or required in the performance of this contract.
7b.	CCO must submit all data in an accurate and timely manner.
7c.	CCO must monitor each subcontractor's performance on an ongoing basis and subject it to formal review at least once a year.
Quality and Utilization	
1.	CCO shall implement an Internal Quality Management (QM) System and Quality Improvement (QI) Program.
2.	CCO must operate under a formal organizational structure for the implementation and oversight of the internal Quality Management Program.
3.	CCO must annually measure provider performance.
4.	CCO must semi-annually perform Internal Audit.
5.	CCO shall conduct annual enrollee satisfaction survey beginning six (6) months following enrollment.
6.	CCO shall perform a minimum of four (4) focused studies each year.
7.	CCO shall have internal controls, policies and procedures, and compliance plan to guard against fraud and abuse.
8.	CCO shall provide a system of Utilization Review.
System Requirements	
1.	CCO must be protected against hardware and software failures, human error, natural disasters, and other emergencies that could interrupt services.
2.	CCO must maintain HIPAA confidentiality requirements.
3.	CCO must be in compliance with State and Federal policies and guidelines.
4.	CCO must maintain HIPAA confidentiality requirements regarding claims payment and describe claims processing operations.
5.	CCO system must reconcile eligibility and capitation records.
6.	CCO must accept enrollment data in electronic format.

Appendix A – Monitoring Standards

Monitoring Standards	
7.	CCO must receive and process information from the State and relevant vendor file information.
8.	CCO must use the MIS to process claims.
9.	CCO must submit encounter data directly to DOM fiscal agent.
10.	CCO must provide methods for sharing information for all members, especially those with special health care needs.
11.	CCO must maintain systems to collect, identify and report third party liability coverage.
12.	CCO must maintain a membership system.
13.	CCO must maintain a provider file for all providers in and out of state.

Appendix B – Performance Measures

DOM Performance Measure	Relevant HEDIS Measure(s)	HEDIS 2010 Benchmark: *50th Percentile*[1]
Effectiveness of Care Measures		
1. BMI for adults *Percentage of members who had an outpatient visit and their body mass index (BMI) documented during the measurement period*	Adult BMI Assessment (ABA)	35.28 percent
2. BMI, weight assessment for nutrition and physical activity counseling for children and adolescents *Percentage of members who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year (BMI Percentile Total)*	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – *BMI percentile (Total)*	29.44 percent
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – *Counseling for Nutrition (Total)*	46.23 percent

[1] HEDIS 2010 benchmarks represent calendar year 2009 performance reported by Medicaid health plans to NCQA in 2010. The 50th percentile benchmarks are an indicator that half of the health plans performed above the benchmark rates and half had rates below the benchmark rates.

Appendix B – Performance Measures

DOM Performance Measure	Relevant HEDIS Measure(s)	HEDIS 2010 Benchmark: *50th Percentile*[1]
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – *Counseling for Physical Activity (Total)*	35.58 percent
3. Use of appropriate medications for people with asthma *Percentage of members age 5-11 and 12-50 who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year*	Use of Appropriate Medications for People with Asthma - Total (ASM)	88.57 percent
4. Asthma education and counseling *Percentage of members with asthma who received education/counseling (e.g. mailings, pamphlets, etc.)*	N/A – see monthly Management Report	DOM Target: 85 - 90 percent
5. Lead Screening for Children *Percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday*	Lead Screening in Children (LSC)	71.62 percent

Appendix B – Performance Measures

DOM Performance Measure	Relevant HEDIS Measure(s)	HEDIS 2010 Benchmark: *50th Percentile*[1]
6. Childhood Immunizations *Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday*	Childhood Immunization Status – Combo 2 (CIS) **Note: The HEDIS measure calculates a rate for each vaccine and nine separate combination rates. This sample HEDIS measure uses Combo 2, which is a combination of vaccines.*	76.64 percent (HEDIS) DOM Contract Requirement: Immunization rate of 90 percent[2]
7. Nephropathy screening *Percentage of members with diabetes who received a nephropathy screening test*	Comprehensive Diabetes Care (CDC) - Medical Attention for Nephropathy	77.70 percent
8. Cholesterol screening for diabetics *Percentage of members with diabetes who received a LDL-C screening test*	Comprehensive Diabetes Care (CDC) - LDL Screening	75.36 percent
9. Cholesterol control for diabetics *Percentage of members 18 through 75 years of age with diabetes mellitus (Type 1 and Type 2) whose most recent low-density lipoprotein cholesterol (LDL-C) level is less than 100 mg/dL*	Comprehensive Diabetes Care (CDC) - LDL Poor Control (<100 mg/dL)	33.57 percent

[2] Penalties apply for renewal contract periods only. Achievement of less than 85 percent screening and 90 percent immunization rate will require a refund of $100 per Enrollee for all Enrollees under age 12 months. Also see Performance Measure for EPSDT screenings.

Appendix B – Performance Measures

DOM Performance Measure	Relevant HEDIS Measure(s)	HEDIS 2010 Benchmark: *50th Percentile*[1]
10. Blood sugar poorly controlled in people with diabetes *Percentage of members with HbA1c results greater than or equal to 9.0 percent*	Comprehensive Diabetes Care (CDC) - HbA1c Poor Control (>9.0 percent) **Note: Lower rates are desired for this measure.*	43.23 percent
11. Blood sugar well-controlled in people with diabetes *Percentage of members with HbA1c results less than or equal to 8.0 percent*	Comprehensive Diabetes Care (CDC) – HbA1c Good Control (<8.0 percent)	46.55 percent
12. Ace inhibitor therapy *Percentage of members 18 and older on persistent medications (ACE inhibitors) for at least 180 days who received at least one annual monitoring*	Annual Monitoring for Patients on Persistent Medications (MPM)	84.10 percent
13. Hemophilia *Percentage of members being treated for hemophilia who received at least an annual monitoring*	N/A – see monthly Management Report	DOM Target: 85 – 90 percent

Appendix B – Performance Measures

DOM Performance Measure	Relevant HEDIS Measure(s)	HEDIS 2010 Benchmark: *50th Percentile*[1]
14. EPSDT Screening *Percentage of children age one or under the age of one who received a Periodic Health Screening Assessment*	Quarterly 416 Report	DOM Target: Screening rate of 85 percent. For a child enrolled from birth through 12 months, EPSDT periodicity schedule dictates six (6) screens[3]

[3] Penalties apply for renewal contract periods only. Achievement of less than 85 percent screening and 90 percent immunization rate will require a refund of $100 per Enrollee for all Enrollees under age 12 months. Also see Performance Measure for Childhood Immunizations.

Appendix C – Required CCO Reports

CCO Report	Frequency	Description	CCO Monitoring Purpose
New Member Cards	Monthly	Total number of new enrollees and the number of mailed ID cards	Reconcile the CCO's report to DOM report and ensure that new enrollees receive ID cards timely
Returned Membership Cards	Monthly	Listing of all membership cards returned by Medicaid Identification number	Correct member contact information
Grievances and Appeals	Monthly	Detailed information regarding member grievances and appeals and CCO resolutions	Ensure follow-up and track/trend grievances and appeals
Complaint and Grievances Summary	Monthly	Summary statistics of the number of formal grievances, inquiries and appeals by category	Ensure follow-up and track/trend grievances
Detail Appeals and Enrollment	Monthly	Detailed information regarding member appeals and CCO resolutions	Ensure follow-up and track/trend appeals
Member Enrollment Statistics and Trends	Monthly/Management Report	Summary report of the total number of members enrolled and disenrolled during the month	Reconcile the CCO's report to DOM report, and identify the number of enrollees disenrolling and auto-assigned
Utilization Statistics and Trends	Monthly/Management Report	Summary statistics regarding inpatient (admissions, readmissions and average length of stay), outpatient and ER usage	Track/trend utilization to ensure the CCO is meeting contractual obligations and appropriately managing care
Claims Processing Summary by Claim Type	Monthly/Management Report	Total number of claims received, paid on time, paid late, denied, paid with interest and average lag time	Ensure the CCO is meeting contractual requirements for timely claims payment
Call Center Statistics	Monthly/Management Report	Number of calls received, average speed of answer, call abandonment rate and average wait time for provider and member call centers	Ensure the CCO is meeting contractual requirements for call center performance
Provider Network	Monthly/Management Report	Unduplicated provider count by provider type	Ensure the CCO is providing an appropriate and adequate network
Prior Authorization	Monthly/Management Report	Number of prior authorizations issued and denied by authorization type	Ensure that the CCO is appropriately managing utilization

Appendix C – Required CCO Reports

CCO Report	Frequency	Description	CCO Monitoring Purpose
Member Grievances	Monthly/Management Report	Summary of grievances include complaint types, number filed and summary of resolution.	Track/trend grievances to identify need for programmatic interventions (Summary of information previously presented in detailed reports)
Disease Management and Care Coordination Activity	Monthly/Management Report	Summary of disease management and other care coordination outreach to enrollees	Verify that the CCO is providing contractually required, appropriate services
Quality and Outcome Measures	Monthly/Management Report	Summary of updates to the CCO's Quality Improvement work plan	Verify that the CCO is managing to its Quality Improvement work plans, as approved by DOM
Pilots/initiatives	Monthly/Management Report	Summary of proposed and ongoing pilots or initiatives	Verify that pilots and initiatives are focused on DOM priority and have been pre-approved by DOM
Key staffing updates	Monthly/Management Report	Summary of relevant staffing changes	Verify that the CCO has sufficient and appropriate staffing to manage the program
Recent successes	Monthly/Management Report	Summary of CCO and member successes	Provide an opportunity for the Vendor to discuss "lessons learned" and report program successes
Issues and challenges and/or corrective action plan	Monthly/Management Report	Summary of recent issues, including barriers and possible solutions	Identify issues that may require DOM intervention and may jeopardize program performance
Quarterly Financial Report	Quarterly	Quarterly financial reports in form and content as prescribed by the National Association of Insurance Commissioners (NAIC)	Verify that the CCO is fiscally sound
Annual Quality Management	Annual	Report summarizing the following topics: • CAHPS - Adult and Child Surveys	Verify that the CCO is meeting contractual obligations and has a process in place to

Appendix C – Required CCO Reports

CCO Report	Frequency	Description	CCO Monitoring Purpose
Evaluation		• Provider Satisfaction Survey • Disease Management Survey • Quality Improvement Program Description and Work Plan • Annual Program Evaluation • Audited HEDIS Results	assess the effectiveness of the program and implement continuous quality improvement
Annual Financial Report	Annually	Annual audited financial statements as of the end of each fiscal year	Verify that the CCO is fiscally sound

Glossary

Acronym	Definition
BMI	Body Mass Index
BTOP	Broadband Technology Opportunities Program
CAHPS	Consumer Assessment of Health Providers and Systems
CAP	Corrective Action Plan
CCD	Continuity of Care Document
CCO	Coordinated Care Organization
CDC	Center for Disease Control
CMS	Centers for Medicare and Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
DOI	Department of Insurance
DOM	Department of Medicaid
DOC	Department of Commerce
DSH	Disproportionate Share Hospital
EHR	Electronic Health Record
EMR	Electronic Medical Record
EQR	External Quality Review
EQRO	External Quality Review Organization
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
ER	Emergency Room
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
HEDIS	Healthcare Effectiveness Data and Information Set
HDR	Heath Data Registry
HIE	Health Information Exchange
HIT	Health Information Technology

Glossary

Acronym	Definition
ICD-10	International Classification of Diseases, 10th Edition
MCO	Managed Care Organization
MEHRS/eScript	Medicaid Electronic Health Records System and ePrescribing System
MississippiCAN	Mississippi Coordinated Access Network
MITA	Medicaid Information Technology Architecture
MMIS	Medicaid Management Information System
MSCHIE	Mississippi Coastal Health Information Exchange
MSDH	Mississippi State Department of Health
MS-HIN	Mississippi Health Information Network
NCQA	National Committee for Quality Assurance
NCI	Navigant, Inc
ONC	Office of the National Coordinator for Health Information Technology
PCP	Primary Care Provider
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
QI	Quality Improvement
QM	Quality Management
RFP	Request for Proposal
REC	Regional Extension Center
RHC	Rural Health Clinic
SDH	State Department of Health
SMHP	State Medicaid HIT Plan
SOP	Strategic Operational Plan for the State of Mississippi

Glossary

Acronym	Definition
SSI	Supplemental Security Income
UPL	Upper Payment Limit

MississippiCAN
Quality Strategy – Draft

Glossary