



MISSISSIPPI DIVISION OF
MEDICAID

Comprehensive Quality Strategy

September 10, 2021

The Mississippi Division of Medicaid responsibly provides access to quality health coverage for vulnerable Mississippians.

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Elevating Quality

In accordance with 42 C.F.R. § 438.340, the Mississippi Division of Medicaid (DOM) is releasing this Comprehensive Quality Strategy for 2021 – 2024. Elevating quality remains one of Mississippi Medicaid’s top priorities. The COVID-19 pandemic has caused a dramatic upheaval over the past 18 months, but it has not diminished the importance of fidelity to high-quality care practices. As Mississippi’s largest payer of health care services, DOM recognizes that it is uniquely positioned to drive positive change in the healthcare market.

The Comprehensive Quality Strategy reflects many ongoing and planned quality improvement efforts within the managed care and fee-for-delivery systems. DOM is pleased to share these strategies and hopes they will lead to improvements in the quality of life for Mississippians on Medicaid.

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1. Introduction

The Mississippi Division of Medicaid (DOM) continually strives to improve the quality of care for the individuals we serve. This is conveyed in the mission of DOM to responsibly provide access to quality care for vulnerable Mississippians. DOM’s dedication to quality care is anchored in its values of accountability, consistency, and respect. DOM partners with beneficiaries, providers, and health plans to continue building a Medicaid delivery system that improves the health of populations, enhances the experience of care for individuals, and effectively manages costs of care.

The 2018 Managed Care Quality Strategy has been retooled into a Comprehensive Quality Strategy (CQS) for submission to the Centers for Medicare and Medicaid Services (CMS) in 2021. Creating one overarching quality improvement strategy provides an opportunity to connect the numerous quality improvement efforts occurring throughout at DOM and move toward coordination of all initiatives under a more unified approach. The CQS also provides an overview of the different methods DOM uses to assess the performance of Mississippi’s Medicaid programs, including program improvement activities, performance results, successes, and opportunities for advancement. The CQS aligns with the CMS Quality Strategy as well as the broader aims of the National Quality Strategy.¹

 <p><i>Making care safer by reducing harm caused in the delivery of care.</i></p>	 <p><i>Ensuring that each person and family is engaged as partners in their care.</i></p>	 <p><i>Promoting effective communication and coordination of care.</i></p>	 <p><i>Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.</i></p>	 <p><i>Working with communities to promote wide use of best practices to enable healthy living.</i></p>	 <p><i>Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.</i></p>
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¹ National Quality Strategy Alignment Toolkit. August 2017. <https://www.ahrq.gov/workingforquality/nqs-tools/alignment-toolkit.html>

1.1 Quality Strategy Aims, Goals, and Objectives

DOM aims to ensure access to affordable, high-quality health care for all Medicaid beneficiaries and to work with enrollees, providers, coordinated care organizations, other state agencies, and community partners to achieve quality care services. As DOM endeavors constantly to improve the quality of health care available to its beneficiaries, the agency seeks both evidence-based practices and innovative delivery systems to provide better access for our beneficiaries. At the heart of improvement is the ability to measure outcomes and invest in efforts that produce positive results while pivoting away from strategies that are less successful. To that end, DOM based its comprehensive quality strategy on these meaningful measures for continuous quality improvement, as illustrated in Table 1.

Table 1. Mississippi Division of Medicaid Comprehensive Quality Strategy Aims, Goals, and Objectives

Aims	Goals	Objectives
Accountability Demonstrate good stewardship of public resources by ensuring high-value, efficient services.	Make Care Affordable	<ul style="list-style-type: none"> • Incentivize innovation by advancing value-based payment arrangements. • Minimize wasteful spending by reducing low-value care. • Maintain compliance with state and federal regulatory requirements.
Consistency Improve the health of Mississippi Medicaid enrollees through better prevention, treatment, and evidence-based interventions that address physical, behavioral, and social needs.	Work with Communities to Promote Best Practices of Healthy Living	Partner with communities to improve population health and address health disparities.
	Promote Effective Prevention & Treatment of Chronic Disease	<ul style="list-style-type: none"> • Ensure timely and proximate access to primary and specialty care. • Improve chronic disease management and control. • Improve quality of mental health and substance use disorder care. • Prevent obesity and address physical activity and nutrition in children and adults.
	Make Care Safer by Reducing Harm Caused in the Delivery of Care	<ul style="list-style-type: none"> • Ensure maternal safety and appropriate care during childbirth and postpartum • Reduce medication errors and improve adherence to medication regimen.
Respect Make health care more person-centered, coordinated, and accessible, empowering the enrollee to be an active participant in their care.	Strengthen Person & Family Engagement as Partners in their Care	Engage and partner with enrollees to improve enrollee experience and outcomes.
	Promote Effective Communication & Coordination of Care	<ul style="list-style-type: none"> • Ensure appropriate follow-up after emergency department visits and hospitalizations through effective care coordination and case management. • Achieve an interoperable health information technology system that keeps health information secure but readily accessible to patients and other authorized parties.

Underpinning these aims, objectives and goals are a robust set of quality interventions and quality performance measures, described in Section 2 “Driving Improvement and Monitoring Progress”.

1.2 Quality Management Structure

DOM receives input from the Mississippi Medical Care Advisory Committee (MCAC) on recommendations for the delivery of high-quality care. MCAC consists of members appointed by the Governor, Lieutenant Governor and the Speaker of the House of Representatives and must be either health care providers or consumers of health care services. MCAC is statutorily required to advise the Mississippi Division of Medicaid about health and medical care services in accordance with Miss. Code. Ann § 43-13-107(3) and 42 C.F.R. § 431.12.

The DOM Quality Leadership Committee (QLC) includes subject matter experts from various DOM business areas. The QLC is responsible for the development, implementation, and evaluation of the CQS. The QLC also provides focus and direction for interdisciplinary quality improvement activities across the agency and externally promotes access to and utilization of quality, evidence-based healthcare.

One of the subcommittees utilized by the QLC is the CCO Quality Workgroup (CQW). Members of the CQW include representatives from DOM, the CCOs, beneficiaries, and the External Quality Review Organization (EQRO). Using directives from the QLC, the CQW meetings are the central forum for communication and collaboration between DOM and the CCOs for quality strategies, evaluating past initiatives, and recognizing opportunities to develop systematic and integrated approaches to quality activities.

As a major purveyor of healthcare in the state of Mississippi, DOM is poised to drive quality improvement transformation and produce measurable results. In State Fiscal Year (SFY) 2022, the QLC will launch the Coalition for a Healthier Mississippi (Coalition), to engage stakeholders in becoming quality partners in elevating Mississippi’s National Quality ranking. Potential stakeholders included in this Coalition are Medicaid providers, CCOs, EQRO, medical and pharmacy associations, other State agencies, other quality organizations and programs in local communities, and national organizations.

Under development is a Quality Learning Collaborative (Collaborative) to aid the QLC in delivering innovative quality improvements and educational supports to the Division’s stakeholders statewide. The purpose of the Collaborative is to engage stakeholders across the state in a transformational approach to quality improvement (QI) innovation and

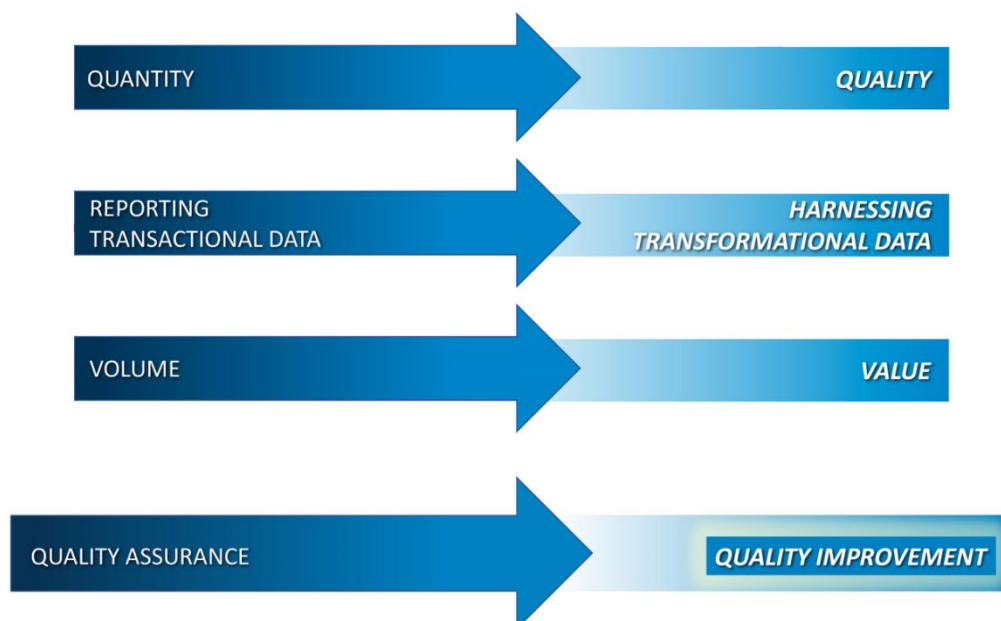
education that will elevate quality and promote positive health outcomes for Medicaid beneficiaries while decreasing healthcare costs and minimizing unnecessary burden for Medicaid beneficiaries and providers.

The Collaborative will lead DOM in transitioning from quality assurance to quality improvement by:

- using technology to analyze available data,
- targeting specific disease processes identified, and
- delivering high-quality initiatives with defined outcome metrics.

The Collaborative goals include:

- Increase engagement and cooperation with external stakeholders to expand the reach of clinical input and perspectives that will assist in developing quality measures to optimize beneficiary outcomes.
- Develop educational resources in collaboration with the Population Health team to further DOM quality initiatives and improve Medicaid service delivery.
- Promote value-driven care with Medicaid providers and facilitate forums for sharing these best practices statewide.
- Advocate for our beneficiaries by championing health equity and promoting Health-In-All policies in Medicaid service delivery and with external stakeholders.



2. Driving Improvement and Monitoring Progress

2.1 Continuous Quality Improvement

DOM requires the CCOs to engage in and support continuous quality improvement in clinical and administrative metrics, and work with providers and DOM to bring innovation to all aspects of healthcare. DOM has identified priority beneficiary populations for targeted improvement, based on data analysis and feedback from enrollees, providers, coordinated care organizations, and community stakeholders. DOM requires quality initiative and performance improvement results to be reported on a monthly, quarterly, and annual basis. For enrollees transitioning between plans, DOM and each CCO maintains a transition of care policy consistent with requirements of 42 C.F.R. § 438.62 to access continued services upon transition to prevent impairment of quality performance metrics. The transition of care policy must be explained to beneficiaries in the materials to members and potential enrollees in accordance with § 438.10. DOM also provides for intermediate sanctions in its CCO contracts that comply with 42 C.F.R. Part 438, Subpart I.

2.2 Priority Focus Areas

Maternal and Infant Health

DOM has long been concerned about the rate of preterm births in Mississippi. Studies show the rate of preterm birth as well as maternal mortality among black mothers continues to be twice that of white women. DOM worked with the Mississippi Hospital Association and providers across the state to reduce non-medically necessary inductions and cesarean sections prior to 39 weeks. Coordinated care organizations were required to select a Performance Improvement Project to address the rates of preterm delivery of their enrollees. Projects focused on increased prescribing and enrollee utilization of 17-hydroxyprogesterone to prevent recurrent premature birth as well as efforts to improve prenatal care visits in the first trimester. DOM collaborated with the Mississippi State Department of Health (MSDH) to provide perinatal case management through the Perinatal High Risk Management/Infant Services System (PHRM/ISS) program to high risk maternity enrollees.² Despite these efforts, the state's rate has continued to climb.³

In 2021, DOM launched the Preterm Birth Task Force (PBTF) to investigate root causes of preterm delivery in Mississippi and develop innovative solutions. The PBTF will work collaboratively to determine how varying PBTF member resources can be maximized to address:

² [Healthy Moms, Healthy Babies - Mississippi State Department of Health](#)

³ National Center for Health Statistics, final natality data. Retrieved August 27, 2021, from www.marchofdimes.org/peristats.

- Decreasing administrative burden and time lag to care management for high-risk enrollees, while improving documentation of the Transition of Care requirements for pregnant members entering the health plans;
- Defining methods to address the increasing rates of poor maternal health outcomes for Black women and babies;
- Determining how to optimize DOM's Family Planning Waiver to improve interpregnancy care services for women who previously delivered a very low birth weight or preterm baby.
- Creating health literacy outreach campaigns

Chronic Disease

Chronic diseases are among the most common health problems in Mississippi. Mississippi's cardiovascular disease death rate is the highest in the nation, and the state ranks second in overall diabetes prevalence. Medical spending on chronic health conditions has grown rapidly in recent years and places a significant burden on state budgets. Cardiovascular and respiratory diseases are in the top All Patient Refined-Diagnosis Related Groups (APR-DRGs) found through analysis of claims data. Medical costs associated with chronic health conditions are expected to continue to rise.

Case and disease management programs target members identified as high risk to encourage improved health outcomes through a combination of assessment, education, monitoring, measurable outcomes, and care coordination. DOM and coordinated care organizations will partner with providers and other community stakeholders to ameliorate modifiable risk factors like physical activity, tobacco use, high blood pressure and high cholesterol, to decrease poor health outcomes due to chronic disease.

To aid in disease management, DOM covers remote patient monitoring (RPM) services for disease management when an individual has been diagnosed with one or more chronic conditions. RPM requires prior authorization by DOM's UM/QIO. For more information about DOM's policies regarding chronic conditions and remote patient monitoring, please visit the agency's [Administrative Code | Mississippi Division of Medicaid \(ms.gov\)](#).

Behavioral Health

In SFY 2020, nearly 20% of the potentially preventable hospital returns among Medicaid beneficiaries were attributed to adult mental health. Results of claims analysis showed the top two APR-DRGs coded for Medicaid enrollees were for the diagnoses of Schizophrenia and Bipolar Disorders. To address next steps in the reduction of preventable hospital admissions due to mental health disorders, the Behavioral Health Work Group resumed in 2021, comprising the Office of Mental Health and other community stakeholders. This group will focus on evaluating how to increase resource allocation to beneficiaries with behavioral health needs and improve clinical outcomes in care management.

In addition to projects developed by the Behavioral Health Work Group, CCOs will be required to select a performance improvement project (PIP) aimed at reducing unnecessary hospitalizations due to Behavioral Health issues as recommended in the EQRO report. Effective September 2020, DOM encouraged adult mental health services by providers outside Community Mental Health Center/Patient Centered Medical Home (CMHC/PCMH), began services for Intensive Community Outreach and Recovery Team (ICORT), Intensive Outpatient (IOP), and mental health hospitalization services.

Table 2. DOM Priority Focus Area Work Plan

Time Period	DOM Quality Focus	Quality Strategy Meaningful Measure	Goal	Objectives	QIPP Quality Metric
SFY 2022	Maternal Health	Promote Effective Prevention & Treatment of Chronic Disease	Reduce Preterm Birth in Medicaid Beneficiaries	Increase the rate of maternity visits during the first 16 weeks of pregnancy to 95 th % by 2024	Timeliness of Prenatal Care (PPC)
	Behavioral Health	Promote Effective Communication & Coordination of Care	Increase initiation of Treatment for Medicaid Beneficiaries with Depression	Increase initiation of anti-depressant medication within 30 days of initial diagnosis from 51% to 75% by 2024	Effective Acute Phase (AMM)
			Increase Continued utilization of Treatment in Medicaid Beneficiaries with Depression	Increase continuation of anti-depressant medication from 38% to 50% by 2024	Effective Continuation Phase (AMM)
	Health Equity	Work with Communities to Promote Best Practices of Healthy Living	Increase beneficiaries taking an active role in their health	Develop Beneficiary Advisory Panel	CCO Member Satisfaction Survey Scores
SFY 2023	Child and Adolescent Health	Work with Communities to Promote Best Practices of Health Living	Increase Adolescent Immunizations for Vaccine Preventable Disease	Increase adolescent vaccination rates for meningitis from 16% to 75% by 2025	Adolescent Immunization Status (IMA)
		Promote Effective Prevention & Treatment of Chronic Disease	Increase Well Child Visits	Increase Child Preventive Care Visits in the first 30	Well Child Visit-First 30 months (W30)

				months of life from 66% to 80% by 2025	
	Health Equity	Work with Communities to Promote Best Practices of Healthy Living	Increase provider collaboration with members to further health goals	Facilitate Providers in Collaboration with Beneficiary Advisory Panel	CCO Member Satisfaction Survey Scores
SFY 2024	Chronic Disease Management	Strengthen Person & Family Engagement as Partners in their Care	Decrease readmission for COPD exacerbation in Medicaid Beneficiaries with Respiratory Illness	Increase rate of members discharged from a hospital with prescription for steroids to 75 th % by 2026	Adults: Pharmacotherapy Management of COPD Exacerbation (PCE)
		Promote Effective Prevention & Treatment of Chronic Disease	Decrease ER utilization for acute asthma in Medicaid Beneficiaries with Respiratory Illness	Increase rate of Asthma- controlling medications compared to Asthma-acute medications to 75 th % by 2026	Asthma Medication Ratio (AMR)
			Decrease cardiac events in Medicaid Beneficiaries with Diabetes	Increase rate of high dose statin medications in members with DM to 75 th % by 2026	Comprehensive Diabetes Care- CDC (SPD)
	Health Equity	Work with Communities to Promote Best Practices of Health Living	Crosswalk lessons learned from Beneficiary Advisory Panel and Provider Summit to delineate future goals within DOM	Perform systematic review of DOM policies and procedures to evaluate opportunities to improve health equity	CCO Member Satisfaction Survey Scores

2.3 Performance Measures and Improvement Projects

National Performance Measures

Although CMS has not identified a list of required national performance measures, DOM continues to report the voluntary adult and child core set measures to CMS on an annual basis. State targets have been set for many of these measures based on national percentiles for performance measure rates. See Mississippi’s state overview on CMS’s [State Profile](#) page and [Mississippi FFY 2015-2019 Core Set Reporting \(ms.gov\)](#).

State Performance Measures

DOM routinely assesses the quality and appropriateness of care and services delivered to enrollees. [Mississippi FFY 2015-2019 Core Set Reporting \(ms.gov\)](#).

MississippiCAN and CHIP Performance Measures

DOM requires CCOs to report annually on patient outcome performance measures, including the Healthcare Effectiveness Data and Information Set (HEDIS®) quality metrics, CMS Adult and Children Core Set, Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, and state-specified quality measures required under 42 C.F.R. § 438.10(c)(3). The measures are submitted by the CCO as delineated in a state-mandated Reporting Manual, formatted using state-specific definitions, and have required time frames by which to calculate and report. Any deviances are to be noted as variances by the CCO, and actions taken for improvement are to be described. DOM may use corrective actions when a CCO fails to provide the requested services or otherwise fails to meet contractual responsibilities related to quality. The CCOs are subject to annual independent reviews through the External Quality Review process. As recommended by the EQRO report, DOM will continue to clarify the core set measures required to be reported by the CCOs. The CCOs are also directed to improve response rates for member satisfaction surveys, CAHPS, as they are presently below the NCQA target rate.

The assessment of a CCO's progress towards meeting the objectives outlined in this update is necessary for the continuous, prospective, and retrospective monitoring of quality of care and improved outcomes. DOM utilizes several methods to assess whether the goals and objectives are met. These methods include:

- Identifying, collecting, and assessing relevant data.
- Reviewing and analyzing periodic reports to monitor and evaluate compliance and performance.
- Reviewing and analyzing program-specific Performance Measures that demonstrate each plan's performance over the prior year.

Quarterly and annual reports submitted by each CCO assist with the identification of the quality and appropriateness of care, best practices, and concerns. Care Management reports provide an assessment of the management of members who voluntarily enrolled in the program. Monthly Case Management reports assess the effectiveness of case management services for actively enrolled members who voluntarily enrolled in a case management program. These programs target members who are pregnant, have high

emergency room usage, have physical health and behavioral health conditions, or have multiple co-morbidities.

Technical and Regulatory Monitoring

CQS was developed in accordance with federal Medicaid managed care regulations (42 C.F.R. § 438.340), which require states to have a written strategy for assessing and improving the quality of health care services offered by managed care entities. Each year, the External Quality Review Organization (EQRO) performs an overall external quality review of Mississippi's coordinated care system as required by 42 C.F.R. § 438.350. The review includes current contract requirements, federal Medicaid managed care regulations and state law. As a result of the most recent EQRO review, DOM has addressed quality improvements in this CQS, and compliance and administrative improvements in the above referenced reporting manual and in subsequent contract language.

CCOs are required to have an internal quality improvement system that meets state and federal standards set forth in the contract between the CCO and DOM. [See the most recent results](#) from examinations of each health plan.

Quality Incentives

DOM requested authority from CMS to undertake three new quality initiatives beginning in July 2019. These initiatives cover three major sources of Medicaid spending: hospitals, CCOs, and the state's academic medical center. All three include quality measures, targeted improvement levels and accountability. The Mississippi Medicaid Access to Physician Services (MAPS), the Quality Incentive Payment Program (QIPP), and the Coordinated Care Value-Based Withhold Program outlined below. [Value-Based Incentives | Mississippi Division of Medicaid \(ms.gov\)](#)

Mississippi Medicaid Access to Physician Services (MAPS)

MAPS is a directed payment program developed in conjunction with the University of Mississippi Medical Center (UMMC). DOM received initial approval from CMS for the MAPS payments in November 2019. Much like Mississippi Hospital Access Program (MHAP), CCOs are responsible for disbursing this additional funding to certain provider groups based on utilization of services.

The program is intended to increase access and quality of care for Medicaid beneficiaries to primary and specialty care services by increasing payments made to qualified practitioners employed by or affiliated with the State's academic medical center.

Quality Incentive Payment Program (QIPP)

QIPP is a component DOM added to the MHAP for hospitals in July 2019. The goal of the QIPP is to utilize Medicaid funding to improve the quality of care and health status of the Mississippi Medicaid population. QIPP is a multi-year project with an increasing percentage of payments being linked to hospital performance.

Readmissions are measured across all hospitals with the readmission being attributed to the original discharging hospital. The metrics exclude maternity and newborn readmissions and the discharges related to major trauma, metastatic malignancies, HIV, and sickle cell anemia. The metric includes Emergency Department visits for a condition related to a recent hospital discharge as well as all clinically related readmissions associated with a hospital discharge within the previous 15 days.

DOM has set a statewide threshold against which all hospitals QIPP Potentially Preventable Hospital Returns (PPHR) actual-to-expected ratios are compared. Hospitals that fail to meet this threshold will be responsible for developing a corrective action plan and meeting improvement targets in future years. MHAP funds not distributed due to a hospital's non-compliance with QIPP requirements are redistributed to the hospitals meeting the quality benchmarks. In July 2021, DOM introduced the quality metric of Potentially Preventable Complications (PPC) into the QIPP to measure hospitals inpatient complication rates against a statewide threshold.

Coordinated Care Value-Based Withhold Program

DOM implemented a Coordinated Care Value-Based Withhold Program on MississippiCAN capitation rate payments in July 2019. This quality withhold is based on established quality metrics, such as Healthcare Effectiveness Data and Information Set (HEDIS) scores, which are already being reported by the CCOs. On October 29, 2020, CMS approved a 1.0% withhold of capitation rates for SFY 2020.

Table 3. MississippiCAN CCO SFY2022 Incentive Withhold Program

MSCAN Incentive Withhold Program Baseline - SFY 2022						
Quality Measure	Sub Measure	Baseline*	Benchmark	Magnolia CY2020**	Molina CY2020**	United CY2020**
Well-Child First 15 Months of Life (W15)	6 or more visits	51.30%	52.10%	56.57%	50.09%	54.39%
Anti-Depressant Mgt (AMM-AD)	Effective Acute Phase Treatment	38.40%	39.00%	46.04%	74.76%	46.77%
	Effective Continuation Phase Treatment	22.30%	22.60%	28.51%	58.89%	30.43%
Comprehensive Diabetes Care	HbA1c Testing	85.70%	87.00%	87.59%	88.37%	84.18%
	Nephropathy Screening	Retired	Retired	Not Reported	Not Reported	Not Reported
Prenatal and Postpartum Care (PPC-AD)	Timeliness of Prenatal Care	88.80%	90.10%	92.21%	95.38%	91.48%
Asthma Medication Ratio (AMR)		69.88%	71.28%	No reporting required for CY2020. This year serves as the baseline year for this program.		
Systemic Corticosteroids (PCE)		42.72%	43.57%	No reporting required for CY2020. This year serves as the baseline year for this program.		
Immunization Combo 2 – (IMA)	Meningococcal, Tdap, HPV	18.67%	19.05%	No reporting required for CY2020. This year serves as the baseline year for this program.		
Potentially Preventable Hospital Return (PPHR)	Actual to Expected Ratio	***	1.07%	No reporting required for CY2020. This year serves as the baseline year for this program.		

*Baseline is calculated based on the average actual results of Magnolia and UHC for calendar year 2019 and 2020.

**As submitted July 2021 for initial CY2020 reporting.

***Actual PPHR A/E Ratio for each CCO from CY2020 – July 2021 PPHR Reports.

2.4 Intelligent Innovation

DOM's approach to the long-term sustainability of its current and future health information technology (HIT) and health information exchange (HIE) statewide infrastructure began with the creation of the Clinical Data Infrastructure Program (CDIP) under the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009. DOM is working to provide a foundational framework to achieve ubiquitous, interoperable healthcare data sharing among participants throughout the broader Mississippi healthcare community.

Interoperability: As DOM recognizes the need to use data to drive change, it is in the process of developing an Interoperability strategy that will improve internal and external data and information sharing. Specifically, the Interoperability ecosystem will include robust analytics tools, an Enterprise Service Bus, Enterprise Master Person Identification (EMPI) and a multifaceted data lake that will allow DOM to reduce internal data silos, ingest and share data quickly, securely, and accurately. This ecosystem will positively impact the DOM's quality strategy as it will create real-time access to data, and it will lead to improved data transparency.

Health Information Networks: In 2020, two organizations, the Mississippi Hospital Association (MHA) and the Mississippi State Medical Association (MSMA), launched two separate state-wide Health Information Networks (HIN). Both proposed HINs aim to positively impact healthcare outcomes by providing participating hospitals, providers, commercial insurers, and appropriate State Agencies improved access to clinical data. Starting July 2020, fifty percent (50%) of hospitals QIPP payments were tied to their intent to collaborate to establish a statewide HIN and to participate in the statewide HIN once established.

Population Health: Transforming population health is a significant driver in quality improvement planning at DOM and is at the core of Medicaid service delivery. A Population Health Nurse Director was hired in 2020 and has laid the groundwork transform available data into actionable information. Using technology, machine learning and data analytics to identify root causes and assess barriers to healthcare, the Population Health team in collaboration with the CCOs, created a Health Literacy Campaign to target diseases where beneficiary empowerment can greatly impact outcomes. These campaigns will utilize traditional print media as well as video formats to leverage beneficiary use of social media. Future planning includes the development of a Beneficiary Advisory Panel, to give members a seat at the table in healthcare decisions and give valuable feedback to the QLC in shaping future quality initiatives and programming.

2.5 External Independent Reviews

DOM has contracted with The Carolinas Center for Medical Excellence (CCME) since 2012 to undertake external quality review activities for MississippiCAN and CHIP programs. The EQRO analyzes and evaluates aggregated information on the CCO quality, timeliness, and access to covered health care services.

The EQRO's current scope of work includes:

- Determining CCO compliance with state standards for access to care, structure and operations, and quality measurement and improvement for the MississippiCAN program and CHIP program review
- Validating performance measures
- Validating performance improvement projects
- Validating consumer and provider surveys
- Validating Network Adequacy and Availability

Validating Performance Measures

CMS requires that states, through their contracts with CCOs, measure and report on performance to assess the quality and appropriateness of care and services provided to members. Validation of performance measures is one of the mandatory EQR activities required by DOM. The purpose of performance measure validation is to assess the accuracy of performance measure rates reported by CCOs and to determine the extent to which reported performance measures adhere to state specifications and reporting requirements. For other performance measures, DOM and CMS provides specifications for data collection used to confirm that the reported results are based on accurate source information.

Healthcare quality PIPs must be designed, conducted, and reported using a sound methodology to achieve real improvements in healthcare processes and outcomes. The EQRO undertakes the following steps in validating PIPs:

- Assess the CCO methodology for conducting the PIP
- Verify actual PIP study findings
- Evaluate the overall validity and reliability of study results to comply with requirements set forth in 42 C.F.R § 438.330(b)(2)

Determining CCO Conformity to Standards

The EQRO reviews the CCO conformity with the state's standards and the standards contained in 42 C.F.R. § 438, Subparts D and E. Those standards include:

- Availability of services
- Assurances of adequate capacity and services
- Coordination and continuity of care
- Coverage and authorization of services
- Provider selection
- Confidentiality
- Grievance and appeal systems
- Subcontractor relationships and delegation
- Practice guidelines
- Health information systems
- Quality assessment and performance improvement program

The EQRO follows CMS’s most current protocol titled “Review of Compliance with Medicaid and CHIP Managed Care Regulations.” This validation occurs annually and contains seven activities:

- Planning for compliance monitoring activities
- Obtaining background information from DOM
- Documenting review
- Conducting interviews
- Collecting any other accessory information (e.g., from site visits)
- Analyzing and compiling findings
- Reporting results to DOM

Validating Consumer and Provider Surveys

An additional responsibility of the EQRO is to validate consumer and provider surveys on quality of care. Validation is attained by following CMS’ most current protocol “Administration or Validation of Quality of Care Surveys,” which requires the following activities to assess the methodological soundness of the surveys:

- Reviews survey purpose(s), objective(s), and intended audiences
- Assesses the reliability and validity of the survey instrument
- Assesses the adequacy of the response rate
- Review the Quality Assurance Plan
- Reviews survey data analysis and findings/conclusions
- Documents evaluation of survey

Validating Network Adequacy and Availability

CCOs must ensure access to medically necessary Medicaid covered services for

beneficiaries and meet network adequacy requirements set forth by 42 C.F.R. §§ 438.68, 438.206, 438.207, and comply with DOM requirements. The EQRO will validate the CCOs' provider networks for the MississippiCAN and CHIP populations. The validations will include a provider access study and evaluation of the provider directory for accuracy. The validations occur quarterly and include the following:

- Develop a study methodology
- Select or develop a standardized data collection tool
- Develop a sampling plan
- Collect and analyze data
- Report Findings

In addition to the federal- and state-required activities, the EQRO suggests activities that DOM may consider to enhance the external quality review process and to support DOM in achieving its objective to improve quality based on the analysis and evaluation of the CCOs' quality, timeliness, and access to health care services. Non-duplication of EQRO activities does not apply as defined in 42 C.F.R. § 438.360(c).

DOM has reviewed the following recommendations from the EQRO report and will be implementing changes to improve the program, which will be reflected in contract language changes, reporting manual changes, and corrective action plans:

- Implementation of interventions, including using correct parameters for measurement of geographic access, to be developed by CCOs for monitoring and improving provider appointment availability
- Improvement of provider credentialing processes
- Inclusion of all required elements for delegation monitoring for monitoring and oversight of vendor services
- Improve PIP outcomes, including behavioral health readmissions
- Ensure that member and provider materials and manuals include member rights and responsibilities, changes in benefits and network providers, and updated contact information, telephone numbers, and hours of operation for Contact Centers. All this information should be in easy to understand language
- Improvement of member satisfaction survey response rate

2.6 Procedures for Identifying, Evaluating, and Reducing Health Disparities

According to a Centers for Medicare & Medicaid Services Office of Minority Health (OMH) 2016 report, racial and ethnic minorities and individuals, people with limited English proficiency (LEP) and low health literacy, sexual and gender minorities, and people with disabilities experience worse health outcomes, decreased access to health care services and

lower quality care than the general population. DOM is committed to equal access to quality and culturally competent care for these enrollees. DOM will work to identify, evaluate, and reduce health disparities based on age, race, ethnicity, sex, primary language, and disability status, within any internal or external policy or program. DOM will also utilize technology to provide transparency of data, specifically regarding performance and health outcomes, to optimize system-wide changes as identified. DOM believes that ensuring equitable improvements in health outcomes will lead to substantial health outcome improvements in all groups. A Beneficiary Advisory Panel (BAP) is currently being assembled to include beneficiaries, advocates, and organizations which provide perspective on health disparities and inequalities. DOM will use the BAP to gain insight into current challenges faced by our members and use the knowledge gained to develop initiatives and programs to reduce health disparities in these populations.

2.7 Delivery System and Payment Reform: Value Based Purchasing

During the next coordinated care procurement cycle, DOM will collaborate with the CCOs to develop an Integrated Primary Care (IPC) value-based purchasing (VBP) model. Each CCO will submit to DOM its proposal for an IPC VBP model, using Patient-Centered Medical Homes and Care Management as key aspects of the model. The CCOs will include information regarding provider recruitment; reimbursement methodology (including what percentage of payments to providers should be devoted to VBP and proposed Alternative Payment Models (APMs)); how utilization review will inform VBP development and implementation, timelines, expected challenges in implementation; and any other information relevant to the development and success of the model. The model will be developed using stakeholder input, including but not limited to providers, members, community-based organizations, other State organizations, and DOM staff. Upon receipt of proposals from all Contractors, DOM will evaluate the proposals and determine a final uniform model prior to the implementation of the Contract.

The CCOs will be required to comply with the final model promulgated by DOM, as well as produce and disseminate reports as outlined in the MississippiCAN and CHIP Reporting Manuals. DOM will analyze the success of the VBP model and will retain the right to alter the VBP, Reporting Requirements, and Performance Measures at any time during the life of the Contract.

At the end of the development process, DOM will publish the Mississippi Division of Medicaid Value-Based Payment Work Plan, a separate document detailing the final VBP program. This document will reflect all updates to DOM's VBP policy.

2.8 CCO Innovation Requirements

In the state's next managed care contracting cycle, prospective contractors will be required to submit an overview of innovative strategies to address each of the following service areas, with these proposals making up a significant part of the scoring. Offerors will be required to address social determinants of health and health equity in their proposals while placing quality improvement at the center of their proposed work.

- Care Management
- Patient-Centered Medical Homes
 - Employing RNs to provide education, tools, and training to assist patient-centered medical homes and other plan providers in implementing programs, closing gaps in care, and improving practice performance
- Performance Improvement Projects
- Health Literacy Campaigns
- Telehealth
- Potential Partnerships
 - Sharing tools with providers and including Clinical Practice Guidelines, medical record documentation standards and feedback on compliance, and review of their quality performance reports

During the readiness review process, contractors will then have to submit more detailed proposals to the Division, which will use those to create standardized, measurable programs, with input from stakeholders around the state. Through this process, the Division aims to take advantage of CCOs' experience and creativity while also leveraging its own ability to bring multiple perspectives to the table to form plans that make an impact without creating an undue burden on beneficiaries or providers.

3. Managing Fee-for-Service

3.1 Overview of UM/QIO and Care Management in the Fee for Service Program

In 2017, DOM sought to improve clinical quality, promote beneficiary and provider satisfaction, and achieve savings by ensuring that benefits are provided for medically necessary services. DOM elicited proposals from qualified organizations to enter into contracts with DOM to provide Utilization Management (UM) and Quality Improvement Organization (QIO) services in accordance with 42 C.F.R. § 456,1(b)(1). Alliant Health Solutions (AHS) was selected in August 2019 for delivery of utilization review, quality management and improvement services, and case management coordination.

Effective utilization management ensures the appropriate allocation of resources by evaluating the medical necessity and appropriateness of care, while supporting improved care and health for the Fee for Service (FFS) population. The first year of the most recent contract has resulted in improvement in cost of manually priced medically unnecessary items as well as decreased utilization of inappropriate Level of Care for Private Duty Nursing (PDN), Personal Care Services (PCS) and Prescribed Pediatric Extended Care (PPEC) has resulted in the first year of the program.

Additionally, DOM's UM/QIO contractor currently provides evidence-based case management services to Mississippi Medicaid FFS beneficiaries that met criteria to one of the five targeted conditions below:

- Disabled Children Living at Home (DCLH)
- Postpartum women in FFS Medicaid
- Hepatitis
- HIV/AIDS
- Hemophilia

Case managers worked with beneficiaries to identify their specific needs and set goals to assist them with addressing both short- and long-term needs. Goals may have included establishing a connection with a primary care provider, preventing hospital readmission by completing needed follow-up care, or providing education and materials to improve the individual's understanding of their medical condition and available support options. Case management goals met during the first year of the program resulted in reduction of non-urgent emergency room (ER) visits, prevention of hospital readmissions, improved medication adherence, and decreased prescription medication over-use. Key interventions included identification of community resources to minimize health impact of social determinants of health (SDOH), encouraging self-management or self-advocacy of chronic conditions, improved health literacy, as well as better care transitions and stabilization in the home.

3.2 Long-Term Services and Supports

The Long-Term Services and Supports (LTSS) business area includes Home and Community Based Services (HCBS) and nursing facilities. HCBS is responsible for operating five areas that include the Assisted Living waiver, Elderly and Disabled waiver, Independent Living waiver, Intellectual Disability/Developmentally Disabled waiver, and the Traumatic Brain/Spinal Cord Injury waiver. HCBS Programs offer in-home services to

help people live at home instead of in nursing facilities. Beneficiaries must apply and be approved for these services.

DOM implemented the eLTSS case management system for all waivers in 2016 and will be incorporating nursing facilities in 2021. This supports efforts to align processes and quality across both institutional and home and community based LTSS. Additionally, the state began electronic visit verification for personal care services in 2017 as required by the 21st Century Cures Act. DOM will complete implementation of Electronic Visit Verification (EVV) for all personal care type services requiring home visits by December 2021. The State Medicaid Agency also contracts with the Dual Special Needs Plans (DSNP), and these contracts were updated in 2021 to include care coordination reporting requirements for several high-risk waiver populations required under the Medicare Improvement of Patients and Providers Act (MIPPA).

3.3 Family Planning Waiver

The Mississippi Family Planning Waiver Demonstration program is for women and men who receive Medicaid benefits limited to family planning services and family planning related services. This includes one annual visit and subsequent visits related to their birth control methods and family planning services. Beneficiaries cannot exceed a total of four visits per calendar year. These beneficiaries are not eligible to receive any other Medicaid benefits. Additional information about the FPW can be found on DOM's public website at [Family Planning | Mississippi Division of Medicaid \(ms.gov\)](#).

3.4 Healthier Mississippi 1115 Waiver

Healthier Mississippi 1115 Demonstration Waiver enrollment began January 1, 2006 and is for individuals ages 65-years-old or older, or individuals who are disabled and do not have Medicare. Effective July 24, 2015, the maximum number of individuals who can be enrolled in this waiver may not be more than 6,000 at any given time. If enrollment reaches 6,000, the waiver is closed to enrollment until the number of individuals enrolled is fewer than 6,000. Additional information about the HMW can be found on DOM's public website at [Healthier Mississippi Waiver | Mississippi Division of Medicaid \(ms.gov\)](#).

3.5 Current Mississippi Medicaid Population

Today, Mississippi Medicaid program serves one in four Mississippians. Most Mississippians enrolled in Medicaid receive services through the managed care delivery

system between DOM and the CCOs, while the remaining beneficiaries receive services through the traditional FFS system. The total number of beneficiaries enrolled in the Mississippi Medicaid program as of June 1, 2021, was just over 768,300; and of these members there were 490,408 beneficiaries enrolled in coordinated care for that month. The total number of beneficiaries enrolled in the CHIP program as of June 1, 2021, was 47,851, and all these members are enrolled in coordinated care. The State directs the CCOs to implement mechanisms for coordination and continuity of care and identifying enrollees with special health care needs eligible to the CCOs for assessment and treatment services as required by federal regulations 42 C.F.R. § 457.1230(c) and 42 C.F.R. § 438.208(c)(1). Additional Medicaid enrollment resources are located on DOM's website at [Resources | Mississippi Division of Medicaid \(ms.gov\)](#).

4. Evaluating, Updating and Disseminating the Quality Strategy

4.1 2018 Managed Care Quality Strategy

The 2018 Managed Care Quality Strategy served as a road map to monitor and implement quality improvement and allowed for necessary revision to strengthen the effectiveness and reporting of the program. It provided a framework to communicate the state's vision, objectives and monitoring strategies addressing issues of healthcare costs, quality, and accessibility for the state's most vulnerable citizens.

The Managed Care Quality Strategy detailed the standards and mechanisms for holding the CCOs accountable for desired outcomes. It also articulated compliance requirements from the CMS federal Medicaid managed care rule, 42 C.F.R. § 438.340(a).

DOM relied upon the annual EQRO technical report for detailed information regarding the regulatory and contractual compliance of the CCOs and results of PIPs and performance measures. Results from this report included information regarding the effectiveness of the CCO program, strengths and weaknesses identified, and potential opportunities for improvement. The information was incorporated into the Managed Care Quality Strategy and used for initiating and developing quality improvement projects over the proceeding three-year period. Feedback from Medicaid beneficiaries used in the development of the Managed Care Quality Strategy was garnered through several methods including the stakeholder meetings, member satisfaction surveys, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS), and member grievance and appeals reporting.

4.2 2021 Mississippi Medicaid Comprehensive Quality Strategy

DOM uses standing advisory and stakeholder groups, including the CCO Quality Workgroup, to review the strategy and its components. DOM will solicit input from multiple internal and external stakeholders through workgroups and posting a draft of the comprehensive quality strategy document on its website for public review and comment. The feedback provided by stakeholders, including Medicaid beneficiaries and their representatives, will be considered in the development of the CQS. The Mississippi Band of Choctaw Indians (MBCI) is consulted in accordance with the state's Tribal consultation policy. Public comment is garnered through DOM's website and public stakeholder meetings prior to submitting the Strategy to CMS for review.

The CQS shall be assessed annually for effectiveness and will be updated to reflect state and federal mandates as significant changes occur, or no less than every three years under 42 C.F.R. § 438.340(c)(3)(ii), 42 C.F.R. § 438.364(a)(4), 42 C.F.R. § 457.1240(e). Significant changes are defined as changes that impact quality activities or threaten the effectiveness of the strategy. The Mississippi Medicaid Quality Strategy has evolved over time in reaction to programmatic changes, the health needs of beneficiaries, clinical practice guidelines, federal and state laws, project outcomes and best practices. DOM continues to utilize data collection and reporting for continuous evaluation of quality initiatives, to identify areas for improvement and to responsibly provide oversight of MississippiCAN, CHIP, and FFS beneficiaries to comply with requirements set forth in 42 C.F.R. § 438.236. Updates to the Strategy are made available on the DOM website upon CMS approval.

5. Next Steps: Roadmap to 2024

DOM continues to work with internal quality and medical management staff, care management partners, and stakeholders to ensure all activities reflect the goals, objectives, strategies, and interventions documented in this plan.

DOM identifies the following as some of the barriers to improved health outcomes:

- Health literacy of members and valuation of preventive care
- Level of engagement in care management and disease management activities
- Childcare issues impacting access to healthcare appointments
- Statewide health professional shortages
- High utilization of emergency departments instead of patient-centered medical homes
- Potentially preventable hospital readmissions especially for mental and behavioral health conditions

- Health disparities effecting control of chronic diseases and maternity outcomes
- Stakeholder engagement and participation in quality improvement projects
- Stakeholder understanding of performance tracking activities
- Provider engagement and participation in quality improvement projects
- Provider understanding of performance tracking activities
- Multifactorial problems and limited resources needed to drive improvements in outcomes

Supported by sound data, DOM constantly evaluates its policies, seeking avenues for innovation. DOM aims to increase awareness and engagement while reducing barriers to access and better health outcomes. Stakeholder and consumer engagement drive DOM forward. That engagement has and will continue to lead DOM to pursue the following strategies to meet the above-referenced challenges.

- **Health Literacy Campaign:** The degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions is at the heart of the individual’s ability to access health services. DOM is evaluating its public-facing materials to ensure they are written in an accessible manner and format (including audio and visual formats) and placed in locations (be those Providers’ offices or on social media) most likely to reach the beneficiaries.
- **CCO Contracting:** DOM is utilizing its upcoming coordinated care contract cycle to seek vendors that can make demonstrable improvements in health outcomes and quality of life for members. Quality and innovation are at the center of the new procurement. Highlights include:
 - **Performance Improvement Projects:** The new contract requires CCOs to utilize a PIP format that aligns with the Institute for Healthcare Improvement (IHI) Model for Improvement methodology. PIPs will be simplified and standardized, directly linking projects and performance with overall CQS goals.
 - **Stronger Care Management Requirements:** CCOs will have to invest more into their Care Management programs, integrating closed loop referrals, warm handoffs, and deeper community partnerships into their programs.
 - **Value Adds:** The Request for Qualifications includes a DOM-curated list of desired value adds to target CCOs’ efforts where they are most needed.
 - **Patient-Centered Medical Homes:** CCOs will be required to develop strong PCMH strategies to target high-needs populations, including pregnant Members and Members with behavioral health conditions.

- Telehealth: Proposals for the upcoming RFQ require an innovative telehealth policy proposal. DOM will align proposals with its agency-wide telehealth advances made during the COVID-19 public health emergency, which allowed greater access to services for DOM’s beneficiaries across the state. See Appendix B Sustainability, Quality, and COVID-19 for details on future planning.
- DOM is currently seeking to participate in the Centers for Medicare & Medicaid Services (CMS): Improving Behavioral Health Follow-Up Care Affinity Group to improve access to and coordination of follow-up care for beneficiaries who visit an emergency department or are hospitalized for a mental health condition. See Section 5.2 below for more details.
- DOM was awarded the Center for Health Care Strategies: Technical Assistance Grant for Promoting Health Equity through Primary Care Innovation to explore how improved delivery models can promote more equitable care for beneficiaries. See Section 5.1 below for more details.
- DOM is in the process of reframing existing workgroups and expanding the reach and scope of projects to upgrade quality improvement projects with our providers and expand and diversify communication with our stakeholders. As stated in a prior section, DOM will create a BAP to better understand the above-referenced issues as well as other multifactorial issues DOM’s beneficiaries encounter. The BAP will allow collaboration with member participants to identify and address barriers to implementing change, seek member-mediated approaches, and explore symbiotic solutions that concurrently empower beneficiaries in making health decisions while informing DOM’s policy making through collaborative, beneficiary-led discussions.

5.1 Center for Health Care Strategies: Technical Assistance Grant for Promoting Health Equity through Primary Care Innovation

In March 2021, DOM was awarded a technical assistance grant from the Center for Health Care Strategies. Coinciding with DOM’s next coordinated care contracting cycle, CHCS will assist DOM in exploring and creating improved delivery methods and incentive arrangements to better promote equitable care across the Mississippi Medicaid population. As one of four states chosen to participate, DOM will also be able to collaborate with three other states to share information, ideas, and best practices, with the ultimate goal of minimizing inequities in the health care system.

5.2 Centers for Medicare & Medicaid Services: Improving Behavioral Health Follow-Up Care Learning Collaborative, Behavioral Health Affinity Group

In September 2021, DOM was invited to join CMS's Improving Behavioral Health Follow-Up Care Learning Collaborative, Behavioral Health Affinity Group (BH AG). The BH AG support state Medicaid and CHIP agencies' efforts to improve access to and coordination of follow-up care for beneficiaries who visit an emergency department or are hospitalized for a mental health or substance use condition. DOM joins four other states in obtaining support and mentoring to identify, implement, and scale data-driven behavioral health care QI initiatives.

6. Conclusion

The CQS provides an opportunity to investigate and catalog the health quality improvement efforts occurring at DOM. The Quality Leadership Committee will work with departments and external stakeholders to align all quality and performance improvement initiatives to standardize and strengthen the outcomes of these programs. Future submissions of the CQS will include detailed reporting on DOM progress in transforming systems to place quality over quantity, value over volume, and elevating quality improvement efforts across the Division.

Appendices

Appendix A

1. Milestones

Title XIX of the Social Security Act, enacted in 1965, provided authority for states to establish Medicaid programs to provide medical assistance to needy individuals. Mississippi Legislature held a special session in 1969 to enable legislation for the Medicaid program in Mississippi. Funds were appropriated and the Mississippi Medicaid Commission was designated as the single state agency to administer the program. State statutes governing Medicaid were included in Sections 43-13-101 et. seq. of the Mississippi Code of 1972. “Medicaid is community oriented and designed to benefit the needy. The program is not designed to benefit providers of service, and it is not to be enacted on their behalf.” -- Mississippi Hospital Association President Richard Malone, August 13, 1969.

In 1984, Senate Bill 3050, entitled the “Mississippi administrative Reorganization Act of 1984,” transferred the powers and responsibilities of the Mississippi Medicaid Commission to the Division of Medicaid in the Office of the Governor. This change established the Division of Medicaid as the single state agency designed to administer the Medicaid Program.

During fiscal year 1989, the Medicaid program implemented widespread changes due to progressive action taken during the 1988 legislative session. The most dramatic changes included expanding eligibility for pregnant women and children under the age of one year whose family income was at or below 185 percent of the federal poverty level (FPL), development and implementation of the Perinatal High Risk Management Program, and automatic determination of Medicaid eligibility for newborn infants using their mother’s Medicaid identification number.

During the 1990s, the state of Mississippi experimented with two approaches to bringing managed care to its Medicaid program: 1) a primary care case management program (HealthMACS) and 2) a traditional health maintenance organization (HMO) program. Under a program initiated by the Department of Finance and Administration (DFA) in 1993, seven preferred provider organizations (PPOs) delivered health services to state employees under contract with the State and Public-School Employees Health Insurance Plans. Mississippi received a 1915(b) waiver in 1993 for HealthMACS, a primary care case management (PCCM) program for Medicaid clients. HealthMACS, launched in a single county in October 1993, was operating in 14 counties as of mid-1996; by March 1998 it had reached statewide operation.

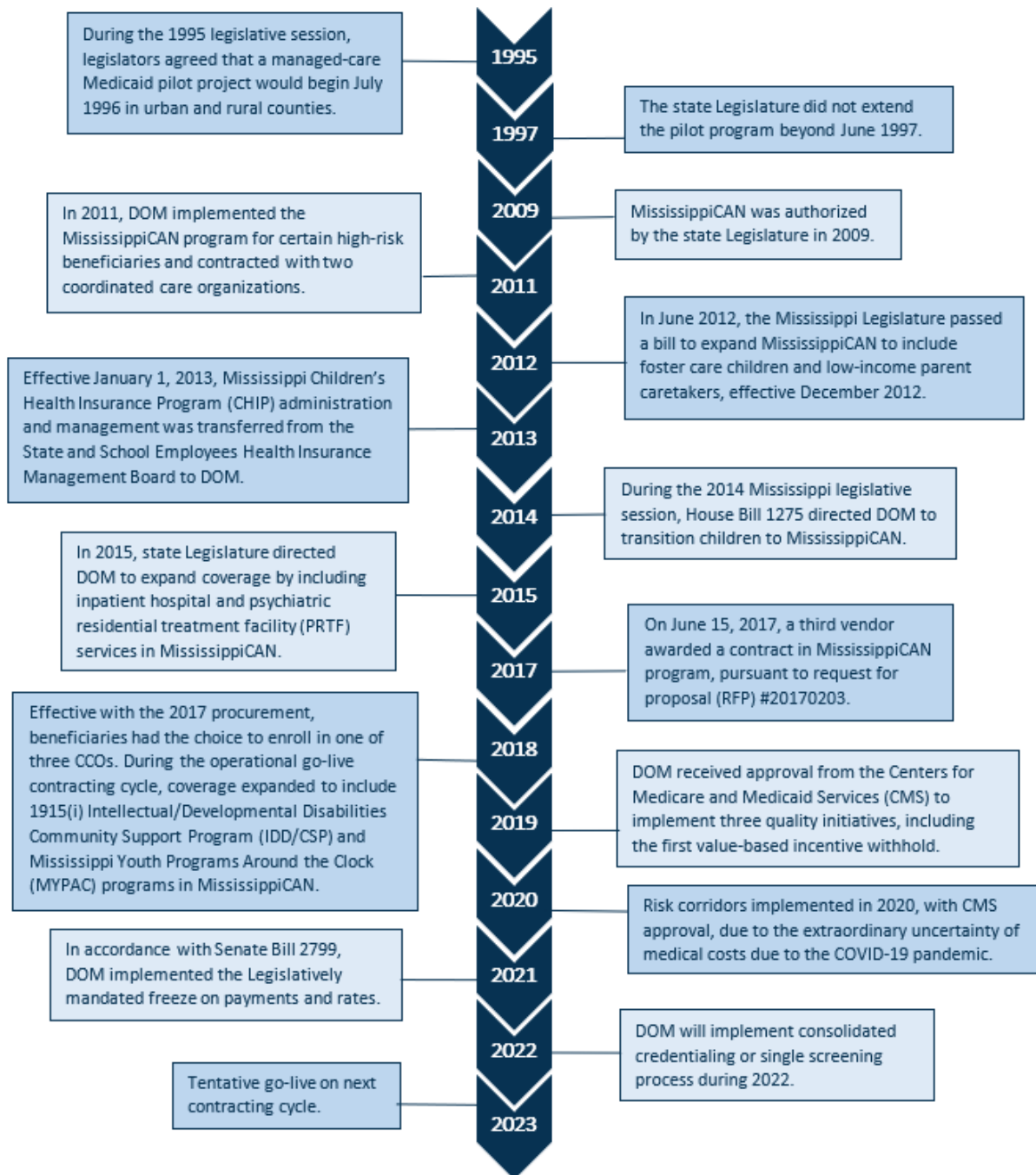
In 1995, the state developed a plan for capitated Medicaid managed-care pilot projects, which was approved by the Health Care Financing Administration (HCFA, now CMS) in February 1996. The program goal was to be a cost-cutting measure and to providing better services. Enrollment in the pilot, which began in the fall of 1996, was based on capitation contracts with licensed HMOs and on voluntary participation by Medicaid participants, which did not require an 1115 waiver. By 2000, all of the participating HMOs had either withdrawn or been placed in receivership. As the program ended, Medicaid HMO enrollees were shifted back to fee-for-service Medicaid and then, if they were eligible, to HealthMACS. This program suffered primarily from administrative difficulties.

MississippiCAN was authorized by the state Legislature in 2009 and implemented in January of 2011 allowing a reemergence of a Managed Care Delivery System. The program was developed with the specific goals of improving access to needed medical services, improving the quality of care, and improving cost predictability. During the Second Extraordinary Session of the 2009 legislative session, House Bill 71 included technical amendments regarding revisions to the MississippiCAN program. Some of the requirements included limiting enrollment to no more than 15 percent of the Medicaid population, allow a 30-day window for Beneficiaries to disenroll from the program, and required coordinated care organizations to reimburse no less than traditional fee-for-service Medicaid.

In October 2012, Mississippi Medicaid implemented a new reimbursement methodology, which was based on All Patient Refined Diagnosis Related Groups (APR-DRGs) and applied to inpatient care in all acute care hospitals, other than Indian Health Services. The APR-DRG methodology was applicable to general hospitals, freestanding mental health hospitals, and freestanding rehabilitation hospitals. This new reimbursement methodology did not apply to outpatient care, Medicare crossover claims, swing bed services, psychiatric residential treatment facilities or nursing facilities.

The 2012 Legislature passed House Bill 421 which authorized certain changes to DOM's coordinated care programs. Changes included an increase from 15% to 45% of Medicaid beneficiaries who could enroll in managed care. Enrollment for certain Medicaid beneficiaries became mandatory with the 2012 changes. DOM transitioned mandatory populations into MississippiCAN using a phased approach to aggressively add additional populations, such as children.

2. Timeline of Managed Care Delivery System



Appendix B

Sustainability, Quality, and COVID-19

The country faced a public health emergency (PHE) beginning in 2020 with the arrival of the novel coronavirus (COVID-19) pandemic. In response to the coronavirus outbreak, DOM expanded coverage of telehealth services throughout the state to align with Governor Tate Reeves' recommendations on leveraging telemedicine to care for patients while limiting unnecessary travel, clinic visits, and possible exposure. DOM released the [Emergency Telehealth Policy](#) on March 20, 2020 as an additional resource for Medicaid providers. The policy outlined temporary services intended to enhance telehealth service delivery while combating the spread of COVID-19. Some of the temporary allowances include use of audio only consultation codes, allowing home as a site of service with no telepresenter present, temporary approval of certain providers to act as distant site providers, and use of certain temporary originating site providers. Additionally, DOM worked closely with state medical associations to allow coverage parity with in-person services to ensure clinicians could remain engaged with their patients during the Quarantine orders.

While telemedicine was available prior to the pandemic, it was not widely embraced by Mississippi Medicaid healthcare professionals or patients. Like many other states, Mississippi saw telehealth utilization reach new levels, especially with behavioral health services. Figure 1 reflects the drastic increase in telehealth utilization, showing the number of unique beneficiaries jump from 6,855 in state fiscal year (SFY) 2019 to over 120,000 in SFY2020, as a result of the COVID-19 pandemic. Mississippi Medicaid also evaluated primary diagnosis and expenditures for telehealth utilization, which is displayed in Table 3.

Effective July 1, 2021, DOM revised Administrative Code to allow several permanent changes including the addition of home as a site of service with no telepresenter needed, federally qualified health centers (FQHCs), rural health clinics (RHC), and community mental health centers (CMHC) can now serve as both distant site providers and originating site providers, schools with school nurses are included as originating site providers, and inpatient hospitals can also serve as originating site providers.

DOM is evaluating how best to support successful telemedicine programs and services so that physicians, care teams, patients and the broader community can experience the benefits of telehealth in practice after the resolution of the PHE. Residents of long-term care facilities and those with multiple comorbidities were among the most vulnerable to poor outcomes from COVID-19. With our CCOs and DSNP partners, DOM is investigating how best to expand future access to long-term care facilities and how to efficiently launch remote patient

monitoring for in-patient use as well as out-patient management of individuals with chronic conditions.

Figure 1. Telehealth Utilization by Beneficiary by Fiscal Year

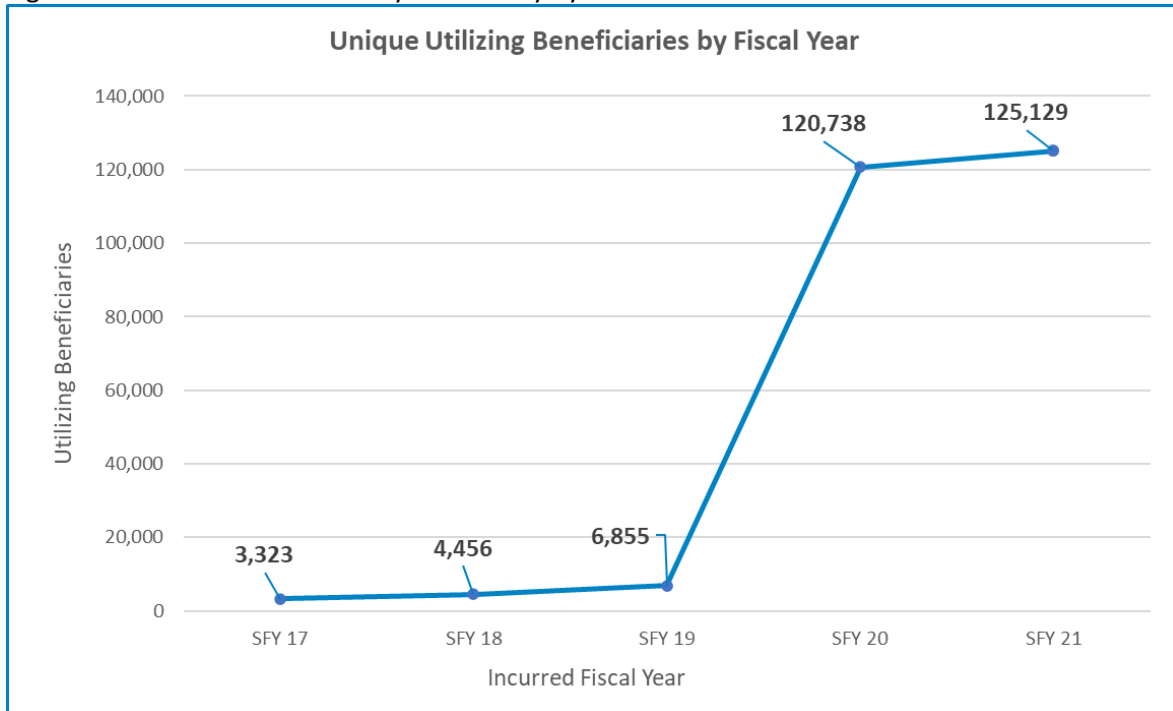


Table 5. Top 25 Diagnoses for Telehealth Visits

Primary Diagnosis	FY2020 Utilizing Beneficiaries	FY2021 Utilizing Beneficiaries
I10- Essential (primary) hypertension (ICD-10)	17,364	14,370
F90.2- Attention-deficit hyperactivity disorder, combined type (ICD-10)	12,472	14,260
Z79.899- Other long term (current) drug therapy (ICD-10)	5,811	6,105
K21.9- Gastro-esophageal reflux disease without esophagitis (ICD-10)	5,659	5,000
F91.3- Oppositional defiant disorder (ICD-10)	5,360	6,368
F41.9- Anxiety disorder, unspecified (ICD-10)	4,801	5,657
E11.9- Type 2 diabetes mellitus without complications (ICD-10)	4,733	3,932
F41.1- Generalized anxiety disorder (ICD-10)	4,667	5,623
F32.9- Major depressive disorder, single episode, unspecified (ICD-10)	4,054	5,011
M54.5- Low back pain (ICD-10)	3,927	2,750
E78.5- Hyperlipidemia, unspecified (ICD-10)	3,867	3,394
G89.4- Chronic pain syndrome (ICD-10)	3,820	2,012
F90.9- Attention-deficit hyperactivity disorder, unspecified type (ICD-10)	3,327	3,925
F20.9- Schizophrenia, unspecified (ICD-10)	3,047	3,353
F33.1- Major depressive disorder, recurrent, moderate (ICD-10)	2,895	3,866
G89.29- Other chronic pain (ICD-10)	2,888	2,952
E78.2- Mixed hyperlipidemia (ICD-10)	2,866	2,518
J44.9- Chronic obstructive pulmonary disease, unspecified (ICD-10)	2,839	2,524
J30.9- Allergic rhinitis, unspecified (ICD-10)	2,808	2,615
M54.16- Radiculopathy, lumbar region (ICD-10)	2,486	1,767
F90.0- Attention-deficit hyperactivity disorder, predominantly inattentive type (ICD-10)	2,290	2,795
F34.81- Disruptive mood dysregulation disorder (ICD-10)	2,252	2,884
R05- Cough (ICD-10)	2,239	3,198
F84.0- Autistic disorder (ICD-10)	2,225	2,576
F43.10- Post-traumatic stress disorder, unspecified (ICD-10)	2,203	2,876