MISSISSIPPI DIVISION OF
MEDICAID

Managed Care Quality Strategy

2026-2029

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

Contents

Section I: Introduction to Mississippi Managed Care

The Mississippi Division of Medicaid (DOM) is a joint state and federal program established by the Social Security Amendments of 1965 and authorized under Title XIX of the Social Security Act (SSA). DOM administers health coverage for eligible low-income populations across the state, including services delivered through Mississippi's Medicaid Managed Care program.

DOM is committed to the continuous improvement of care quality for individuals enrolled in managed care. This commitment is reflected in DOM's mission:

To responsibly provide access to quality health coverage for vulnerable Mississippians

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Figure 1

DOM's Values

Mississippi's Medicaid Managed Care program is guided by DOM's seven core values, illustrated in Figure 1. These values inform DOM's collaborative approach with beneficiaries, providers, and managed care organizations (MCOs) to strengthen a delivery system that improves population health outcomes, enhances the individual experience of care, and effectively manages costs for both the Mississippi Medicaid State Plan and the Children's Health Insurance Program (CHIP), in accordance with 42 CFR §457.1240(e).

As Mississippi's largest payer of health care services by direct expenditures, DOM recognizes both its responsibility and its capacity to influence quality improvement within the managed care market. Accordingly, maintaining high-quality care practices remains a central priority of the managed care program.

In response to significant changes within its managed care program—specifically, the departure of United Healthcare as a contracted MCO and the implementation of a new managed care contract with Mississippi True dba TrueCare (TrueCare) —DOM is issuing this Managed Care Quality Strategy (MCQS) in accordance with 42 CFR §438.340(a). This

strategy outlines DOM's approach to monitoring, evaluating, and improving quality within the managed care system and is expected to remain in effect through 2029, unless an earlier update is warranted pursuant to 42 CFR §438.340(c)(3).

Populations Served

Mississippi is a predominantly rural state, with a large portion of its Medicaid recipients living in underserved and rural areas. Additionally, many beneficiaries face chronic diseases such as diabetes, cardiovascular disease, and behavioral health challenges, further underscoring the need for comprehensive care. Mississippi's Medicaid program provides health coverage for eligible, low-income populations. These populations include children, low-income families, pregnant women, the aged, and the disabled. Mississippi is required to cover mandatory eligibility groups defined by federal law but has flexibility in covering optional eligibility groups. Eligibility for these groups is determined by a number of factors including family size and income.

For more information regarding enrollment and specific eligibility requirements, please visit DOM's Medicaid Coverage-Who Qualifies for Coverage site.

Mississippi Medicaid Managed Care Review

The Mississippi Legislature enacted Medicaid in 1969, with the addition of Mississippi CHIP in 1998. DOM was designated by state statute as the single state agency responsible for administering Medicaid and CHIP programs in the state of Mississippi. There are approximately 700,000 Mississippians enrolled in our Medicaid and CHIP programs[1].

The Medicaid program operates under two primary structures: traditional Fee-for-Service (FFS) and a managed care program referred to as Mississippi Coordinated Access Network (MississippiCAN or MSCAN). The FFS model includes individuals who are dually eligible and/or enrolled in Long Term Care programs. MississippiCAN emphasizes comprehensive care and predictable health investments through Managed Care Organizations (MCOs) serving over 430,000 beneficiaries in 2025[2].

The CHIP program operates exclusively as a managed care program.

Evolution of Medicaid Managed Care

MississippiCAN is a statewide coordinated care program designed to meet the following goals:

[1]Mississippi Division of Medicaid. (n.d.). *Resources*. Mississippi Division of Medicaid. https://medicaid.ms.gov/resources/
[2]Ibid.

- Improve beneficiary access to needed medical services.
- Improve quality of care.
- Improve program efficiencies and cost predictability.

DOM contracts with three MCOs — Magnolia Health Plan (Magnolia), Molina Healthcare of Mississippi (Molina), and TrueCare — who are responsible for providing services to beneficiaries.

Figure 2 illustrates DOM's framework to quality improvement and progress monitoring.

Figure 2

Driving Improvement and Monitoring Progress

Medicaid managed care in Mississippi has evolved significantly since its inception, reflecting broader national trends in health care delivery and financing. The state's shift toward managed care began in the 1990s with a focus on improving cost efficiency and care coordination for Medicaid beneficiaries. MississippiCAN was authorized by the state legislature in 2011, which marked a key milestone, implementing a managed care program that contracted with health plans to deliver services to certain populations, such as low-income families, pregnant women, and children. Over time, Mississippi expanded its managed care initiatives to incorporate additional populations and services. See *Appendix A* for a timeline with key milestones of managed care in Mississippi since its inception.

Quality Oversight for MCQS

The Office of Managed Care oversees the day-to-day operations of the three MCOs contracted with DOM. The Office of Managed Care in collaboration with the Office of Health Services and the Quality Division of the Utilization Management and Quality Improvement Organization (UM/QIO) contractor provide oversight of the MCO's annual quality work plan and to ensure continuous quality improvement for beneficiaries. An organizational chart detailing DOM's reporting structure can be found in *Appendices B and C.* See DOM's State Plan website for more details.

In addition to internal assessment, DOM utilizes several external groups to perform programmatic oversight and evaluation of the MSCAN, CHIP, FFS, and the MCQS. External Quality Review Organization (EQRO) will be discussed later in Section 3.

Medicaid Advisory Committee

The Mississippi Medicaid Advisory Committee (MAC) is set forth by federal regulation to advise DOM about health and medical care services in accordance with 42 CFR § 431.12.

Beneficiary Advisory Council

The Beneficiary Advisory Council (BAC) is comprised of individuals who are currently or have been Medicaid beneficiaries and individuals with direct experience supporting Medicaid beneficiaries. The BAC advises DOM and the MAC regarding their experience with the Medicaid program and supports policy development and effective administration of the Medicaid program.

Tribal Engagement

DOM complies with Section 1902(a)(73) and Section 2107(e)(1)(C) of the SSA by seeking advice on an ongoing basis from a designee of the Mississippi Band of Choctaw Indians (MBCI) concerning Medicaid and CHIP matters having a direct impact on Indian health programs and urban Indian organizations.

At a minimum, DOM consults with the Mississippi Band of Choctaw Indians (MBCI) by providing written notice to the Tribe's designated representative regarding amendments to the State Plan. This notice includes a description of the proposed change and its direct impact and is sent at least 30 days before submitting any Medicaid state plan amendment, and at least 60 days before submitting any waiver proposals, extensions, amendments, renewals, or demonstration project proposals that are likely to directly impact Indian health programs, Tribal organizations, or urban Indian organizations (I/T/Us). This communication is made via email. Direct impact is defined as any Medicaid or CHIP program changes that are more restrictive for eligibility determinations, changes that reduce payment rates or payment methodologies to I/T/U providers, reductions in covered services, changes in consultation policies, and proposals for demonstrations or waivers that may impact I/T/U providers.

Barriers to Care and Managed Care Opportunities

Mississippi's Medicaid program is facing several key demographic shifts that may affect future funding, enrollment, and service delivery such as an aging population, rural population decline, and economic factors such as high poverty rates and fluctuations in employment levels. DOM identifies the following as some of the known barriers to improved health outcomes that serve as an opportunity for our newly implemented MCOs:

- Level of engagement in care management and disease management activities.
- Health literacy of beneficiaries and valuation of preventive care.
- Statewide health professional shortages.
- Potentially preventable hospital returns (PPHRs) especially for mental and behavioral health conditions.
- Health outcomes affecting control of chronic diseases and maternity outcomes.
- Stakeholder understanding and participation in quality improvement projects.
- Provider engagement and participation in quality improvement projects and performance tracking activities
- Multifactorial problems and limited resources needed to drive improvements in outcomes.

DOM regularly evaluates its internal policies as well as MCO programs and value-added services. DOM will partner with its MCOs to increase awareness and engagement, reduce barriers to access, and seek new avenues for innovation to achieve better health for our Mississippi populations.

Section II: Mississippi Medicaid's Continuous Quality Improvement

Mississippi Medicaid continues to invest in innovative, data-driven strategies to strengthen key service areas, including care management, performance improvement projects, health literacy initiatives, telehealth expansion, and strategic provider partnerships. These efforts are designed to support ongoing quality improvement across the Medicaid program.

As part of this approach, Mississippi Medicaid collaborates with providers to develop and continuously refine tools that promote high-quality care and regulatory compliance. These tools include updated clinical practice guidelines, standardized medical record documentation, compliance feedback mechanisms, and provider quality performance reports, all of which support consistent care delivery and continuous performance improvement.

The Managed Care Quality Strategy (MCQS) was developed in accordance with 42 CFR §438.340 and 42 CFR §457.1240 to ensure alignment with federal regulatory requirements. *Appendix D* includes a crosswalk that maps each required regulatory element to the corresponding section of the MCQS.

The MCQS is evaluated annually to assess its effectiveness and is updated to incorporate state and federal requirements as significant changes occur, or at a minimum every three years in accordance with 42 CFR §438.340(c). DOM defines a "significant change" as a

substantial or meaningful modification to the policies, processes, or methodologies used to measure, monitor, or improve the quality of care delivered through Mississippi Medicaid programs.

MS Medicaid Goals and Objectives Overview

The MCQS aims to further DOM's mission by defining the goals and objectives of Mississippi's Medicaid and CHIP managed care programs, as required per 42 CFR § 438.310(c)(1). DOM aims to align its MCQS objectives with those from Centers for Medicare & Medicaid Services' (CMS) National Quality Strategy, leveraging several approaches toward transparency, advancing safety culture through partnership, and incentivizing zero harm through quality measurement, public reporting, and value-based programs and models[3]. By setting clear goals and objectives shown in Figure 3, DOM can focus its efforts, mobilize resources, and drive effective improvements in care quality, patient safety, and health outcomes for its beneficiaries. As required per 42 CFR § 438.10(c)(3), quality measures outlined in *Appendix E* will be made available at least annually on DOM's website.

Figure 3

Medicaid Goals and Objectives

3 Centers for Medicare & Medicaid Services. (2024). *CMS quality strategy*. CMS. https://www.cms.gov/quality-strategy

Quality Standards and Benchmarks

Quality measurement is a key component of quality improvement. Quality performance benchmarking helps providers gain insights, identify best practices in care, and improve outcomes[4]. The MCQS provides an overview of the different methods DOM uses to assess the performance of Mississippi's managed care programs, including program improvement activities, performance results, successes, and opportunities for advancement.

DOM requested authority from CMS for quality initiatives beginning in July 2019. These initiatives address major sources of Medicaid spending, including hospitals (such as the state's academic medical center), physicians, emergency ambulance providers, and MCOs. The programs incorporate quality measures, targeted performance improvement levels, and accountability requirements and are described in the following sections. More information on these programs may also be found on the Quality landing page of DOM's website. Additionally, as details are finalized, DOM will post information on new CMS initiatives in their early implementation periods—including Transforming Maternal Health (TMaH), the Rural Health Transformation model, and the Cell and Gene Therapy Access Model—on its public facing website.

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), MCOs 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

4 Centers for Medicare & Medicaid Services. (2024). *Quality measure and quality improvement*. CMS. https://www.cms.gov/quality-measures-quality-improvement

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.

Managed Care Value-Based Withhold Program

DOM implemented a Managed 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 MCOs. For additional information, please visit Measuring Managed Care Performance - Mississippi Division of Medicaid.

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 MCOs, hospitals, and outpatient providers. The VBP program builds upon the current MCO withhold program already in place. MCOs 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 MCO 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.

MCOs 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 MCOs, detailing performance outcomes and achievement. DOM plans to pay out earned performance payments to eligible MCOs 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 MCO 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 MCOs 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 MCOs 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.

Ambulatory Payment Classification (APC) Opt-Out Program

The Rural Hospital Ambulatory Payment Classification (APC) Opt-Out program supports access to high-quality outpatient care for Mississippi Medicaid beneficiaries enrolled in Managed Care Plans by strengthening services provided by small rural hospitals. In a predominantly rural state like Mississippi, where many communities depend on a single hospital for care, supporting the financial stability of rural hospitals is essential to maintaining access to critical health services.

Under this state-directed payment arrangement, Managed Care Organizations (MCOs) make separate payments for covered services delivered to managed care enrollees by eligible rural hospitals. This program helps preserve outpatient services in rural and underserved areas, supports prevention and chronic disease management, and promotes consistent access to care statewide. The program also reinforces accountability and care effectiveness through the use of quality measures across participating providers.

Transforming Reimbursement for Emergency Ambulance Transportation (TREAT)

In the 2022 regular legislative session, House Bill 657 authorized the additional payment program for ground emergency ambulance services to be funded with a health care provider fee. This state directed payment arrangement through managed care will be made quarterly to the eligible ground ambulance providers for SFY 2023. For more information regarding the TREAT program, please visit the following DOM site: https://medicaid.ms.gov/transforming-reimbursement-for-emergency-ambulance-transportation-treat/.

The quality measures associated with this program are the following:

- Maintain ground emergency ambulance providers in all of the Mississippi 82 counties;
- Managed care utilization of ground emergency services; and
- Identify existing sources of data for emergency ambulance provider performance measures to be able to identify future opportunities for quality improvement initiatives.

Quality Measurement Framework

A critical part of DOM's effort is the integration of the Health Care Payment Learning & Action Network (HCPLAN, or LAN) to better foster collaboration across stakeholders, such as health care providers, payers, and policymakers, and encourage the use of VBP models. By using these models, providers shift their focus from service volume to quality and outcomes, aligning with DOM's goals of managing costs and improving care.

Quality improvement aims to create standardized processes and strengthen infrastructure to reduce variation, achieve predictable results, and ultimately improve health outcomes. Infrastructure may involve health information technology (IT), leadership priorities, and physical capital, while processes may include standard operating procedures and the availability and quality of education and training opportunities for staff.

Health Disparities

DOM is committed to equal access to quality care for its enrollees. To comply with 42 CFR § 438.340(b)(6), DOM will work to analyze trends across age, race, ethnicity, sex, primary language, and disability status to inform policy improvements and strengthen program impact. For the purpose of this analysis, DOM defines disability using the Supplemental

Security Income (SSI) program criteria: "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months."

DOM will also utilize technology to provide transparency of data, specifically regarding performance and health outcomes, to optimize system-wide changes as identified. To support this effort, DOM is preparing to implement MCO Scorecards as part of its Medicaid and CHIP Quality Rating System, which will allow enrollees and caregivers to compare plans based on quality metrics and performance measures (see *Appendix F*). These scorecards, aligned with federal requirements and CMS-specified quality measures, will enhance public reporting, promote accountability, and foster continuous improvements in program design and strategic planning.

In addition, all MCOs must develop a care management program that aims to identify and address the unique needs of its beneficiaries. The process begins with conducting a health risk screening that meets or exceeds National Committee for Quality Assurance (NCQA) standards. This data is used to assign beneficiaries to varying risk levels for care management, as appropriate. More details of care coordination will be discussed in later sections.

Language and information access is another crucial component of Mississippi's approach. DOM hopes to empower Medicaid enrollees and their caregivers to actively participate in their care by providing them with education, resources, and support tools. DOM works with MCOs to implement innovative, evidence-based educational programs designed to increase beneficiary awareness of health risks and encourage self-care and active participation in managing personal health.

Long Term Services and Supports

The Long-Term Services and Supports (LTSS) business area includes home and community-based services (HCBS) and services in institutional facilities. Mississippi HCBS encompasses operations for five 1915(c) waivers including the Assisted Living waiver, the Elderly & Disabled waiver, the Independent Living waiver, the Intellectual Disabilities/Developmental Disabilities waiver, and the Traumatic Brain Injury/Spinal Cord Injury waiver as well as one 1915(i) State Plan Community Support Program. HCBS programs offer in-home care as an alternative to institutional care in nursing facilities or intermediate care facilities. Beneficiaries must apply and be approved for these services based on established clinical and financial eligibility criteria. As these services are carved out of managed care in Mississippi, MCOs must have in effect mechanisms to identify individuals who require special health care needs and/or LTSS, and those mechanisms must comply with 42 CFR § 438.208(c)(1). The assessment mechanisms must utilize health

care professionals who are trained and qualified to assess and address special health care needs. Once identified, MCOs are responsible for making referrals to appropriate fee for service LTSS programs as required by 42 CFR 438.71.

DOM implemented the eLTSS care management system for all waivers in 2016 and 2017 and incorporated institutional facilities in 2022. This supports efforts to align processes and quality across both institutional and home and community-based LTSS. Additionally, the State began Electronic Visit Verification (EVV) for personal care services in 2017 as required by the 21st Century Cures Act. DOM also contracts with numerous Dual Special Needs Plans and as required by the Medicare Improvement of Patients and Providers Act (MIPPA), these contracts were updated in 2021 to include care coordination reporting requirements for several high-risk waiver populations.

Performance Reporting

DOM monitors several quality performance measures to evaluate the effectiveness of health care delivered by MCOs and to measure progress toward established goals and objectives. These measures and targets, described previously, are updated annually on the DOM website and are included in *Appendix E*.

To set performance targets, DOM statewide performance is compared to NCQA Healthcare Effectiveness Data and Information Set (HEDIS®) Quality Compass data, where available, and targets are set based on national benchmarks (50th, 75th, 90th, etc. percentiles). If HEDIS Quality Compass data is unavailable, statewide performance is compared to available CMS Child and Adult Core Sets. DOM may update performance targets as needed to promote continuous improvement. For more information on quality measure reporting and performance, see Mississippi's state overview on CMS' State Profile page.

Collection and submission of performance measurement data

DOM requires MCOs to report annually on its defined performance measures, which are delineated in our MCO contracts, formatted using state-specific definitions, and have required timeframes to calculate and report. Any deviances are to be noted as variances by the MCO, and actions taken for improvement are to be described. DOM may use corrective action plans (CAPs) when a MCO fails to provide the requested services or otherwise fails to meet contractual responsibilities related to quality. DOM also reports aggregate quality performance data to both NCQA and CMS annually, and implements internal processes to ensure timely collection, analysis, and reporting of nationally reported quality measures.

Mechanism to detect both underutilization and overutilization of services

DOM operates a structured and proactive utilization review system designed to ensure high-quality, medically necessary care while optimizing resource use. This system, built in partnership with MCOs, will be reviewed and approved annually by DOM, and establishes

clear accountability through defined criteria for medical necessity, pre-authorization, referrals, and appeals, ensuring transparency and fairness for providers and beneficiaries. Further, DOM works to assess utilization of services to determine appropriate spending and reduce wasteful spending. A strong emphasis is placed on continuous quality assessment, particularly for beneficiaries with complex health needs, with built-in mechanisms for physician oversight, provider performance evaluations, and the integration of emerging medical technologies. For more information on requirements, please see the managed care contract Section 8.16. Utilization Review of the latest contract MississippiCAN, CHIP Contracts - Mississippi Division of Medicaid.

Performance Improvement Projects

For MississippiCAN and CHIP, DOM requires MCOs to perform a minimum of five, either clinical or non-clinical, Performance Improvement Projects (PIPs) each year. Topics must be prevalent and significant to the population served. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery. 438.340 (b)(3)(ii) Further, PIPs shall meet all relevant CMS requirements and shall be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. Each health plan is required to submit all PIP topics to DOM for approval, see Section 8.11 of the MSCAN contracts for more details on our MississippiCAN, CHIP Contracts - Mississippi Division of Medicaid public site.

Each MCO must submit PIP results to the EQRO for validation annually. The EQRO validates and scores the submitted projects in accordance with the protocol developed by CMS titled, External Quality Review (EQR) Protocol 1: Validating PIPs. The EQRO makes recommendations for PIP topics for the following evaluation year based on the results of the validation process and DOM priorities. Please see Mississippi External Quality Review section of MississippiCAN Resources webpage for the most recent year's PIPs including all three MCOs' topics, aims and interventions.

Care Coordination and Integration

DOM requires MCOs to implement mechanisms for coordination and continuity of care as required by federal regulations 42 CFR § 457.1230(c) and 42 CFR § 438.208(c)(1). This includes coordination of behavioral health/substance use disorder and physical health services, as well as use of closed-loop referrals and community-based organization partnerships. Care coordination is critical to ensuring beneficiaries receive needed services in a supportive, effective, efficient, timely, and cost-effective manner. MCOs are responsible for ensuring care coordination for beneficiaries through their care management teams.

Section III: External Quality Review Organization (EQRO)

The Balanced Budget Act of 1997 requires states that contract with managed care organizations to evaluate their compliance with the state and federal regulations in accordance with 42 CFR 438.358. To meet this requirement, DOM contracted with an EQRO to evaluate all MCOs participating in MississippiCAN and CHIP. To assess the health plan's compliance with quality, timeliness, and accessibility of services per 42 CFR § 438.350, the EQR can be divided into six areas, including: administration, provider services, beneficiary services, quality improvement, utilization management (UM), and delegation. MCO quality, timeliness, and access to covered health care services are part of the EQR per 42 CFR 438.340(b)(4)

Current scope of EQRO work:

- Validation of performance measures (see section D, pp. 61 and 87 of MSEQR 2024-2025 Annual Comprehensive Technical Report for Required Protocol 1: Validation of PIPs and Required Protocol 2: Validation of Performance Measures).
- Overall review of conformity to standards (see Executive Summary section, p. 3 of MSEQR 2024-2025 Annual Comprehensive Technical Report for Required Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations.)
- Verify Network Adequacy (see section B, p. 37 of MSEQR 2024-2025 Annual Comprehensive Technical Report for Required Protocol 4: Validation of Network Adequacy).
- Validation of Quality of Care Surveys (see section B, p. 38 of MSEQR 2024-2025 Annual Comprehensive Technical Report for Protocol 6: Administration or Validation of Quality of Care Surveys).
- Reviewing the Division's Quality Strategy, including a program evaluation of the previous three-year period for inclusion in the updated MCQS (see Executive Summary: Assessment of DOM's Quality Strategy section, p. 3 of MSEQR 2024-2025 Annual Comprehensive Technical Report).

In addition, an EQRO will assess the degree to which the health plans addressed deficiencies identified during the previous EQR and provide feedback for potential areas of continued improvement. Per 42 CFR 438.340(c)(2), more details can be found in the recent 2023-2024 EQR reports and 2024-2054 EQR report. Updates to the MCQS take into consideration the recommendations provided in these reports.

Access Standards

MCOs are required to ensure beneficiary access to all medically necessary, Medicaid-covered services and to meet network adequacy standards in accordance with 42 CFR §§ 438.68, 438.206, and 438.207, as well as all applicable DOM requirements. The EQRO validates MCO provider networks serving the MississippiCAN and CHIP populations. These validations include a provider access study and an assessment of provider directory accuracy.

DOM has elected to incorporate EQRO-recommended activities into its quality strategy to enhance the EQR process and further support efforts to improve the quality, timeliness, and access to care provided by the Managed Care Organizations (MCOs). For more information on network adequacy and availability of services standards, please see Section 6.2: Provider Network Requirements of the most recent Managed Care Contract.

In accordance with 42 CFR 438.236, DOM requires MCOs to adopt and disseminate evidence-based clinical practice guidelines that align with national standards for disease and chronic condition management. These guidelines must be accessible to providers, beneficiaries, and potential enrollees upon request. For a detailed listing of the guidelines adopted by each MCO, please see *Appendix G*, and for additional information, refer to Section 8.15: Clinical Practice Guidelines of the most recent Managed Care Contract.

Transition of Care Policy

Transitional care management is a type of care management program to support beneficiaries' transition of care when discharged from an institutional clinical or inpatient setting. DOM and each MCO maintains a transition of care policy consistent with requirements of 42 CFR § 438.62 to access continued services upon transition to ensure continuity of care for beneficiaries. DOM requires its MCOs to make the transition of care policy publicly available and accessible to its beneficiaries and potential enrollees in accordance with 42 CFR § 438.10. MCOs are required to maintain and operate a formal transitional care management program to support transitions of care for its beneficiaries. They are also required to develop relationships with both state and local agencies, as well as state and local community-based organizations for both input on transitional care management strategies and for referral of beneficiaries for services. As part of this requirement, MCOs must develop a Transition of Care Partnership and Referral Report detailing partner agencies and community-agencies it plans to utilize in its transition of care strategy. This report will include a list of agencies and community-based organization contacts that the MCO plans to utilize for referrals.

MCOs must assemble an interdisciplinary team to design and implement the transition of care plan and provide oversight and management of all transition of care processes. The

transition of care team will consist of transitional care nurses in addition to any staff necessary to enhance services for beneficiaries and provide support for their return to the home or other community setting, and team beneficiaries must be located within the state of Mississippi. The care management team works with beneficiaries to improve adherence with medications and treatment and helps to ensure the beneficiary and any family caregiver(s) are informed and understand how to administer care post-discharge.

Closed-Loop Referrals

Transition of care teams are required to use closed-loop referrals for all referrals made for beneficiaries, using the warm hand-off method when possible. This method ensures the referral is made by connecting the beneficiary directly to the entity in receipt of the referral, regardless of provider type. If a referral is made for a beneficiary, a transition of care team representative must follow-up with the beneficiary about that referral within seven (7) calendar days after the referral is made. When the referral is made, a transitional of care team representative must discuss with the beneficiary any challenges utilizing the referral and work to resolve any issues the beneficiary may have in accessing the referral. At follow-up, the transition of care team representative must determine why the referral was not utilized and assist the beneficiary in utilizing the referral. On a quarterly basis, MCOs must report on the number and type of referrals made, follow-ups, and number of referrals completed by beneficiaries.

Remedies

MCOs are expected to meet or exceed all DOM objectives and standards as described in their contract. Performance reviews are periodically conducted, and all areas of responsibility and contract requirements are subject to performance evaluation. If standards are not met, DOM may pursue contractual remedies for noncompliance. Those remedies may require a corrective action plan (CAP) and/or impose intermediate sanctions, which comply with 42 CFR § Part 438, Subpart I. For more information on requirements, please see Section 14. Remedies of the most recent Managed Care Contract. In the past three years, DOM has imposed intermediate sanctions on its contracted MCOs. More specifically, each MCO received at least one CAP in at least one area of responsibility (administration, provider services, UM, beneficiary services, quality improvement, and delegation). However, all three DOM MCOs operating during 2022–2024 showed year-over-year improvement.

Non-Duplication of Services

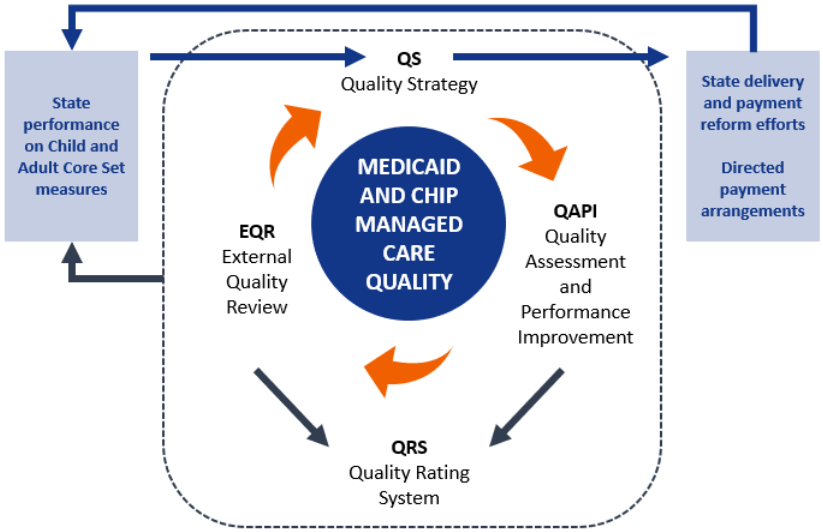
Non-duplication of EQRO activities does not apply as defined in 42 CFR §438.360(c).

Section IV: Quality Strategy Development and Public Comment

The 2025 MCQS serves as a roadmap to monitor and implement quality improvement and allow for necessary revision to strengthen the effectiveness of quality programs and initiatives. The MCQS is part of a multi-pronged approach to ensure high-quality care delivery through state managed care programs. It is best implemented when aligned with quality tools and initiatives such as the Medicaid and CHIP Child and Adult Core Set measure reporting, NCQA HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS) reporting, PIPs (as part of the Quality Assessment and Performance Improvement [QAPI] programs), VBP initiatives, and the annual EQR.

Figure 4

Medicaid and CHIP Managed Care Quality Initiatives Relationship



To promote excellence in health care access, quality, and outcomes, Mississippi engaged key leaders and stakeholders through the development of the MCQS. Feedback is gathered through workgroups and public comment on a DOM website posted draft. This inclusive process allows input from Tribal populations, beneficiaries, health systems, MCOs, providers, and the public, helping to shape and evolve our quality improvement strategies.

In accordance with 42 CFR § 438.340(c)(1), the 2025 MCQS draft was made available publicly on January 14, 2026. The required 30-day public comment period runs through February 14, 2026. The public was invited to give written and verbal comments on the

draft MCQS during this public comment period. These comments will be used to inform the final 2026-2029 MCQS document.

Figure 5:

Stakeholder Feedback Process

Section V: Conclusion

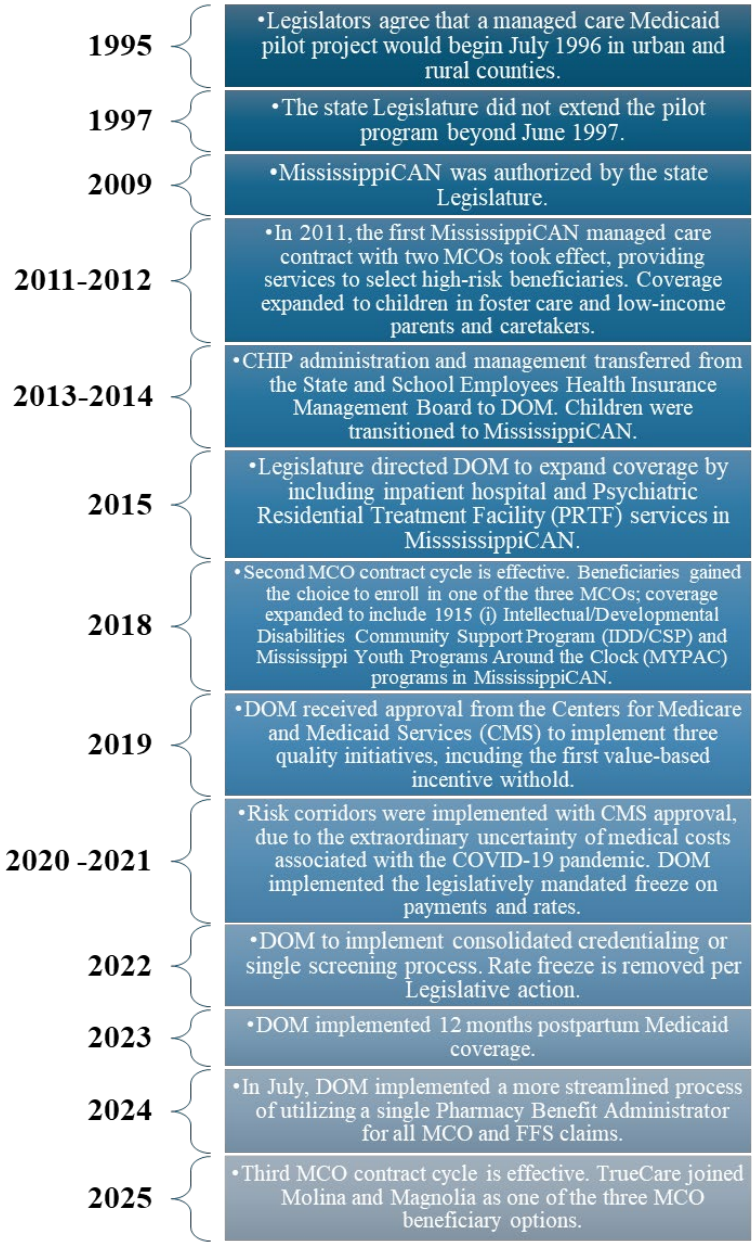
The goals and objectives of DOM are to ensure beneficiaries have access to health care and positive health outcomes can be realized through a quality improvement program. Through adequate capacity and services, coordination and continuity of care, appropriate and objective health risk assessments, timely authorization of services, and continual improvements utilizing best practices, DOM can support its beneficiaries and providers. Engagement and feedback are critical to the success of this MCQS, to DOM's quality efforts moving forward, and to Mississippi Medicaid's transformation efforts broadly.

The Managed Care Quality Strategy is intended to focus on measuring service utilization and outcomes, reporting, and effectively communicating findings, and improving coordination of care across settings, providers, and specified domains. Together, these elements provide a durable framework for quality improvement and accountable managed care oversight.

Section VI: Appendices

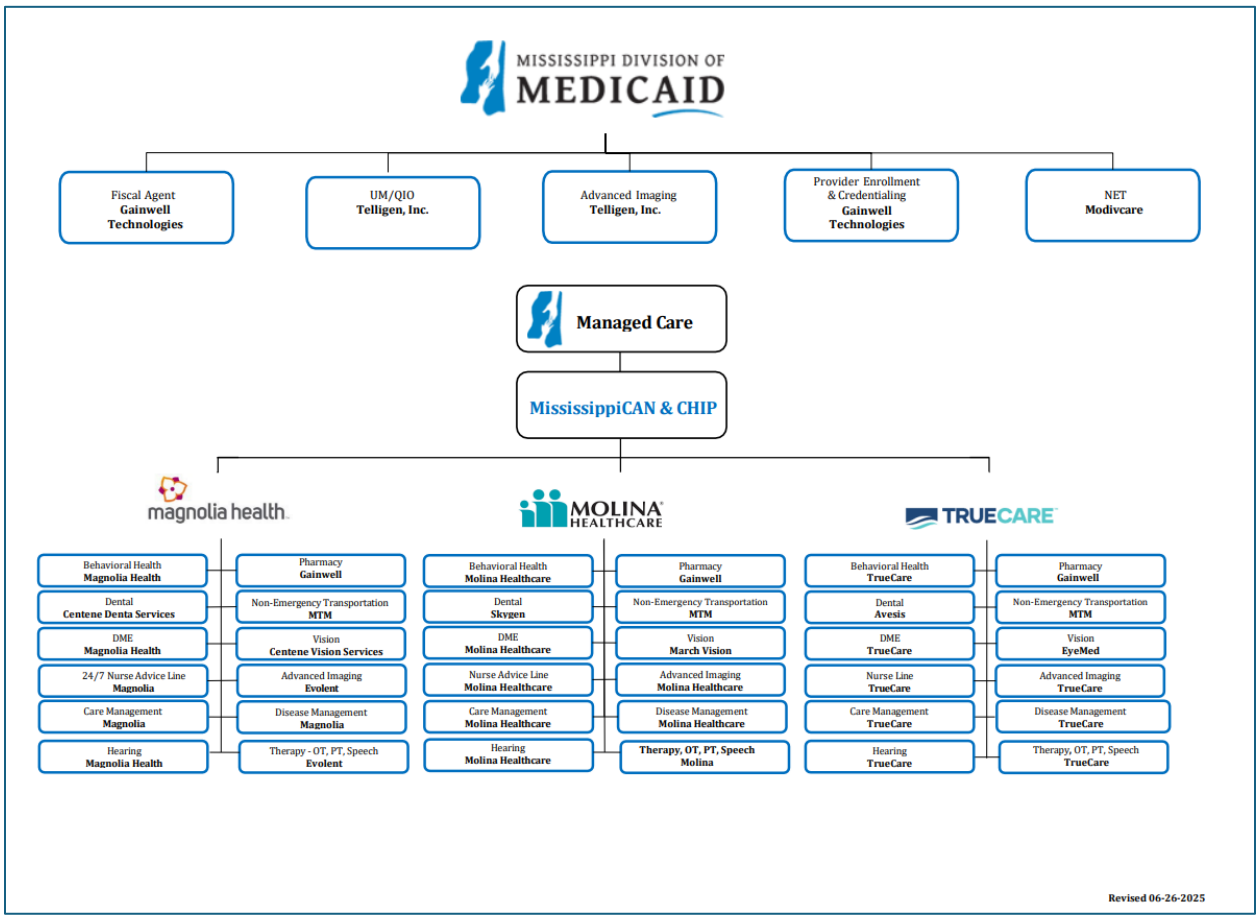
Appendix A:

Timeline of Key Milestones in MS Managed Care



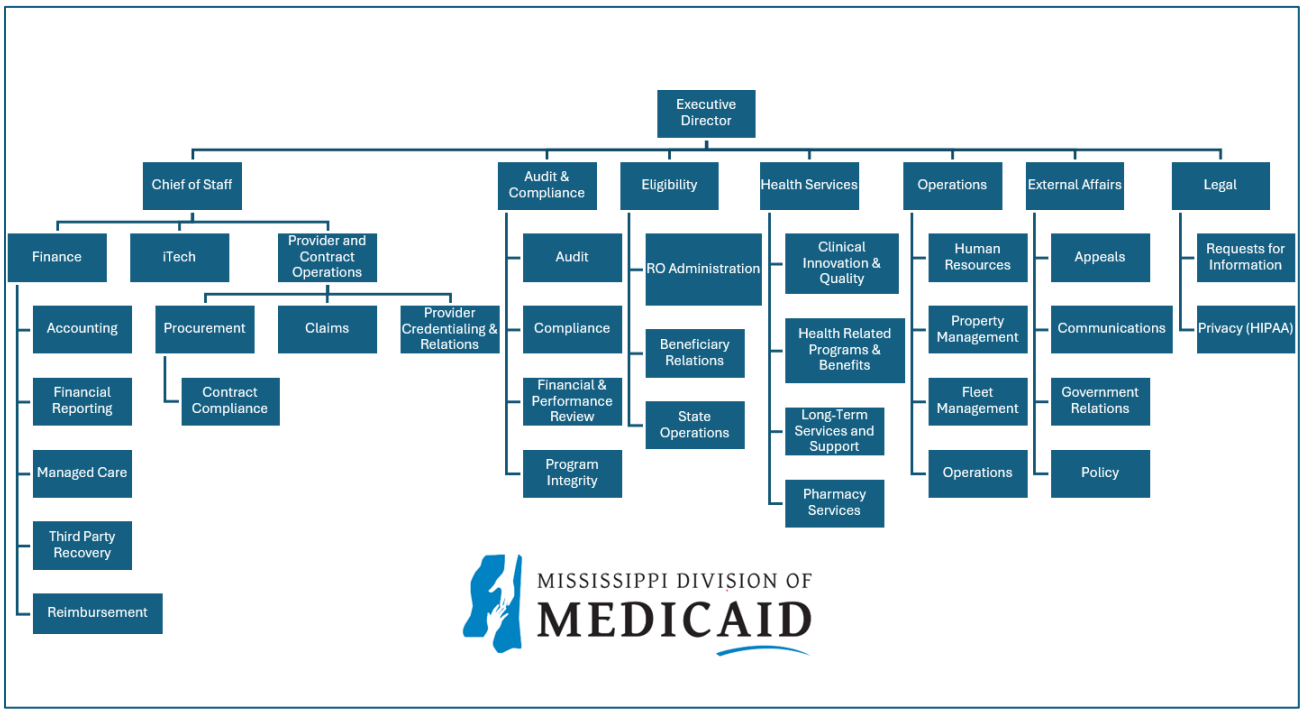
Appendix B:

Managed Care Organizational Chart



Appendix C:

MS DOM Organizational Chart



Appendix D:

Quality Strategy and CFR Requirements Reference Guide Crosswalk[5]

CFR Reference	CFR Requirement	Quality Strategy Section/Page Number
42 C.F.R. §438.340(b)(1)	"State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by 42 C.F.R. § 438.68 and 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with 42 C.F.R. § 438.236."	p. 15
42 C.F.R. §438.340(b)(2)	"The State's goals and objectives for continuous quality improvement which must be measurable and take into consideration the health status of all populations in the State served by the MCO, PIHP, PAHP, and PCCM entity described in 42 C.F.R. § 438.310(c)(2)."	p. 4
42 C.F.R. §438.340(b)(3)(i)	The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, PAHP, and PCCM entity described in 42 C.F.R. § 438.310(c)(2) with which the State contracts, including but not limited to, the performance measures reported in accordance with 42 C.F.R. § 438.330(c). The State must identify which quality measures and performance outcomes the State will publish at least annually on the website required under 42 C.F.R. § 438.10(c)(3)"	p. 9
42 C.F.R. §438.340(b)(3)(ii)	"The performance improvement projects to be implemented in accordance with 42 C.F.R. § 438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP"	p. 13
42 C.F.R. §438.340(b)(4)	"Arrangements for annual, external independent reviews, in accordance with 42 C.F.R. § 438.350, of the quality outcomes and timeliness of, and access to, the services covered under each MCO, PIHP, PAHP, and PCCM entity (described in 42 C.F.R. § 438.310(c)(2)) contract."	p. 14
42 C.F.R.	"A description of the State's transition of care policy required under 42 C.F.R. § 438.62(b)(3)."	p. 15

[5] *Managed care State quality strategy*, 42 C.F.R. § 438.340 (2024). Electronic Code of Federal Regulations. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-E/section-438.340
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CFR Reference	CFR Requirement	Quality Strategy Section/Page Number
§438.340(b)(5)		
42 C.F.R. §438.340(b)(6)	"The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. For purposes of this paragraph (b)(6), "disability status" means, at a minimum, whether the individual qualified for Medicaid on the basis of a disability. States must include in this plan the State's definition of disability status and how the State will make the determination that a Medicaid enrollee meets the standard including the data source(s) that the State will use to identify disability status."	p.10
42 C.F.R. §438.340(b)(7)	"For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part."	p. 16
42 C.F.R. §438.340(b)(8)	"The mechanisms implemented by the State to comply with 42 C.F.R. § 438.208(c)(1) (relating to the identification of persons who need long-term services and supports or persons with special health care needs)."	p. 16
42 C.F.R. §438.340(b)(9)	"The information required under 42 C.F.R. § 438.360(c) (relating to nonduplication of EQR activities)."	p. 22
42 C.F.R. §438.340(b)(10)	"The State's definition of a "significant change" for the purposes of paragraph (c)(3)(ii) of this section. Quality strategy must be updated whenever significant changes occur within the Medicaid program."	p. 8
42 C.F.R. §438.340 (c)(1)(i)	"The State must make the strategy available for public comment before submitting the strategy to CMS for review, including obtaining input from the Medical Care Advisory Committee, beneficiaries, and other stakeholders."	p. 20
42 C.F.R. §438.340 (c)(1)(ii)	"If the State enrolls Indians in the MCO, PIHP, PAHP, or PCCM entity described in § 438.310(c)(2), consulting with Tribes in accordance with the State's Tribal consultation policy."	p. 12
42 C.F.R. §438.340 (c)(2)	"Review and update the quality strategy as needed, but no less than once every 3 years."	p. 14

Appendix E:

Quality Metrics and Performance Targets[6]

MS DOM QUALITY METRICS AND PERFORMANCE TARGETS				
Metric Name	**Metric Specifications**	**Baseline Performance (year)**	**Performance Target**	**Program MSCAN**
Well Child Visits - First 30 Months of Life (W30)				
Children 15 months of age with 6+ visits	HEDIS	53.7% (SFY 2024)	56.4% (SFY 2024)	✓
Immunizations for Adolescents (IMA)				
Immunizations for Adolescents (IMA)	HEDIS	20.0% (SFY 2024)	22.5% (SFY 2024)	✓
Anti-Depressant Management				
Effective Acute Phase Treatment	HEDIS	52.9% (SFY 2024)	55.6% (SFY 2024)	✓
Follow up After Hospitalization for Mental Illness				
30 Days - Ages 6 to 17	HEDIS	N/A (SFY 2024)	71.4% (SFY 2024)	✓
Timeliness of Prenatal Care				
Timeliness of Prenatal Care	HEDIS	90.1% (SFY 2024)	94.9% (SFY 2024)	✓
Comprehensive Diabetes Care - CDC (SPD)				
Hemoglobin A1c Control for Patients with Diabetes (<8%)	HEDIS	N/A (SFY 2024)	50.1% (SFY 2024)	✓
Blood Pressure Control for Patients with Diabetes	HEDIS	N/A (SFY 2024)	60.8% (SFY 2024)	✓
Eye Exams for Patients with Diabetes	HEDIS	N/A (SFY 2024)	51.1% (SFY 2024)	✓
Adults & Children: Asthma ages 5-64				
(AMR) Total	HEDIS	70.8% (SFY 2024)	72.9% (SFY 2024)	✓
Adults: Pharmacotherapy Management of COPD Exacerbation (PCE)				
Systemic Corticosteroid	HEDIS	51.3% (SFY 2024)	53.8% (SFY 2024)	✓
Reduction in C-Section Rate				
Reduction in C-Section Rate	HEDIS	N/A (SFY 2024)	N/A (SFY 2024)	✓
QIPP PPHR A/E Ratio				
QIPP PPHR A/E Ratio	HEDIS	1.0 (SFY 2024)	1.0 (SFY 2024)	✓

[6]Centers for Medicare & Medicaid Services. (n.d.). *Medicaid and Children's Health Insurance Program (CHIP) managed care quality strategy toolkit*. CMS. https://www.cms.gov/medicaid-chip-managed-care-quality-strategy-toolkit

Appendix F:

Managed Care Scorecard

Mississippi is preparing to implement MCO Scorecards as part of its a Medicaid and CHIP (MAC) Quality Rating System (QRS), with full implementation no later than December 31, 2028. This scorecard will allow individuals to compare managed care plans based on quality metrics, empowering them to make informed decisions about their care. Mississippi will adopt the 16 mandatory quality measures defined by CMS, using nationally recognized specifications, and will ensure the integrity of these measures through data collection, validation, and calculation of quality ratings. In alignment with federal requirements, DOM will enhance its public-facing website to meets these standards and allows users—including non-enrolled individuals and caregivers—to view and compare plan ratings. DOM will work closely with CMS to meet all reporting requirements, including annual submissions, and will prepare to utilize the forthcoming technical manual from CMS in 2027 to support system implementation[7]. By increasing transparency and comparability, the system fosters a competitive environment that rewards quality and innovation in care delivery.

[7] Centers for Medicare & Medicaid Services. (n.d.). Medicaid and CHIP Quality Rating System. Retrieved January 8, 2026, from https://www.medicaid.gov/medicaid/quality-of-care/medicaid-and-chip-managed-care-quality/medicaid-and-chip-quality-rating-system

Appendix G:

MCO Clinical Practice Guidelines

2025 Adopted MS Managed Care Organization Clinical Practice Guidelines for Physical and Behavioral Health		
Health Condition/Disease	**Clinical Practice Guideline**	**Recognized Source**
Antipsychotic Prescribing for Children and Adolescents	Guidance on Strategies to Promote Best Practice in Antipsychotic Prescribing for Children and Adolescents	Substance Abuse and Mental Health Services Administration (SAMSHA)
Anxiety/Panic Disorder	Panic Disorder: A review of treatment options	American Academy of Clinical Psychiatrists
Immunizations: ≥ 19 Years of Age Immunization Schedule	Recommended adult immunization schedule for ages 19 years and older	Advisory Committee on Immunization Practices (ACIP)
Immunizations: 0-18 Years of Age Immunization Schedule	Recommended child and adolescent Immunization Schedule for ages 18 years or younger	Advisory Committee on Immunization Practices (ACIP), Centers for Disease Control and Prevention
Asthma	Guidelines for the Diagnosis and Management of Asthma	National Institutes of Health (NIH): National Heart, Lung, and Blood Institute (NHLBI)
Attention Deficit Hyperactivity Disorder (ADHD): Pediatrics	Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents	American Academy of Pediatrics
Autism	Identification, Evaluation, and Management of Children with Autism Spectrum Disorder	American Academy of Pediatrics
Bipolar Disorder	VA/DoD Clinical Practice Guideline for the Management of Bipolar Disorder	Department of Veterans Affairs and Department of Defense
Cancer	National Comprehensive Cancer Network Site	The National Comprehensive Cancer Network® (NCCN®)
Chronic Obstructive Pulmonary Disease (COPD)	Global Strategy for Prevention, Diagnosis and Management of COPD: 2024 Report	Global Initiative for Chronic Obstructive Pulmonary Disease (GOLD)
Coronary Artery Disease	2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease: Executive Summary: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines	American College of Cardiology and American Heart Association Task Force on Clinical Practice Guidelines
Dental Health	ADA Center for Evidence-Based Dentistry Clinical Practice Guidelines	The American Dental Association (ADA)
Depression	Management of Major Depressive Disorder (MMD) (2016)	United States Department of Veteran Affairs (VA) and the Department of Defense (DoD); American Psychological Association
Diabetes	Standards of Care in Diabetes	American Diabetes Association
Heart Failure	2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines	American College of Cardiology (ACC) Foundation, American Heart Association (AHA) Task Force on Practice Guidelines, and the Heart Failure Society of America (HFSA)

2025 Adopted MS Managed Care Organization Clinical Practice Guidelines for Physical and Behavioral Health		
Health Condition/Disease	**Clinical Practice Guideline**	**Recognized Source**
HIV/AIDS	CDC HIV Guidelines and Recommendations	Centers for Disease Control and Prevention
Hypertension	Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults	American College of Cardiology
Kidney Disease	Evaluation and Management of Chronic Kidney Disease	National Kidney Foundation, Kidney Disease Outcome Quality Initiative (NKF KDOQI)
Lead Toxicity	Prevention of Lead Toxicity	The American Academy of Pediatrics, Council on Environmental Health
Maternal Care	Obstetric Care Consensus, Levels of Maternal Care	The American College of Obstetricians and Gynecologists, ACOG Committee Opinion
Obesity & Weight Management	Adult Weight Management (AWM) Guideline; Clinical Report: Preventing Obesity and Eating Disorders in Adolescents; Managing Overweight and Obesity in Adults: Systematic Evidence Review from the Obesity Expert Panel; Final Recommendation Statement Obesity in Children and Adolescents: Screening; Clinical Practice Guideline for Multicomponent Behavioral Treatment of Obesity and Overweight in Children and Adolescents	American Academy of Pediatrics (AAP); Journal of Obesity and Metabolic Syndrome; National Institute of Health (NIH)
Opioids & Opioid Prescribing	CDC Clinical Practice Guideline for Prescribing Opioids for Pain	Centers for Disease Control and Prevention
Opioid Management - Treatment of Opioid Use Disorder	National Practice Guideline for the Treatment of Opioid Use Disorder	American Society of Addiction Medicine
Oppositional Defiant Disorder	Practice Parameter for the Assessment and Treatment of Children and Adolescents with Oppositional Defiant Disorder	American Academy of Child and Adolescent Psychiatry (AACAP)
Perinatal Care	Guidelines for Perinatal Care	American Academy of Pediatrics and American College of Obstetricians and Gynecologists
Periodicity Schedule	Periodicity Schedule: Recommendations for Preventive Pediatric Health Care	American Academy of Pediatrics Bright Futures
Pneumonia	Management of Adults with Hospital-Acquired and Ventilator-Associated Pneumonia: Clinical Practice Guidelines by the Infectious Diseases Society of America and the American Thoracic Society (2016); The Management of Community-Acquired Pneumonia in Infants and Children Older Than 3 Months of Age: Clinical Practice Guidelines by the Pediatric Infectious Diseases Society and the Infectious Diseases Society of America (2011)	Infectious Diseases Society of America (IDSA) Pediatric Infectious Diseases Society (PIDS)
Postpartum Care	ACOG Committee Opinion, Optimizing Postpartum Care	The American College of Obstetricians and Gynecologists, American

2025 Adopted MS Managed Care Organization Clinical Practice Guidelines for Physical and Behavioral Health		
Health Condition/Disease	**Clinical Practice Guideline**	**Recognized Source**
		Academy of Family Practitioners
Preventive Pediatric Care: 0-21 Years of Age	Recommendations for Preventive Pediatric Health Care	Bright Futures/American Academy of Pediatrics
Respiratory Illness	Adult and Pediatric Treatment Recommendations AFP by Topic: Respiratory Tract Infections Diagnosis and Treatment of Respiratory Illness in Children and Adults	Centers for Disease Control and Prevention (CDC) American Academy of Family Physicians (AAFP) Institute for Clinical Systems Improvement (ICSI)
Schizophrenia	Practice Guideline for the Treatment of Patients with Schizophrenia Practice Parameter for the Assessment and Treatment of Children and Adolescents with Schizophrenia	The American Psychiatric Association, American Academy of Child and Adolescent Psychiatry (AACAP); American Academy of Child and Adolescent Psychiatry (AACAP)
Sickle Cell Disease	Evidence-Based Management of Sick Cell Disease, Expert Panel Report (2014)	National Heart, Lung and Blood Institute (NHLBI)
Substance Abuse Treatment	Practitioner Training Link https://www.samhsa.gov/practitioner-training	SAMHSA – Substance Abuse and Mental Health Services Administration
Suicide Risk	Assessment and Management of Patients at Risk for Suicide	Department of Veterans Affairs & Department of Defense
U.S Preventive Services Task Force Recommendations	Pediatric and Adolescent Services Recommendations	U.S. Preventive Services Task Force
Vision Screening (Adult)	Comprehensive Adult Eye & Vision Examination	American Optometric Association
Vision Screening (Pediatric)	Comprehensive Pediatric Eye & Vision Examination	American Optometric Association