1. Mission and Vision

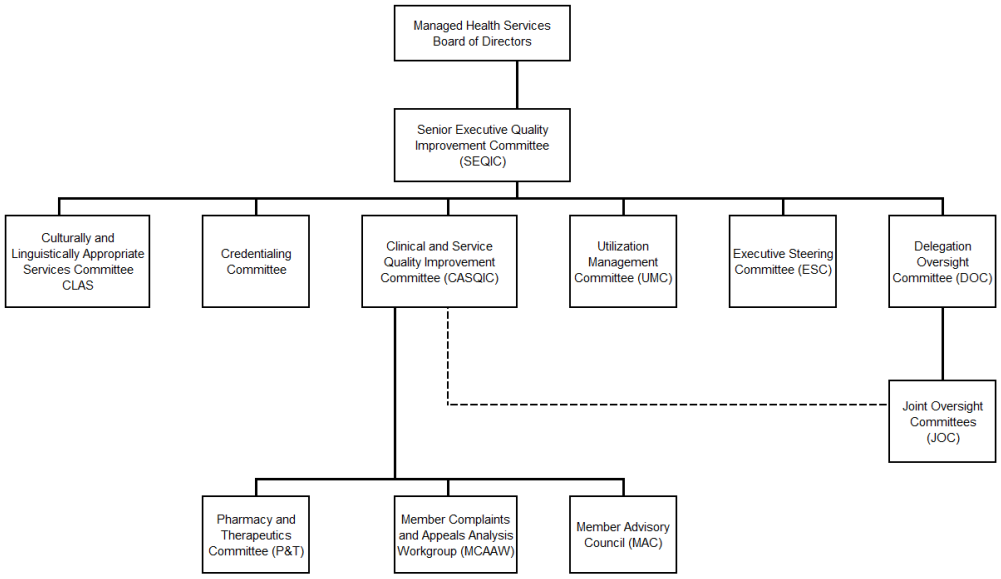
The mission of the Managed Health Services Quality Improvement program is to monitor and improve both care and services for all stakeholders. Improved health outcomes through safe, high quality care and service in a culturally and linguistically sensitive manner that exceeds member expectations for the experience is the vision.

2. Governance

The Managed Health Services (MHS) Board of Directors (BOD) has the ultimate authority and accountability for quality of care, safety of care and quality of services provided to members. The BOD meets a minimum of two times per calendar year with at least one meeting convened at a point in time where mid-course modifications can be considered. The MHS BOD is responsible to review, act upon and approve the quality improvement program description, strategic work plan and annual evaluation. The BOD receives progress and status reports describing interventions and actions taken, progress in meeting objectives and improvements achieved. The BOD recommends additional interventions and actions to be taken when objectives are not met.

3. QI Program Structure

As shown by the organizational chart, MHS has the infrastructure necessary to improve the quality and safety of clinical care and services provided to all members. It begins with the BOD setting the course for organization wide quality improvement (QI) by delegating responsibility for quality program development, implementation and evaluation to the Senior Executive Quality Improvement Committee (SEQIC). The BOD has assigned the authority and responsibility to establish, maintain and support an effective QI program to the MHS CEO, an ex-officio member of the BOD and chair of SEQIC. The MHS Chief Medical Director (CMD), a primary care physician, serves as physician representative to the BOD and co-chair of SEQIC. The CMD has direct oversight of all quality functions within the health plan, provides the BOD with quality updates and presents the annual QI program description, strategic work plan and program evaluation for their review and approval. Additional committees and workgroups have been established to analyze resources, compare progress to objectives, prioritize opportunities for improvement, analyze potential barriers to meeting improvement goals and plan how to address them. The following chart identifies the reporting relationships of the committees and workgroup that support the QI program:



A. Senior Executive Quality Improvement Committee (SEQIC)
SEQIC is composed of the CEO (chair), CMD (co-chair), Chief Operating Officer, Vice President Medical Management, Vice President Finance, Manager of Human Resources, Vice President Compliance, Vice President Customer Experience, Vice President Quality Improvement and Vice President Network Development and Contracting. All members have voting rights. SEQIC meets quarterly or more frequently as needed. A quorum for action items is no less than three voting members, excluding the chair, present by teleconference, fax, e-mail, or in person. Vote or consensus determines decisions reached. Minutes are maintained documenting decisions made and actions of the committee. Minutes and reports are presented to the BOD but not available as part of "discoverability" or other proceedings associated with litigation.

Functions:
- Establish standards and criteria for care and service delivery.
- Approve policy and procedures
- Oversight of the QI program
- Approve and monitor the QI program description, strategic work plan and annual program evaluation
- Approve and monitor actions of the UMC, CASQIC, DOC, Credentialing Committee, HESC, and CLAS

B. Clinical and Service Quality Improvement Committee (CASQIC)
CASQIC is composed primarily of community practitioners representing primary and specialty care practitioners and medical groups reflective of the MHS network. Delegated vendors and subcontractors, community partners, consumer advocates,

members, and Plan associates comprise the remainder of the committee. The Cenpatico Behavioral Health Medical Director is an ex-officio member. Committee composition ensures practitioner participation in the QI program through the committee's planning, design, implementation and review functions.

Voting rights are restricted to practitioners from the community, CMD (chair), MHS Medical Directors and the MHS Pharmacy Director. Plan staff participate as non-voting members. CASQIC meets at least six times per year or more frequently, as needed. A quorum for action items is 50% of the voting members, excluding the chair. Members may be present by teleconference and vote via fax, e-mail, or in person. Decision-making is by vote or consensus. Minutes taken are presented to SEQIC.

Functions include:

- Review information and reports from EPSDT, HEDIS/QRS, CAHPS/QHP and delegated vendors for compliance with standards and criteria for delivery of care and services to the member population
- Analyze and evaluate the results of QI activities, conduct quantitative and causal analysis of data and trends
- Identify and prioritize needed actions
- Promote and recommend improvement in care and services
- Ensure follow-up as appropriate, and evaluate the effectiveness of improvement activities
- Review and recommend approval of preventive health & clinical practice guidelines
- Review and recommend approval of policies or policy decisions for effective operation of the QI program and achievement of QI program objectives
- Review and recommend approval of Quality Improvement Activity (QIA) reports
- Act as liaison to the medical and behavioral health providers for dissemination of QI information
- Review and discuss operational issues that have resulted in poor service to any of our customers
- Provide clinical and service related quality data as performance feedback to network providers and internal MHS departments
- Review MCAAW, MAC and P&T Committee meeting minutes
- Review and recommend for approval the annual QI program description, work plan and evaluation
- Serve as the first step in the appeal process for denied re-credentialing providers, practitioners, and facilities
- Practitioner members may also serve as peer reviewers for clinical quality of care issues involving sentinel events, adverse outcomes, and member complaints/concerns, as appropriate

C. Utilization Management Committee (UMC)

The UMC's primary purpose is to provide oversight of the utilization management

program and associated activities to ensure the integration of UM activities into all functional areas and departments. The MHS Chief Medical Officer chairs this committee which meets a minimum of six times annually. Additional voting members include five participating physicians, the MHS Pharmacy Director, a Behavioral Health Medical Director, VPMA, MHS Medical Directors and the VPMM. Plan staff participate as non-voting members. A minimum of three voting members must be present for a quorum. The UMC Chair will be the determining vote in the case of a tie. Minutes taken are presented to SEQIC.

Functions include:

- Analysis of UM data,
- Identification of trends
- Address identified issues
- Monitor appropriateness of care, over and under-utilization of services
- Review and approval of medical necessity criteria and departmental policies and procedures.

D. Credentialing Committee (CC)

The CC is responsible for the review and assessment of provider applications to participate with the Plan and establishes the qualifications of each participating provider through training, experience, and performance consistent with the standards established by the provider credentialing policies to participate as an MHS provider. A network participating physician chairs this committee which meets a minimum of six times annually. No fewer than six providers consisting of a broad representative group of participating practitioners are voting members, as do the Provider Network Director, Compliance Director and QI Manager (non-voting). Minutes taken are presented to SEQIC.

Functions include:

- Review initial credentialing files with a significant deviation from the standard of practice
- Review re-credential files when there is evidence of malpractice, Medicare/Medicaid and state sanctions, restrictions on licensure and/or limitations on scope of practice
- Review member complaints of quality of service issues when making re-credentialing decisions.
- Make recommendations to SEQIC to approve or deny an applicant's participation.

E. Member Complaint and Appeals Analysis Workgroup (MCAAW)

An internal staff committee, MCAAW is responsible for conducting multidisciplinary review and trend analysis of member non-behavioral health complaints and appeals, and recommend systems improvements as indicated by the results of that analysis.

MCAAW meets quarterly with additional meetings as deemed necessary. Membership includes Plan staff representative of areas directly related to complaints or appeals. To conduct an official

meeting a quorum, 50% or more of appointed members, must be present. Minutes taken are presented to CASQIC for consideration when making recommendations to enhance member and provider satisfaction.

Functions include:

- Review aggregate member complaint and appeals data to ensure recognition of adverse trends
- Conduct quantitative and qualitative analysis including regional variances when applicable
- Identify system improvement needs
- Recommend improvement strategies that are based on industry standards and best practices
- Conduct ongoing monitoring

F. Member Advisory Council (MAC)

MAC is the voice of the membership. MAC meetings are held at least quarterly in the community with a council comprised of new and continuing members and community partners. Meetings are facilitated by MHS staff. Invitations are extended to potential attendees identified by eligibility and location. Meeting minutes document items and topics presented along with comments made by the Council members. MAC meeting minutes are presented to CASQIC for review and consideration.

Functions include:

- Provide perspective on new ideas for services, member materials, website and online features, policy, procedure and operational changes
- Relay understanding of information of the health plan, forms, outreach and educational materials presented for their review.
- Provide insight and recommendations for improvement opportunities.

Areas of misunderstanding or confusion identified at MAC meetings are conveyed to Plan staff responsible for improvements. Revisions will be made and reintroduced at the next MAC meeting. The process will continue until MAC members indicate their understanding.

G. Executive Steering Committee (ESC)

The ESC Committee is a cross-departmental committee that directs activities designed to raise CAHPS/QHP and HEDIS/QRS scores. The global objectives are to meet state P4P objectives and capture withholds, as well as meet Centene Corporate goals, fulfill OMPP contract requirements and achieve the benchmark 90th percentile NCQA Quality Compass for CAHPS/QHP and HEDIS/QRS scores. The CMD chairs the quarterly ESC meetings with members that include senior leadership. Minutes taken are presented to SEQIC.

Functions include:

- Develop effective processes to achieve desired outcomes

- Set intermediate goals for results
- Maintain NQCA accreditation and reach for “Excellent” rating

H. Pharmacy and Therapeutics Committee (P&T)
The purpose of the P&T Committee is to review and make decisions for changes to the drugs listed for coverage, the edits related to controls or limitations of drug coverage, and the policies and procedures governing provision of drug coverage under the Medicaid Preferred Drug List (PDL). Voting members of the Committee include the CMD (chair), the MHS Pharmacy Director plus community based practitioners and pharmacists representing various clinical specialties that adequately represent the needs of the MHS members. Outside specialty consultants, independent and free of conflict with respect to MHS and pharmaceutical manufactures, may be recruited, as necessary, to provide input related to their areas of expertise and to provide advice on specialty practice standards.

The P&T committee meets quarterly with a quorum required to transact business and make decisions. A quorum consists of more than 50% of committee members, 3 of whom must be community based practitioners. The P&T Committee will on occasion need to make drug coverage and utilization edit decisions off-cycle from the P&T Committee meeting schedule. Ad-hoc votes will be secured from the committee via email. Minutes taken are presented to CASQIC.

Functions include:
- Ensure clinical decisions are based on the strength of scientific evidence and quality standards of practice
- Formulary management through the review and potential revision of drugs listed for coverage, controls or limitations.
- Ensure regulatory compliance
- Monitor drug utilization and medication safety
- Review and approval of policies and procedures governing provision of drug coverage under the Medicaid Preferred Drug List (PDL)

I. Delegation Oversight Committee (DOC)
MHS has established a DOC to provide an organized and systematic approach to assure oversight of delegated functions, including quality improvement. As part of oversight and coordination of activities, the DOC requires all delegates and vendors to report quarterly to the committee. This includes all Centene affiliate companies through Envolve People Care: behavioral health programs provided by Cenpatico, health and life coaching by Nurtur, and the NurseWise Nurse Advice Line. In addition reports are received from LCP the transportation vendor and Envolve Health vision care. The Compliance Committee Chair leads the DOC with members representing departments that delegate any function to another entity or have relationships with vendors. Minutes taken are presented to SEQIC.

Functions include:

- Pre-assessment of the delegate's capacity to perform required activities prior to delegation
- Ongoing monitoring and evaluation of performance through quarterly or regular reports or as specified in corrective action plans
- Annual approval of the delegate's required annual documentation utilizing the program description, work plan, evaluation, and policies and procedures
- At least annual performance evaluation of the delegate's ability to perform delegated activities according to defined requirements which can occur on-site or by desktop
- Create integrated work groups of both MHS and vendor staff to conduct collaborative discussions and activities regarding vendor reporting and quality improvement.

J. Culturally & Linguistically Appropriate Services Committee (CLAS)

The CLAS Committee assesses cultural and linguistic competence across MHS, including the providers, contractors, and staff that serve MHS members. CLAS makes recommendations for action in order to close the disparities gap in health care and bring about positive health outcomes. Central to their purpose is the development of work plans to address gaps and the evaluation of MHS' success in addressing those gaps. The MHS Member & Network Analysis QIA is reviewed (and findings followed up as needed) at least annually at the CLAS. The Director of Compliance chairs CLAS with members representing each MHS department. Minutes taken are presented to SEQIC.

K. Joint Oversight Committees (JOC)

JOC meetings are held at least quarterly to monitor vendor performance with requirements outlined in the service agreement and compliance with NCQA standards. Meeting attendees include the vendor (in person or telephonically), the MHS Business Owner and staff representatives from Compliance, QI, Medical Management, Medical Affairs and Operations as appropriate.

Vendors include:

- Envolve People Care
  - Cenpatico Behavioral Health
  - NurseWise Nurse Advice Line
  - Nurtur Disease Management and Lifestyle Management
- Envolve Vision
- Envolve Pharmacy Solutions
- Envolve Dental Health and Wellness
- LCP Transportation
- National Imaging Associates
- Medline DME

Meetings will be facilitated by the Business Owner with minutes taken and reported to CASQIC and DOC. Discussion to include:

- All products and delegated activities the vendor services.
- Member and provider experience (complaints, grievances, satisfaction).
- Performance metrics (quality, outcomes, trends, comparison to goal).
- Identified barriers.
- Opportunities for improvement.

Vendors not meeting performance requirements will be placed on a corrective action plan in compliance with CC.COMP.21.01.

L. Other MHS Committees/Work Groups Associated with the QI Program

MHS utilizes interdepartmental work groups, which may include representatives of affiliate partners such as Cenpatico, to conduct root cause/barrier analysis and suggest improvement strategies during the QIA development process. MHS also convenes ad hoc issue focused practitioner advisory groups to gain the practitioner perspective on improvement strategies, pay-for-performance issues and any relevant concerns that may arise.

4. Scope

The MHS QI program is comprehensive, systematic and continuous. The scope ensures all demographic groups, care settings and services are included as it applies to all product lines, addressing key care and service venues and functions provided to all customers; members, practitioners, providers, employers, state agencies and Plan employees. The scope of quality review is reflective of the health care delivery systems, including quality of clinical care, quality of service and clinical safety.

Activities to fulfill the scope reflect the member population in terms of age groups, disease categories and special risk status in key areas that include:

- Preventive care
- Perinatal and postpartum care
- Primary, specialty and behavioral health care access and availability
- Potential quality of care issues
- Quality of care and services review
- Concerns, complaints, grievances and appeals
- Emergency services
- Inpatient Services
- Ancillary Services
- Continuity and coordination of care
- Behavioral health

- Maintenance of chronic care conditions
- Member, practitioner and provider experience

The scope of the QI program is contained in three key documents, the annual QI Program Description, annual QI Program Evaluation and QI Strategic Work Plan.

A. Program Evaluation

At least annually, MHS reviews QI program activities, process and outcome data to assess effectiveness and compliance with external accreditation and regulatory standards. This evaluation includes a summary description of completed and ongoing QI activities identified in the program description. The evaluation informs the development of the upcoming year's QI program description and strategic work plan. The evaluation includes:

- Trending of results with comparative analysis to objectives
- Progress toward meeting established goals
- Completed and ongoing QI activities
- Analysis and evaluation of overall effectiveness of the QI program
- Progress meeting network wide safe clinical practices
- Barriers to achieving objectives
- Opportunities for improvement

The annual program evaluation is presented to CASQIC, SEQIC and BOD for review and approval. Components for Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect detailing state required or priority initiatives are submitted annually to the Office of Medicaid Policy and Planning.

B. Strategic Work Plan

Based on the year end program evaluation a new QI Strategic Work Plan is developed. The purpose of this work plan is to identify goals and plans for achievement in the coming year. This is a dynamic document that can be amended and expanded to meet state requirements and the needs of our membership. Presented quarterly to CASQIC, the components include:

- Planned activities & objectives for improving:
  - Quality of clinical care
  - Safety of clinical care
  - Quality of service
  - Member, provider and practitioner experience
- Timeframe for completion
- Staff responsible for each activity
- Monitoring techniques
- Status updates, progress and barriers
- Evaluation of effectiveness

5. Goals

The QI Program is designed to advance MHS towards the goals sanctioned by the Board by developing and maintaining a system that:

- Is committed to providing MHS members with a healthcare delivery system that meets and exceeds generally accepted definitions of quality
- Assess, monitors and improve level of performance as needed:
  - Clinical Care Quality
  - Continuity & Coordination of Care
  - Services to Members with Complex Health Needs
  - Quality of Service
  - Safety of Clinical Care
  - Satisfaction with the Care/Service Experience
- Identifies and responds to the cultural and linguistic needs of the membership
- Actively involves practitioners and providers in the improvement of the quality of patient care
- Seeks member input and incorporates it into QI program activities
- Provides a definition of performance standards via Healthcare Effectiveness Data and Information Set (HEDIS) and the Quality Rating System (QRS), standardized measures designed to allow reliable comparison of health plan performance among Medicaid and Ambetter HIM members, respectively.
- Monitors member satisfaction via the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Qualified Health Plan (QHP) standardized surveys that measure patient satisfaction with the experience of care among Medicaid and Ambetter HIM members, respectively.
- Provides healthcare services in a manner consistent with:
  - Generally accepted principles of professional practice
  - Evidence-based guidelines
  - Cultural and linguistic needs and preferences of members
- Achieves compliance with NCQA, State and Federal regulatory standards
- Analyzes the existence of significant healthcare disparities in clinical areas

6. Objectives

Toward the satisfaction of the above-listed goals, the following objectives have been established:

- Identify clinical priorities for members within each line of business
- Ensure effective resources and programs are in place to address clinical priorities via the following mechanisms:
  - Adoption and distribution of preventive health and clinical guidelines
  - Provider education
  - Member education
  - Care gap/appointment outreach calls

  - Case Management
  - Care Coordination
  - Disease Management
  - ER diversion/medical home promotion
  - Primary-Specialty care coordination
  - Medical-Behavioral Health (BH) care coordination
  - Health promotion incentive programs
  - Grievance and appeals mechanisms
- Examine trends related to service utilization and respond to identified issues
- Collaborate with community partners
- Coordinate with other internal and external performance monitoring activities and management functions
- Assurance of availability and accessibility of culturally and linguistically appropriate services through systematic monitoring of provider network adequacy/geographic distribution
- Ensure appropriate appointment and after-hours access via annual monitoring of the PMP network
- Include the voice of the customer to inform QI Program direction through Member and Provider participation
- Implement focused activities for Members with Complex Health Needs
  - Children with Special Needs Program
  - The Medically Frail
- Comply with State and NCQA standards
- Participate in the Office of Medicaid Policy and Planning (OMPP) Quality Strategy Committee and relevant subcommittees
- Participate in External Quality Review Organization (EQRO) initiatives developed by the OMPP
- Evaluate the QI program annually and modify it as necessary to achieve program effectiveness

Monitoring and improvement committees, workgroups and projects are designed to support the full scope of the QI Program. They focus on topics relevant to the MHS population, especially those that are high-volume, high-risk or problem prone. Specific activities include:

- Annual HEDIS/QRS audits of quality indicators related to preventive health & chronic condition management
- Member and provider annual experience surveys
- Comprehensive Quality Improvement Activities (QIA's)
- Monitoring over and under-utilization of services, particularly Emergency Room visits and narcotic prescriptions
- Monitoring MHS utilization review activities to ensure that they do not have a negative impact on quality of care and service (through review of denials of authorizations, grievances and appeals)

- Trend analysis of member complaints
- Investigation of quality of care and service issues identified through review of member complaints or by Medical Management staff
    - Monitoring and promotion of care continuity and coordination between practitioners & settings; special focus on Members with Special Needs and the Medically Frail
- Monitoring care safety, including poly-pharmacy and hospital acquired condition review and follow-up
- Evaluation of practice sites and medical recordkeeping practices
- Annual review of adopted preventive health and clinical practice guidelines with recommendation for additional guidelines to correspond to changes in the make-up of the MHS member population
- Annual retrospective evaluation of QI program activities and effectiveness
- Adaptation of the following year's program, informed by the above-noted annual evaluation

7. Issue Identification

Important aspects of clinical quality improvement are identified by reviewing quality related complaints, grievances and appeals, monitoring the organization's key performance measures, conducting satisfaction surveys and other techniques, as appropriate. Criteria for selecting important aspects of clinical and service QI topics include:

- Is the clinical quality concern reflective of the MHS population?
- Is there an opportunity to improve outcomes?
- Does this issue involve high-volume, high-risk, high-cost, or problem-prone areas of concern?
- Is this issue included in the health services delivery areas of concern as identified in the scope of work?
- Are there objective or reasonable subjective criteria for assessing improvement in service for the selected topic?

Any committee or subcommittee, work group, or department can identify, recommend, and pursue opportunities for assessing improvement with the endorsement from defined levels of oversight.

A. Framework for Process Improvement

MHS has chosen to utilize Deming's Plan – Do – Study – Act (PDSA) cycle as a framework for process improvement. Deming's model serves as a guide to team members as they follow the methodology of process improvement, and is summarized below:

- Once the priority opportunity for improvement has been identified, a multidisciplinary team of process owners convenes to perform barrier analysis and recommend actions.
- The action **plan** includes what interventions should be implemented to achieve the desired outcome.
- The next step is to **do** the intervention or make the change on a small scale or pilot basis.
- After implementation of the intervention, the team should **study** the results of the intervention to determine its effectiveness.
- If the desired result is achieved, the next step is to **act** to implement the intervention on a wider scale.
- If the desired outcome is not achieved, the planning phase should begin again.

B. Documentation of Service and Clinical QI Activities

Selected care, service and safety QI activities are recorded in a standardized format as a QIA. Included in documentation are the study methodology, quantitative and qualitative analysis of findings, identification of barriers to improvement and both planned and implemented improvement strategies.

2017 QIA's:

Access to Member Services	Emergency Room Utilization/ER to PMP Transition
Access to Primary Care	Exchange of Information Between PMP's and Specialists
Access to Specialty Care	Exchange of Information Between BH Practitioners & PMPs
ADHD Follow-up Care	Member Satisfaction
Alcohol & Other Drug Dependence Treatment	Network Adequacy
Appropriate Use of Antidepressant Medications	Perinatal Depression Screening & Management
Availability of Primary Care Practitioners	Postpartum Care
Availability of Specialty Care Practitioners	Satisfaction with Case Management
Care Coordination for Members with Special Needs	Satisfaction with the Utilization Management Process
Member and Network CLAS Analysis	Readmission Prevention/Transition from Hospital to Home
Diabetes Screening for Members with Severe Mental Illness	Transitioning from Adolescent to Adult Care
Effectiveness of Case Management	UM Inter-Rater Reliability

Additionally, QI projects (QIPs) designated for State reporting are documented in the required OMPP format.

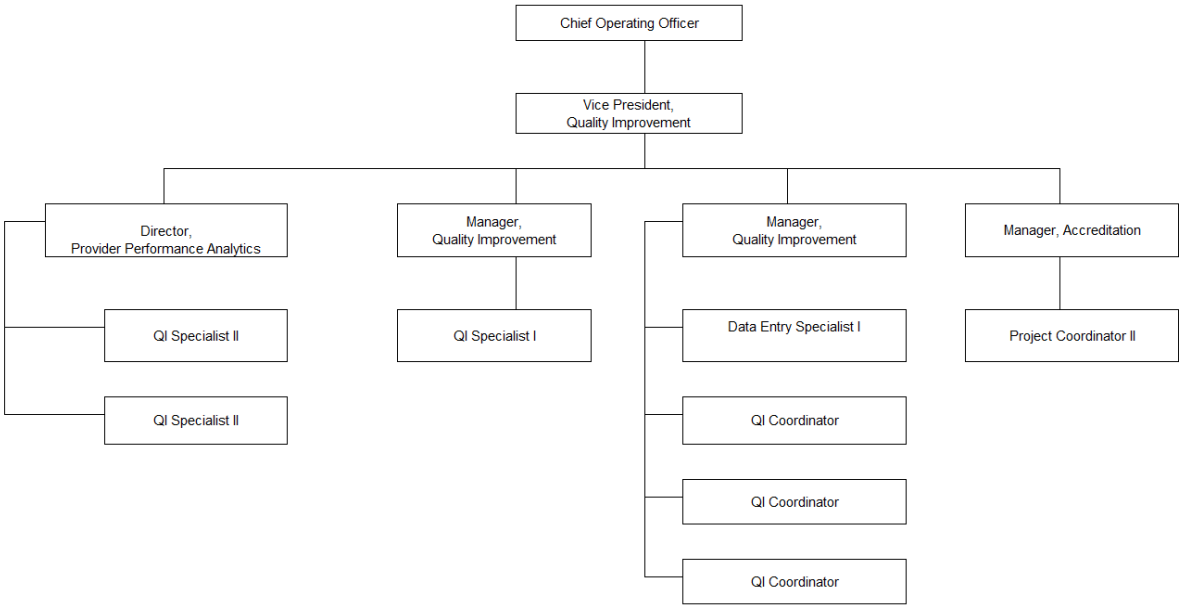
2017 QIP's

Alcohol and Other Drug Dependence Treatment	HHW, HCC, HIP
Capitation Rate Calculation Sheet (CRCS)	HHW, HCC, HIP
Emergency Room Utilization	HHW, HCC, HIP
Health Needs Screening	HHW, HCC, HIP
Readmission Prevention	HIP, HCC

7. QI Department

The QI department is a component of MHS Operations with the Vice President of QI reporting

directly to the Chief Operating Officer. The chart demonstrates staff reporting relationships:



8. Resources

A. Personnel

Personnel dedicated to the QI program include members of the QI department plus Plan staff with responsibilities that include:

- The QI VP serves as quality liaison to the Quality Division of Indiana's Office of Medicaid Policy and Planning (OMPP) as a member of the Quality Strategy Committee.
- Director of Provider Performance Analytics, Accreditation and QI Managers and staff are responsible for activities pertaining to compliance with MHS, Department of Insurance, OMPP and NCQA standards and regulations. This includes:
  - HEDIS/QRS collection and reporting
  - CAHPS/QHP
  - P4P and P4O measures
  - Clinical quality of care and service case reviews
  - Staff, Member, practitioner and provider education
  - Committee and workgroup participation
- The CMD leads QI program activities by chairing CASQIC and ESC, participating in CC, MCAAW, OMPP Quality Strategy Committee, Indiana State DUR and Therapeutics Committee, the OMPP Medical Directors collaboration group and serves as the QI liaison to the MHS Senior Leadership Team.
- MHS Medical Directors conduct internal medical necessity reviews and actively participate in the UMC and CASQIC which includes peer review.
- The VP of Medical Management, UM and Case Management Directors, and Clinical Director of Behavioral Health identify and act on opportunities to improve quality and utilization of services in medical management programs. Case Management and

UM teams are responsible for identification and referral of potential quality of care and service issues.

- The Compliance Department oversees MHS-OMPP quality collaboration activities and delegation oversight. The Director chairs CLAS and leads related activities. The Manager of Grievance and Appeals oversees the appeals functions, reports to MCAAW and CASQIC internally and to OMPP as required.
- The Director of Credentialing and Provider Data Management staff perform initial credentialing and recredentialing activities, including facility assessments and reassessments.
- The VP of Network Development and Contracting, Directors of Provider Relations and their teams of QI Auditors and Provider Relation Specialists orient new practitioners, disseminate quality information to the provider network, identify barriers and gaps in care or service, educate providers and members on preventive and clinical standards and facilitate compliance through proven interventions.
- Member Services representatives conduct telephonic preventive health outreach and review care gaps at member call-in. Responses to after call surveys are analyzed, trends identified and improvement plans implemented.
- The Pharmacy Director oversees quality and safety of medication management, including development of the Preferred Drug List and monitoring of poly-pharmacy and Class I & II drug recalls.
- The Customer Experience team sponsors community health promotion events for members, creates and coordinates health education communication materials and presentations for members and practitioners. Facilitation at MAC meetings results in opportunities for members to communicate their experience with various aspects of the Plan. Comments and concerns, both positive and negative are the basis for improvement opportunities.

B. Data, Analytical Support

Resources include regular and ad hoc reports obtained from the corporate health informatics teams, Impact Pro, Impact Intelligence, CRM, TruCare, QSI, Portico, and the MHS' SQL server. Analytical support is available through the MHS Reporting & Business Analytics Department and the corporate Centene Data Analysts as needed.

MHS utilizes numerous data sources in the development, monitoring, and evaluation of the QI Program. As applicable, these sources include, but are not limited to, the following:

- Claims and encounter data
- Member Enrollment data, including age, gender, language, race and ethnic diversity
- Authorization data
- Inter-rater Reliability testing of clinical staff through Milliman Criteria
- Member complaints and appeals information
- Medical record review data

- Pharmacy data
- Health information exchange data (Indiana Health Info. Exchange; Michiana Health Info. Exchange)
- P4P quarterly scorecards
- Member incentive data
- HEDIS/QRS and CAHPS/QHP data
- Satisfaction with CM surveys
- Effectiveness of CM via SF-12 surveys, All-Cause readmission rates and NICU admissions
- Behavioral health data
- Financial indicators
- Data from delegates and vendors
- Web site utilization data
- Translation services through language line utilization
- GeoAccess data: geographic distribution and practitioner-to-member ratios
- Practitioner satisfaction survey
- Call center average speed of answer and abandonment rate

9. Contracted Provider Participation in the QI Process

In addition to providing care and service to MHS members contracted providers serve on QI committees. Their role includes, but is not limited to:

- Provide input based on clinical and regional practice
- Development and application of credentialing and recredentialing criteria
- Participate on committees and work groups to provide input and expertise in discussions regarding clinical QI activities and intervention strategies
- Clinical peer review for potential quality of care and service issues and recommendation of actions needed as well as follow-up activities such as development of corrective action plans.
- Participate in the recommendation, development and revision of preventive health and clinical practice guidelines, utilization protocols, clinical and medical policies.
- Recommend potential areas of focus for QI initiatives based on review of performance and outcome trends.
- Input on opportunities for improvement in member safety and recommendation of systems improvements as applicable.
- Input into prioritization of clinical care, service and safety issues and recommendation of needed actions and follow-up as necessary.

10. Quality Partnerships

MHS actively pursues and maintain partnerships within our communities as described by the following:

A. Healthcare Providers, Practitioners, Facilities, and Contractors

Healthcare practitioners, providers and contractors are informed of MHS member care/service expectations, as well as standards of performance to expect from MHS, via the provider contract, provider manual, newsletters and social media. Through education and committee participation, MHS assures practitioner involvement in the QI Program. Methods include active practitioner participation in Credentialing Committee meetings, CASQIC meetings, provider workshops and the Provider Advisory Group. Provider surveys, peer reviews, office training sessions, the MHS website, provider newsletters and provider bulletins provide information about QI activities.

B. Member Involvement

Education occurs through social media, member newsletters, the MHS website, educational mailings, new member handbooks, one-on-one counseling, MAC meetings, and focus group participation with cultural or linguistic minority members to determine the best way to meet needs.

C. Delegated Activity Providers

Where services are delegated, ongoing communication and training in clinical quality improvement principles and functions are available to delegates. Providers of delegated activities are required to maintain and report clinical QI activities to MHS through the DOC. An agreed-upon reporting schedule is in place for each delegate to ensure that the data is reported. All delegated providers are reviewed annually through a review/audit process.

D. Office of Medicaid Policy and Planning (OMPP)

MHS' QI program is designed for compliance with all applicable OMPP standards. MHS staff participate in the OMPP Quality Strategy Committee and subcommittees that currently include Neonatal and Health Services Utilization.

E. Centene Quality Management Group

The QI VP participates in monthly conference calls with Centene Corporate QI staff and other Health Plan QI Directors. MHS also conducts the HEDIS/QRS audit in partnership with Centene and participates in ad hoc reporting and improvement projects.

11. Serving a Diverse Membership

MHS deems it of critical importance to ensure accessible care that meets the cultural, racial, ethnic and linguistic needs of the member population, through assessment of member/practitioner characteristics and network adjustment as indicated. To that end, MHS annually conducts a comprehensive assessment of its membership and practitioner network. Findings are reviewed and discussed at CASQIC where improvement needs and action plans are developed.

Indiana's population is increasing in ethnic diversity, particularly in the Hispanic, Asian and East African populations. Indiana, like other states has historical patterns of health care disparities. It also suffers from health literacy issues. It has a large rural population and underserved urban areas. In order to reduce disparities the QI program regularly reviews reports concerning network adequacy, complaints about access and availability of care, and care that should be delivered in a respectful, culturally competent manner.

Complaint and CAHPS/QHP data is reviewed at the regional level to determine areas that may need joint intervention by Provider Network and QI teams to overcome an underserved area or population. MHS has also focused on reducing disparities in infant mortality found in certain regions or among various groups of members. MHS conducts member focus groups to better understand the member perspective on cultural issues and gather community insight on options for improvement. MAC meetings facilitate discussion of member materials to assess understandability.

As previously noted, MHS also has an active CLAS Committee to ensure ongoing compliance with the U.S. Dept. of Health and Human Services Office of Minority Health CLAS standards. It reviews any member complaints related to CLAS issues and assesses cultural and linguistic competence across MHS (including providers, contractors, and staff that serve MHS members), and makes recommendations for action in order to resolve any identified health care disparities, such as differences in treatment among different racial groups. EPSDT chart audit sites are preferentially selected for providers who underperform on well-child care. Observations are made of office staff behavior and counseling may be provided as needed.

MHS provides CLAS-related education to all new practitioners and at least annually to the general practitioner network, to ensure awareness of and sensitivity to the cultural needs of their diverse member panels. All MHS employees also receive CLAS training. Additional activities aimed at meeting CLAS needs include nursing advice and interpretation services available in multiple languages, provision of member materials in languages relevant to the MHS membership and Family Education Network one-on-one outreach activities facilitated through the MHS-Indiana Minority Health Coalition partnership.

12. Serving Members with Complex Health Needs

The MHS approach to serving members with complex health needs is stratified, to ensure that all levels of complexity are addressed:

- Families of low-risk children with special health needs receive relevant educational materials on a quarterly basis
- Members with complex health needs receive Care Coordination assistance by an LPN, Social Worker or Health Coach with:
  - Health monitoring

  - Coordination of social services
  - Appointment scheduling
  - Transportation
- Hospitalized members receive discharge planning assistance
- Aged, blind and disabled members with poly-pharmacy receive Medication Therapy Management which includes:
  - Member education
  - Development of a Medication Action Plan
  - Safety alerts
  - Care gap alerts
- Complex Case Management services are offered to members with physical or developmental disabilities, multiple chronic conditions or severe injuries. Conditions and diseases managed might include, but are not limited to, spinal injuries, transplants, cancer, serious trauma, AIDS, multiple chronic illnesses, and serious and persistent mental illness. Case Management goals include:
  - To practice cultural competency, with awareness and respect for diversity,
  - To facilitate informed choice, consent and decision-making,
  - To use a comprehensive, holistic approach that promotes evidence based discussions,
  - To promote self- determination through advocacy,
  - To coordinate efforts to move the member towards self- care management,
  - To promote optimal member safety,
  - To assist with navigating the health care system to promote effective care delivery especially during transitions between providers or communications between Primary Care Practitioners and Specialists,
  - To use member centered, strengths-based, collaborative partnership approaches that assist members with multiple or complex conditions,
  - To assist the member and provider in facilitating care to optimize health outcomes or improve the member's functional capability in the most appropriate setting and in a cost effective manner,
  - To perform a comprehensive assessment of the member's condition and care needs.
  - To develop and implement a member-centered plan of care, which includes identified or potential needs, prioritized goals, a monitoring schedule and follow-up to evaluate the member status.

Medical Management identifies candidates by mining data from multiple sources, comprehensive assessment (including but not limited to medical and behavioral health status/functional status/psychosocial needs/CLAS preferences/resources), care planning, stratification and care coordination. Further details are available for review in the MHS Medical Case Management policy/procedure.
The Children with Special Needs Program additionally provides case management services to members with chronic conditions such as neurological disorders, developmental disorders, HIV/AIDS, blood diseases and musculoskeletal disorders.

This approach also includes appropriate client identification, stratification, intervention and documentation.

Quality measures related to Complex Case Management effectiveness and member satisfaction with those services are evaluated through ongoing departmental activities. Areas for improvement are addressed and documented through the Quality Improvement Activity process and summarized in the QI Program Evaluation.

13. Collaboration, Continuity and Coordination

To ensure continuity and coordination of care MHS collaborates with other organizations and vendors:

- Envolve People Care
  - Behavioral Health (Cenpatico)
  - Disease Management (Nurtur)
  - Nurse Advice Line (NurseWise)
- Envolve Pharmacy
- Envolve Vision
- Envolve Dental Health and Wellness
- LCP Transportation

Together, at quarterly meetings, MHS and each of these entities review and analyze quality data and discuss improvement needs and plans. Meeting minutes are presented at CASQIC. In addition, MHS actively participates on state government, medical society and Department of Health initiatives. Recent examples include Opioid Reduction, Neonatal Abstinence Syndrome, Prematurity Prevention, Substance Abuse treatment in pregnancy and Reduction of Infant Mortality. Results of these collaborations are communicated to CASQIC and appropriate workgroups for review and analysis.

A. Behavioral Health (BH)

Cenpatico is our NCQA accredited MBHO affiliate. The Cenpatico Medical Director, a board certified psychiatrist, is the designated practitioner involved in the behavioral health aspects of the MHS QI program and a member of CASQIC, DOC and specialty advisory groups as applicable.

In addition this Medical Director chairs Cenpatico's QI Committee and is a member of their UM Committee, Credentialing Committee and Provider Advisory Committee. When needed other Cenpatico behavioral health practitioners may be asked to review data and suggest recommendations regarding: use of psycho-pharmacological medications, management of follow-up for enrollees with coexisting medical and behavioral disorders, behavioral health access and appointment availability.

Cenpatico maintains its own QI Program, overseen by MHS through delegation oversight. Evaluation and follow-up activities related to BH complaints are the

responsibility of Cenpatico along with some UM and credentialing functions.

MHS collaborates with Cenpatico to support the integration of care between medical and behavioral health providers by the following:

- Monthly MHS sends a record of behavioral health services and medications prescribed to members by psychiatrists to the member's PMP, to be included in the member's medical record.
- Coordination of care between BH and Medical practitioners/settings.
- MHS Medical Management and MHS Medical Affairs staff meet semi-weekly through medical and inpatient rounds to assess and coordinate care for members with co-existing conditions
- MHS distribution of a depression survey to all enrolled pregnant members with responses coordinated with behavioral health case management
- Cenpatico case management team to review and refer members to behavioral health providers.
- Nurtur, the disease management partner coordinates medical and behavioral health co-existing conditions with MHS and Cenpatico
- Upon discharge from a psychiatric inpatient facility, the behavioral health case manager faxes a discharge form to the member's MHS PMP
- MHS encourages medical and behavioral health providers to utilize a care coordination fax form listing the member's services and medications

MHS and Cenpatico collaborate on the selection of behavioral practice guidelines designed to meet the needs of the MHS population. MHS monitors the outcome of efforts to improve behavioral health for its members through review of appropriate HEDIS/QRS measures such as:

- Follow-up after hospitalization for serious mental illness,
- Alcohol and other substance abuse screening and treatment,
- Adherence with behavioral health medications for depression and schizophrenia
- Diabetes screening for people with schizophrenia or bipolar disorder using anti-psychotic medications

14. Patient Safety

Many of the aforementioned activities promote the safety of clinical care and services provided to members. Specific examples of initiatives that demonstrate MHS' commitment to improving safe clinical practice include, but are not limited to:

A. Safety Metrics

MHS classifies quality issues from Level 0 (none) to Level 4 (resulting in serious permanent injury or death) and tracks and trends the types of issues and also by individual practitioners and providers. MHS has identified the following safety metrics for formal ongoing monitoring and corrective action planning:

- Hospital-Acquired Conditions - list defined by CMS (CASQIC)
- Polypharmacy (P&T Committee)
- Class I & II drug recalls (P&T Committee)

B. Pharmacy & Therapeutics (P&T)

The MHS P&T committee takes safety concerns into account when approving medications for inclusion in the Preferred Drug List (PDL). Additional medication safety activities include:

- P&T Committee review of FDA safety issues and recalls; when a high level of concern for safety is identified, US Script supplies MHS with a list of members that may be affected, to inform follow-up activities
- On-line alerts to dispensing pharmacies that identify potential drug-drug interactions
- Medication Therapy Management, which involves:
    - RPh-to-member in-person Comprehensive Medication Review
    - Safety alerts and resolution monitoring
- Polypharmacy notices to practitioners
- Drug Utilization Review, including opiate usage monitoring (in pregnancy, multiple prescribers, etc.)
- Call outreach re: lab monitoring needed for members on persistent medications
- Medication specific adherence communication and outreach to members (re: continuation of asthma controller meds., antidepressants)
- Under-utilization letters to practitioners (re: need for ACE-I/ARBs for members with diabetes, controller meds. for members with asthma who frequently refill rescue inhalers)
- Plans are underway to initiate psychotropic medication utilization review (PMUR) in children <18 for targeted review & peer-to-peer education/consultation between the prescribing practitioner and the BH Medical Director as needed, with the goal of redirecting therapy to be consistent with evidence-based guidelines.

C. Organizational Provider Assessment and Reassessment

The organizational provider assessment process is in place to maintain the quality and safety of the facility/ancillary network in the MHS service area. Only providers meeting the MHS participation criteria are accepted for contracting. Prior to contracting, each potential network provider undergoes a site evaluation to determine if the provider meets criteria established by MHS. Network organizational providers must also have appropriate license, accreditation, and Medicare certification in order to participate.

Reassessment occurs, at minimum, every three years and includes the following facility and ancillary providers: hospitals; home health agencies, skilled nursing facilities, and freestanding surgical centers. MHS confirms that the provider continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body at least every three years. In the case of non-accredited providers, MHS reviews the Indiana State Department of Health (ISDH) survey in order to verify that the provider meets the MHS standards.

D. Quality of Care Review Process

The quality of care review process promotes member safety by evaluating (including via the formal peer review process as appropriate) clinical safety issues identified through member complaint review or by Medical Management. Additionally, all Hospital Acquired Conditions identified via monthly claims reports undergo quality of care review. The process involves medical record review, practitioner/provider/member interview if deemed necessary, first-level review by a QI Coordinator, forwarding of any findings indicative of substandard care to the Chief Medical Director, and CASQIC peer review of cases forwarded by the CMD. Corrective action plans are developed as appropriate and subsequent systems improvements monitored. Findings of substandard care are tracked and trended and also provided to the Credentialing Director for consideration during the re-credentialing process.

The QI department educates in-house staff on quality issue identification and the appropriate use of CRM and TruCare software for classifying and routing issues. Examples of safety issues uncovered and successfully addressed through review of hospitalized patient include the prevention of pressure ulcers and appropriate recognition of meningitis, non-recognition of abnormal pre-operative test results, partially compensated shock, monitoring for nephrotoxicity and appropriate management of acute respiratory failure. CAPS have been focused at the practitioner, provider and members receiving home health services.

E. Credentialing and Recredentialing

Practitioners are initially credentialed prior to admission to the network and re-credentialed every three years. As part of this process staff conduct site visits to PMP offices to assess safety and accessibility of care and services. When standards are not met, a corrective action plan is developed prior to completion of the credentialing process. The recredentialing process occurs every three years. The process includes, but is not limited to, a review of quality of care and safety information and member complaints.

F. On-Site Office Evaluation and Medical Record Review

MHS conducts on-site practitioner office inspections and medical record reviews when quality or safety concerns have been identified through the member complaint process. The review process promotes safe clinical practice by evaluating the physical space, medical records (to determine compliance with medical record documentation standards and medical recordkeeping systems), in addition to assessment of continuity and coordination of care. Assistance is provided as interventions to resolve identified issues are developed, implemented and monitored until resolved. Results are summarized, reported to CASQIC and included in the annual QI program evaluation.

G. Preventive Health and Clinical Practice Guidelines

Preventive Health and Clinical Practice Guidelines relevant to the MHS member

population are updated annually or as needed when new information becomes available. The intention is to promote safer clinical practice by providing evidence-based reference information to practitioners and members.

H. Monitoring Provider Accessibility, Availability

As previously mentioned, ongoing evaluations are performed to ensure adequate practitioner availability and access for PMP, Specialist and Behavioral Health. Availability monitoring includes an analysis of CLAS elements. Access standards are communicated via the provider manual and provider/member websites. Compliance with standards is also assessed during the initial office site visit and annually thereafter at all PMP offices. Non-compliant issues are addressed through corrective action plans that are reported to CASQIC.

I. Health Needs Screening

Health Needs Screening of new members facilitates timely identification and referral of conditions and circumstances that might benefit from Medical Management services.

J. Hospital Readmission Reduction

CASQIC monitors same and all-cause readmission rates/trends via the Transition from Hospital to Home QIA. To promote safe, successful transitions home and avoid readmission, the MHS UM Social Worker coordinates discharge plans with hospital staff to ensure adequate home support. Additionally, all MHS members recently discharged from the hospital receive Case Management outreach follow-up.

K. Right Choices Program (RCP)

The RCP provides clinical guidance for members who are over utilizing narcotics and emergency room services. The program goal is to enhance continuity and coordination of care by facilitating the establishment and utilization of a medical home for participating members.