MISSISSIPPI DIVISION OF
MEDICAID

Comprehensive Quality Strategy

December 31, 2024

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

Elevating Quality 2024

Elevating quality remains one of Mississippi Division of Medicaid's (DOM) top priorities. The COVID-19 pandemic caused a dramatic upheaval over the last several years, 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.

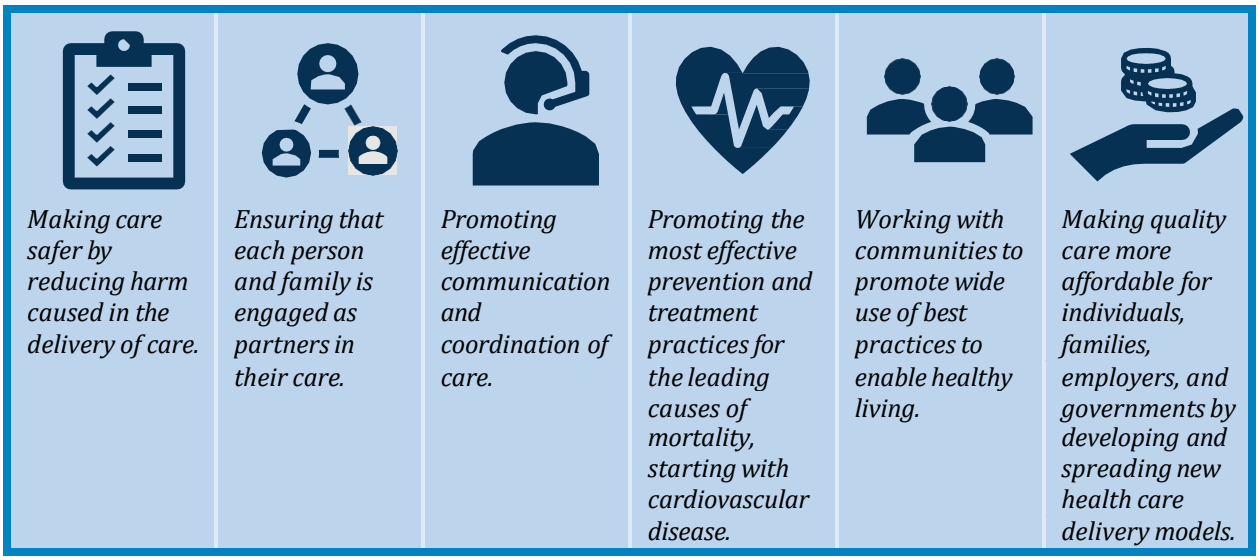
In accordance with 42 C.F.R. § 438.340, DOM is releasing this updated Comprehensive Quality Strategy (CQS) in December 2024, which addresses changes to the DOM's quality programs since the 2021 Quality Strategy submission. As there are several significant changes in the process of implementation, including the onboarding of three new Managed Care Organizations (MCO)'s, DOM plans to submit a new comprehensive iteration of the CQS to CMS in second quarter of 2025, after it is made available for public comment and tribal consultation. The new CQS is anticipated to remain in effect between 2025 until 2028, unless significant changes warrant an earlier update.

Table of Contents

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 2021 Managed Care Quality Strategy was created to be an overarching quality improvement strategy, providing an opportunity to connect the numerous quality improvement efforts occurring throughout DOM and move toward coordination of all initiatives under a more unified approach. The CQS also provided 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]



[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. DOM requires its CCOs to develop and make available to providers clinical practice guidelines consistent with national standards for disease and chronic illness management of members. For more information on clinical practice guidelines, please see *Section 10.M: Clinical Practice Guidelines* of the latest MississippiCAN contract. 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 Goals and Objectives

Goals	Objectives
Make Care Affordable	Incentivize innovation by advancing value-based payment arrangements. Minimize wasteful spending by reducing low-value care.
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	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.
Make Care Safer by Reducing Harm Caused in the Delivery of Care	Ensure maternal safety and appropriate care during childbirth and postpartum Reduce medication errors and improve adherence to medication regimen.
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	Ensure appropriate follow-up after emergency department visits and hospitalizations through effective care coordination and care management. Achieve an interoperable health information technology system that keeps health information secure but readily accessible to patients and other authorized parties.

Underpinning these 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.

Effective July 9, 2024, DOM began the transition from the MCAC to the Medicaid Advisory Committee (MAC) as well as the establishment of the Beneficiary Advisory Committee (BAC), as outlined in CMS Final Rule CMS-2442-F "Ensuring Access to Medicaid Services". The final rule renames and expands the scope of states' MCAC, as well as establishing minimum requirements for MAC membership.

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. 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 worked collaboratively to determine how varying PBTF member resources can be maximized to address:

- 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.

Further details of DOM's maternal health quality programming can be found in Section 2.3.2 Quality Incentives of this document.

Chronic Disease

Chronic diseases are among the most common health problems in Mississippi, with a cardiovascular disease death rate that 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.

Care 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 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 Utilization Management/Quality Improvement Organization (UM/QIO). For more information about DOM's policies regarding chronic conditions and remote patient monitoring, please refer to Part 225: Telemedicine of 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 focused 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 were 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

DOM Quality Focus	Quality Strategy Meaningful Measure	Goal	Objectives	QIPP Quality Metric
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 95th% by 2025	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 diagnosis from 51% to 75% by 2025	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)
	Communities to Promote Best Practices of Healthy Living	Promote beneficiaries taking an active role in their health	Implement the Beneficiary Advisory Council	CCO Member Satisfaction Survey Scores
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 months of life from 66% to 80% by 2025	Well Child Visit- First 30 months (W30)

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 75th% 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 75th% 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 75th% 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

2.3.1 National Performance Measures

DOM continues to report both mandatory and 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.

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©(3). The measures are submitted by the CCOs 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 Care Management reports assess the effectiveness of care management services for actively enrolled members who voluntarily enrolled in a care 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

The 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.

2.3.2 Quality Incentives

DOM initiatives cover three major sources of Medicaid spending: hospitals, CCOs, and the provider services. DOM continues previous quality incentive programs from the 2021 Quality Strategy, as well as an implementation of a new Value-Based Payment plan, outlined below. Reporting and withholds from these programs can be viewed at 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 were 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, and are currently being reported by the CCOs.

Mississippi Value-Based Payment Programs (MS VBP)

MS VBP bolsters high-quality healthcare and improved outcomes achieved by providers, hospitals, and MSCAN care management. One of the methods DOM is deploying to achieve this goal is the development of financial incentives through a VBP program and state directed payment (SDP) for CCOs, hospitals, and outpatient providers. The VBP program builds upon the current CCO withhold program already in place. CCOs will earn financial incentive based on achievement on outcomes established by the Division. The state-directed payment will provide financial incentives through add-on payments, recognizing the contributions of hospitals and other providers. In alignment with the CQS, the VBP program targets three primary focus areas: maternal health, metabolic health, and mental health. Each domain has 1-2 associated quality measures, listed below:

- **Maternal Health**: Cesarean Birth (PC-02) and Mississippi Outcomes for Maternal Safety (MOMS)
- **Metabolic Health:** Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)
- **Mental Health:** Antidepressant Medication Management (AMM-AD)

MS VBP launched in July 2024, made effective by the SFY 2025 managed care contracts under MSCAN. The MS CCO VBP Incentive program will be phased in such that a portion of incentives are tied to pay for reporting on the implementation of redesigned systems and performance measures (Category 2B of the LAN framework) and will transition to pay for performance (Category 2C of the LAN framework) while a portion of incentives will begin as pay for performance.

CCOs will be evaluated on an annual basis to determine whether established benchmarks were met for each measure. Hospital assessment completion and outpatient provider timely follow up visit completion will also be evaluated annually. Following each performance year, submitted data will be aggregated, reviewed, and analyzed, and DOM will issue stakeholder performance feedback reports to CCOs, detailing performance outcomes and achievement. DOM plans to pay out earned performance payments to eligible CCOs through a lump sum payment following SFY year end.

Mississippi Outcomes for Maternal Safety (MOMS) Initiative

To reduce Severe Maternal Morbidity (SMM), MS VBP will incentivize CCO support for implementation of care delivery redesign, referred to as the MOMS initiative. Care redesign includes new discharge and follow-up post-discharge appointment requirements. Incentives to CCOs will initially be paid based on pay-for-reporting implementation activities and will transition to pay-for-performance in future years. Incentives to hospitals with maternity services (both in-state and out-of-state) and outpatient providers will be shared through a state directed payment that CCOs will distribute annually. Throughout implementation, performance on the MOMS initiative will be evaluated in two parts:

- Part A: MOMS Assessment Completion – Percentage of qualified patients for whom a MOMS assessment was completed and score was assigned at discharge following delivery.
- Part B: Timely Postpartum Follow-up – Percentage of qualified patients that completed their initial postpartum follow-up visit within the requisite time frame based on their assigned MOMS score.

The MOMS assessment was developed using a data-driven, research-backed approach. The MOMS assessment will be completed by the time of discharge based on the real-time condition of the patient and factors that have been proven to contribute to SMM. The goal of the MOMS assessment is to evaluate the SMM risk of the patient and support timely postpartum follow up according to the patient's needs in an effort to improve maternal health outcomes and combat maternal morbidity.

2.4 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. For more information on network adequacy and availability of services standards, please see Section 7.b: *Provider Network Requirements* of the latest MississippiCAN Contract. 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).

2.5 Procedures for Identifying, Evaluating, and Reducing Health Disparities

According to a CMS 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[1], within any internal or external policy or program. All contracted CCOs must develop a Care Management Program that aims to identify and address the unique needs of its members. The process begins with conducting a Health Risk Screening (HRS) that meets or exceeds National Committee for Quality Assurance (NCQA) standards, with the purpose of identifying a members' health-related social needs. This data is used to assign members to varying risk levels for Care Management, as appropriate. Details of this program and process can be located within the most recent Coordinated Care Procurement Contract. 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.

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.

[1] For the purposes of 42 CFR 438.340 (b)(6), the State uses the same definition of disability used under the SSI program.

2.6 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). A UM/QIO vendor was selected in August 2019 for delivery of utilization review, quality management and improvement services, and care 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.

Additionally, DOM's UM/QIO contractor currently provides evidence-based care 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

Care 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. Care 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. To determine initial eligibility for these services, a team of qualified providers perform an independent evaluation. Additional information on how DOM identifies members who need LTSS or members with special health care needs can be found on pages 6 and 7 of the Mississippi Medicaid State Plan.

DOM implemented the eLTSS care 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. 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 (FPW) 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 2021 Managed Care Quality Strategy

The 2021 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. 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 CQS and used for initiating and developing quality improvement projects. Feedback from Medicaid beneficiaries used in the development of the CQS 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 to review the strategy and its components. DOM solicited input from multiple internal and external stakeholders through workgroups and posted 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, were considered in the development of the CQS. The Mississippi Band of Choctaw Indians (MBCI) was consulted in accordance with the state's Tribal consultation policy. Public comment was garnered through DOM's website and public stakeholder meetings prior to submitting the Strategy to CMS for review.

Significant changes are defined as changes that impact quality activities or threaten the effectiveness of the strategy. 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). An evaluation of the effectiveness of the Quality Strategy conducted within the last three years can be found within the latest EQR Annual Comprehensive Technical Report under the *Assessment of DOM's Quality Strategy* section.

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 2030

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.
- 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.

6. Conclusion

The CQS provides an opportunity to investigate and catalog the health quality improvement efforts occurring at DOM. DOM works with members, providers, hospitals, and other 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 care 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 care 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.

Senate Bill 2799 was enacted into law during the 2021 Legislative Session, requiring the CCOs to follow a uniform credentialing process for provider enrollment in the Managed Care Programs. Beginning October 2022, this new process would eliminate the need for a provider to be credentialed or recredentialed multiple times, instead having only one process via centralized credentialing with Medicaid Enterprise System Assistance (MESA). The Division is working to make final system and process changes to reduce administrative

burdens for health care providers, by enabling providers to credential through a single avenue that will qualify them and then allow them to contract with any CCO.

The 2023 Legislature passed Senate Bill 2212 which extended the time a pregnant member remained enrolled in Medicaid to 12 months postpartum.

2. Timeline of Managed Care Delivery System