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PURPOSE
Managed Health Services (MHS) is committed to the provision of a well-designed and well implemented Quality Improvement (QI) program. The QI program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of health care. This approach provides a continuous cycle for assessing the quality of care and service and the impact on member outcomes in areas that include preventive health, acute and chronic care, behavioral health, continuity and coordination of care, patient safety, administrative, vendor and network services. The MHS QI program is contained in three primary documents that are annually presented to the Clinical and Service Quality Improvement Committee (CASQIC), Senior Executive Quality Improvement Committee (SEQIC) and Board of Directors (BOD) for review and approval.

1. QI Program Description
The QI Program Description is a written document that outlines structure and process used to monitor and improve the quality and safety of clinical care and the quality of service. Topics addressed in this QI Program Description include the scope, goals, objectives, responsibilities, authority and structure.

2. QI Work Plan
The QI Work Plan is based upon the previous years' program evaluation. It defines the planned activities and objectives for improving quality and safety of clinical care, quality of service, member, provider and practitioner experience. Each objective is presented with the expected timeframe for completion, employee or team responsible, monitoring and reporting process. It is presented annually to CASQIC for approval with quarterly status updates of progress and/or barriers.

3. QI Program Evaluation
Annually, MHS formally evaluates process and outcome data to assess overall QI program effectiveness and compliance with internal expectations, external accreditation and regulatory standards, documenting findings in the QI Program Evaluation. This evaluation informs the development of the upcoming year's QI Program Description and Work Plan with components that address quality of service, quality of care, member safety and experience through:

- Completed and ongoing interventions and activities
- Analysis of results including barrier analysis and identification of opportunities for improvement
- Evaluation of overall effectiveness of the QI program

SCOPE

The MHS QI program is comprehensive, systematic and continuous, promoting the tenets of continuous performance improvement to address quality and safety of clinical care and quality of service for all Medicaid, Marketplace (Ambetter for MHS) and Medicare (Allwell for MHS) Members.

The scope ensures all demographic groups, care settings and services are included. It applies to all product lines and benefit packages, addressing care and service venues and functions provided to members, practitioners, providers, state agencies, vendors and staff. Activities to fulfill the scope reflect the member population in terms of age groups, disease categories and special risk status in key areas:

- Acute and chronic care management
- Adherence with medical and behavioral health preventive health and clinical practice guidelines
- Behavioral healthcare (BH)
- Care furnished to members with complex health needs
- Compliance with confidentiality laws and regulation
- Continuity and coordination of care across care settings and delivery systems
- Delegated entity oversight
- Department performance and service
- Employee, practitioner and provider cultural competency
- Marketing practices
- Member enrollment and disenrollment
- Member, provider and practitioner complaint, grievance and appeals system
- Member, provider and practitioner satisfaction
- Patient Safety
- Population Health Management
- Primary, specialty and behavioral health access, availability and network adequacy
- Selection and retention of providers (credentialing and re-credentialing)
- Utilization Management, including under and over utilization

GOALS

The QI program is designed to assess, monitor and improve services provided to the membership with goals that include:

- Provide medical, behavioral health, vision and oral health care in a manner consistent with:
  - Generally accepted principles of professional practice;
  - Evidence-based guidelines;
  - Cultural and linguistic needs and preferences of a diverse membership
- Health plan services will meet industry-accepted standards of performance;
- Enhance efficiency, promote effective utilization of resources and improved outcomes;
- Minimize fragmentation and/or duplication of services through integration of QI activities across all areas;

- Member, provider and practitioner satisfaction with the care and service experience that meets performance benchmarks;
- Compliance with all applicable regulatory requirements and accreditation standards.
- Utilize a Management Information Systems (MIS) for data collection, integration, tracking, analysis and reporting that accurately and timely reflects performance.

OBJECTIVES
The following QI Program objectives are further defined in the QI Work Plan:

- Establish and maintain a health delivery system that promotes continuous QI;
- Adopt evidence based clinical and preventive medical and behavioral health guidelines as a means for identifying, addressing and improving practice variations that reduce disparities;
- Utilize standardized process and outcome performance measures that are clearly defined, objective, measurable and allow tracking over time;
- Identify and serve members with complex health conditions and multiple needs;
- Identify and address members' cultural and linguistic needs;
- Facilitate continuity and coordination of care across transitions and settings of care;
- Monitor member satisfaction via the Consumer Assessment of Healthcare Providers and Systems (CAHPS), Qualified Health Plan (QHP) and Experience of Care & Health Outcomes (ECHO) standardized surveys;
- Provide periodic QI information to members and participating providers;
- Seek input and work with members, providers and community resources to improve quality of care and service.

RESPONSIBILITIES

1. Confidentiality

Confidential information is defined as data or information that can directly or indirectly identify a patient or physician. In this regard, all QI documents, correspondence, worksheets, meeting minutes, findings and program recommendations are considered strictly confidential.

2. Conflict of Interest

MHS defines conflict of interest as participation in any review of cases when objectivity may not be maintained. No individual may participate in a quality of care or medical necessity decision regarding any case in which he or she has been professionally involved in the delivery of care. Physician reviewers may not participate in decisions on cases where the physician reviewer is the consulting physician or where the physician reviewer's partner, associate or relative is involved in the care of the member, or cases in which the physician or other consultant has previously reviewed the case. When a physician member of any committee perceives a conflict of interest related to voting on any provider related or peer review issue, the individual in question is required to abstain from voting on that issue.

3. Behavioral Healthcare (BH)

MHS incorporates behavioral health aspects into the QI Program. The Chief Medical

Director, a Pediatrician experienced in the diagnosis and treatment of BH conditions and Envolve PeopleCare (EPC) Chief Medical Director or his/her delegate who is a medical doctor or Clinical Psychologist with a PhD or PsyD participate in and advise the Clinical and Service Quality Improvement Committee (CASQIC) on behavioral and mental health aspects of the program which includes the management of substance abuse services.

4. Serving a Diverse Membership
MHS will provide services to people of all cultures, races, ethnic backgrounds and religions in a manner that values, affirms, recognizes and respects the worth of the individual member, protects and preserves the dignity of each. To that end, MHS has developed and implemented a Cultural Competency Plan (CCP) based on the Office of Minority Health's Culturally and Linguistically Appropriate Services (CLAS) Standards.

The CCP is MHS' framework and commitment that care and services are delivered in a culturally and linguistically sensitive manner. It incorporates responsibilities and interventions of member, provider/ practitioner and MHS staff. The CCP is updated annually to evaluate effectiveness of cultural competency strategies and initiatives. Current strategies include:

- Staff education on cultural competence and cross-cultural communication
- Distribution of cultural competence resources and training to providers and practitioners.

5. Population Health Management (PHM)
In 2018 MHS will develop and implement a cohesive strategy to address member needs across the continuum of care. The strategy will be comprehensive with objectives focused on:

- Keeping members healthy
- Managing members with emerging risk
- Patient safety
- Outcomes across settings
- Managing multiple chronic conditions
- Supporting the delivery system of network practitioners and providers

6. Serving Members with Complex Health Needs
MHS has the structure and process to ensure all levels of complexity are identified and addressed:

- The Children with Special Needs Program provides case management (CM) services to members with chronic conditions and various developmental and neurological disorders. Upon identification members are assessed and stratified according to need. A plan of care is developed with actions, interventions and treatment goals designed to educate, inform and maximize quality of life.
- Complex Case Management (CCM) services are offered to members with physical, behavioral and/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 mental illness. Following a comprehensive assessment by an LPN and/or Social Worker assistance is provided to develop and implement a member-centered plan of care, which includes identified or potential needs, prioritized goals, monitoring schedule with follow-up to evaluate status.

- To promote safe, successful transitions home and avoid readmission, hospitalized members receive discharge planning assistance prior to leaving the facility. A comprehensive assessment is initiated to facilitate the transition, optimize health outcomes and improve the member's functional capability in the most appropriate setting.
- Aged, blind and disabled members with poly-pharmacy concerns receive Medication Therapy Management with:
  - Member education
  - Development of a Medication Action Plan
  - Safety alerts
  - Care gap alerts

7. Regulatory Compliance and Reporting

MHS performs quality of service, clinical performance and utilization studies throughout the year based on requirements established by contract or other state, regulatory and accreditation agencies. MHS' functional areas utilize standards/guidelines from these sources plus those disseminated by national and state associations, the Centers for Disease Control, state and federal government for compliance reporting.

A. 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.

B. 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 MHS standards.

8. Performance Measurement
A. National Committee for Quality Assurance (NCQA).
MHS is required to achieve and maintain NCQA Health Plan Accreditation status. In 2019 MHS will submit a renewal application documenting ongoing compliance with the following standards:

- Quality Management and Improvement
- Population Health Management
- Network Management
- Utilization Management
- Credentialing and Recredentialing
- Member Rights and Responsibilities
- Member Connections

To demonstrate adherence to adopted clinical practice and preventive health guidelines MHS collects and annually reports to NCQA applicable medical and behavioral health outcome and performance measurement data as defined by the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS measures are scored in the following categories:

- Staying Healthy
- Getting Better
- Living with Illness
- Access and Service

To assess and improve member experience MHS annually monitors Medicaid member satisfaction with health care and health plan services through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Ambetter from MHS members are monitored through the Qualified Health Plan (QHP) Enrollee Experience Survey. Responses are analyzed with performance compared to MHS, Centene Corporate and national standards and benchmarks. Areas not meeting the mark are discussed, improvement opportunities identified, interventions developed, implemented and measured. Findings from the CAHPS/QHP surveys are reported to NCQA with applicable composites and ratings counted towards the Accreditation score for access and service.

With the recent integration of behavioral healthcare MHS will survey adults and children who recently received mental, behavioral health and substance abuse care. Surveys will be mailed in August with questions to capture satisfaction with their experience and treatment outcomes with results reported in the fourth quarter.

B. Indiana's Family and Social Services Administration, Office of Medicaid Policy and Planning (OMPP)
OMPP requires ongoing measurement of clinical and non-clinical effectiveness and member satisfaction by monitoring access to care, member and provider grievances, satisfaction and call center performance. MHS collects and reports data quarterly to

measure performance against benchmarks and standards. Specific interventions are developed and implemented to improve performance with the effectiveness of each intervention measured and reported.

OMPP requires that MHS work with Burns and Associates, their External Quality Review Organization (EQRO), to annually undergo an independent review of quality of, timeliness of and access to health care services. Claims and encounter data submitted to the EQRO is assessed and compared to standard. Areas in need of improvement are identified and discussed with interventions for improvement implemented when necessary.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally-mandated comprehensive preventive health care program designed to improve the overall health of Medicaid eligible infants, children and adolescents from birth to twenty-one years old. MHS must ensure that all covered EPSDT services are provided in accordance with 405 IAC 5-15-8 and the latest guidance from the American Academy of Pediatrics. Blood lead level screening is one important EPSDT component. In accordance with IC-12-15-12-20, MHS will screen/test children between the age of nine months and six years for lead poisoning, identify anyone with an elevated lead level and facilitate access to recommended follow-up treatment.

9. Patient Safety

A. Quality of Care. Monitoring and promoting patient safety is integrated throughout many activities across MHS starting with identification of potential and/or actual quality of care (QOC) issues. A QOC issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential adverse event, up to and including death of a member. Adverse events are defined as an injury caused by medical management rather than the underlying disease that prolonged hospitalization or produced a disability at the time of discharge or both.

The QOC review process promotes member safety by evaluating (including via the formal peer review process as appropriate) clinical safety issues identified through member complaint/grievance or upon notification by MHS staff, network practitioners, facilities or ancillary providers, members or member representatives, Medical Directors or the Board of Directors. Additionally, all Hospital Acquired Conditions identified via monthly claims reports undergo QOC review.

The process involves an in-depth review of the medical record and interview of the practitioner/provider and/or member necessary. QOC issues are classified according to severity, from Level 0 (none) to Level 4 (resulting in serious permanent injury or death). Records indicative of substandard care are submitted to the Chief Medical Director and presented to CASQIC where corrective action plans are developed as appropriate and subsequent systems improvements monitored.

Patient safety issues, both QOC and adverse events, are tracked, trended and reported

to the Clinical and Service Quality Improvement Committee (CASQIC). They are also reported to the Credentialing Director for consideration during the re-credentialing process. Indiana Protective Services is notified when abuse, exploitation or unsafe conditions are suspected.

B. 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 an assessment of continuity and coordination of care. Assistance from the QOC Manager and Team 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.

C. Pharmaceutical Management. The MHS Pharmacy and Therapeutics (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, Envolve Pharmacy Solutions 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:
  - Pharmacist (RPh)-to-member in-person Comprehensive Medication Review
  - Safety alerts and resolution monitoring
- Polypharmacy notices to practitioners
- Drug Utilization Review, including opiate monitoring
- 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)

D. Information and Education. MHS supports patient safety initiatives in the ongoing education of physicians, providers and members about safe practice protocols and procedures.

- 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.

- 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 Delegation Oversight Committee. An agreed-upon reporting schedule is in place for each delegate to ensure that the data is reported. All delegated providers are assessed annually through an established audit process.
- Member 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.

AUTHORITY

The MHS Board of Directors (BOD) oversees development, implementation and evaluation of the QI program. They have ultimate authority and accountability for oversight of the quality of care (QOC), safety of care, quality of service (QOS) and member experience.

Meeting a minimum of two times per calendar year with at least one meeting convened at a point where mid-course modifications can be considered, the BOD supports the QI program by:

- Providing strategic direction
- Adopting the annual QI Program documents
- Ensuring availability of the resources, support and systems necessary for optimum performance of QI functions
- Analyzing the QI Program Evaluation and QI Work Plan to assess whether program objectives defined in the QI Program Description were met and recommending adjustments when necessary

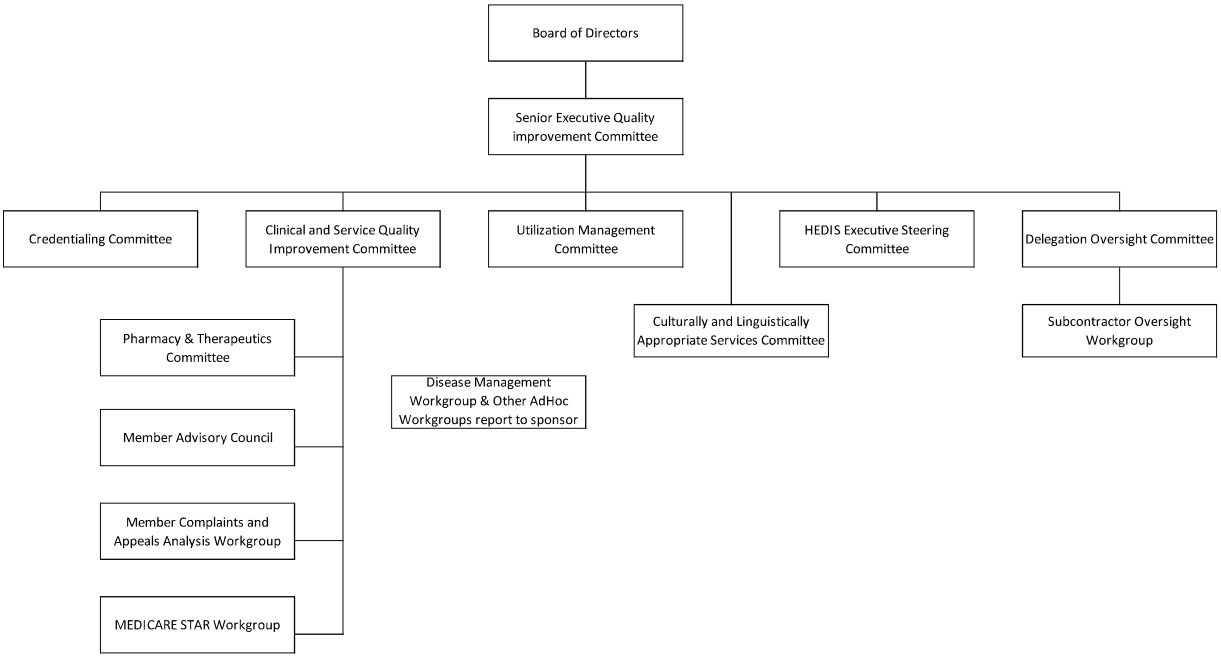
DELEGATION

MHS does not currently delegate any quality improvement activities.

STRUCTURE

1. Committees

The BOD has delegated daily oversight, operating authority and the responsibility to establish, maintain and support an effective QI program to the MHS CEO, an ex-officio member of the BOD and chair of the Senior Executive Quality Improvement Committee (SEQIC). The MHS Chief Medical Director (CMD), a practicing pediatrician, serves as physician representative to the BOD and SEQIC co-chair. The chart identifies the reporting relationships of the various committees and workgroups that support the QI program.



In addition to the following standing committees, MHS utilizes interdepartmental work groups, which may include representatives of affiliate partners to conduct root cause/barrier analysis and suggest improvement strategies. MHS also convenes ad-hoc issue focused advisory groups to gain the perspective on improvement strategies, pay-for-performance issues and any relevant concerns that may arise. All committee and work group activities are documented, minutes taken reflect attendance, agenda topics, person responsible, participant discussion, committee findings, required follow-up activities and timeline for completion.

A. Senior Executive Quality Improvement Committee (SEQIC)

SEQIC is accountable to the BOD. Members of SEQIC include the CEO (chair), CMD (co-chair), Chief Operating Officer, Senior Vice President of Medical Management, Vice President of Finance, Manager of Human Resources, Vice President of Compliance, Vice President of Customer Experience, Vice President of Quality and Process Improvement, Vice President HIP Operations and Vice President Network Development and Contracting. All members have voting rights.

SEQIC's purpose is to provide oversight and direction in assessing the appropriateness of care and service delivered, and to continuously enhance and improve the quality of care and services provided. This is accomplished through identification, evaluation, and resolution of process problems and identification of opportunities to improve outcomes and education of members, providers and staff.

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 include:

- Establish standards and criteria for care and service delivery.
- Approve policy and procedure
- Oversight of the QI program
- Monitor and approve QI program documents
- Approve and monitor actions of the following Committees:
  - Clinical and Service Quality Improvement (CASQIC)
  - Utilization Management (UMC)
  - Credentialing (CC)
  - Executive Steering (ESC)
  - Culturally and Linguistically Appropriate Services (CLAS)
  - Delegation Oversight (DOC)

B. Clinical and Service Quality Improvement Committee (CASQIC)

CASQIC is composed primarily of community practitioners representing independent and group primary, specialty and behavioral health providers and practitioners. As a group they are reflective of the MHS network. Delegated vendors and subcontractors, community partners, consumer advocates, members, and MHS staff may comprise the remainder of the committee. Committee composition ensures active practitioner participation in the QI program through regular planning, design, implementation and review functions.

Voting rights are restricted to community practitioners, CMD (chair), Medical, Behavioral Health and Pharmacy Directors. MHS 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 Pay for Performance (P4P), Pay for Outcomes (P4O), EPSDT, HEDIS/QRS, CAHPS/QHP and delegated vendors for compliance with standards and criteria for delivery of care and services to the membership
- Analyze and evaluate the results of 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 medical and behavioral preventive & clinical practice guidelines;
- Review and recommend approval of policies or policy decisions for effective QI operations and achievement of objectives;
- Review and recommend approval of Quality Improvement Activity (QIA) reports;
- Act as liaison to network medical, behavioral, vision and oral health providers for dissemination of QI information;

- Review and discuss operational issues that have resulted in less than stellar 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 documents; Program Description, Strategic Work Plan and Program 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 medical, pharmacy and behavioral health clinical QOC issues and member grievances as appropriate

C. Utilization Management Committee (UMC)

The UMC provides oversight and operating authority of the utilization management program and associated activities to ensure efficient integration of utilization management (UM) and medical management (MM) activities into all functional areas and departments. The MHS CMO chairs the committee which meets a minimum of six times annually. Additional voting members include participating physicians, the MHS Pharmacy Director, Behavioral Health Medical Director, CMD, MHS Medical Directors and the Senior Vice President of MM. 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 data to detect and correct patterns of potential or actual inappropriate under or over utilization which may impact health care services, coordination of care, appropriate use of services or resources.
- Assurance that services rendered are medically necessary and conform to acceptable practice standards
- Annually review and approve the medical necessity criteria and protocols, departmental policies and procedures, the UM/MM Program Evaluation and Program Description
- Analysis of inter-rater reliability evaluations for those who make UM decisions (medical, behavioral health and pharmacy)

D. Credentialing Committee (CC)

The CC is responsible for administering credentialing program oversight and operating authority. It is the vehicle through which credentialing and re-credentialing activities are communicated to SEQIC.

The CC reviews credentials, assesses quality indicators and makes decisions regarding provider and practitioner participation in the MHS network. A network participating physician chairs the CC 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. Minutes taken are presented to SEQIC. Functions include:

- Review initial credentialing files containing 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.
- Review and approval of the annual Program Description, departmental policies and procedures

E. Member Complaint and Appeals Analysis Workgroup (MCAAW)

An internal staff committee, MCAAW is responsible for conducting multidisciplinary review and tend analysis of member complaints, grievances and appeals. MCAAW meets quarterly with additional meetings as deemed necessary. To conduct an official meeting a quorum of 50% or more of members must be present. Minutes taken are presented to CASQIC. Functions include:

- Review aggregate member grievance and appeals data
- Ongoing monitoring with tracking/trending of findings
- Undertake quantitative and qualitative analysis when applicable
- Identify system improvement needs
- Recommend best practice improvement strategies and interventions
- Follow-up following PDSA cycles

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 with invitations 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 meetings are conveyed to MHS staff responsible for improvements with revisions reintroduced at the next MAC meeting.

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, achieve the benchmark 90th percentile NCQA Quality Compass for CAHPS/QHP and HEDIS/QRS scores.

The VP of Quality and Process Improvement chairs ESC meetings with members that include senior leadership along with the Quality and Process Improvement Director and

Managers. 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)

Voting members of the P&T 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 and behavioral health consultants, independent and free of conflict with respect to MHS and pharmaceutical manufacturers, may be recruited to provide input and advice related to their areas of expertise.

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. Committee functions include:

- Ensure clinical decisions are based on the strength of scientific evidence and quality standards of practice
- Evaluate and recommend drugs for inclusion in/removal from the Medicaid and Medicare Preferred Drug Lists (PDL)
- Review and recommend formulary management procedures such as prior authorizations, step therapies, age restrictions, quantity limits, therapeutic interchange and generic substitution
- Ensure regulatory compliance
- Review and monitor drug utilization data and medication safety
- Review and approval of annual Pharmacy Program Description and all associated policies and procedures

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: health and life coaching by Nurtur and the NurseWise Nurse Advice Line and Envolve Pharmacy Solutions, Envolve Vision and Envolve Dental. In addition, reports are received from National Imaging Associates, Medline DME and LCP Transportation. The Manager of Delegation Oversight 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)

To ensure ongoing compliance with the U.S. Dept. of Health and Human Services Office of Minority Health CLAS standards this committee assesses cultural and linguistic competence across MHS, including providers, practitioners, vendors, contractors and employees. The Director of Compliance chairs CLAS with members representing MHS departments. Minutes taken are presented to SEQIC. Committee functions include:
- Develop and implement Cultural Competency Plan (CCP)
- Review grievances related to CLAS
- Assess cultural and linguistic competence across MHS (providers, contractors, staff)
- Identify disparities and gaps
- Make recommendations for action that will result in positive health outcomes and/or resolve identified disparities

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 (EPC)
  - NurseWise Nurse Advice Line
  - Nurtur Disease Management and Lifestyle Management
- Envolve Vision
- Envolve Pharmacy Solutions
- Envolve Dental
- LCP Transportation
- National Imaging Associates
- Medline DME

Meetings are facilitated by the MHS 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. STARS CAHPS Improvement Committee (SCIC)

The SCIC Committee is a cross-departmental committee that identifies improvement initiatives and implements them for all lines of business in the areas of:

- CAHPS administration, oversight, analysis and improvement for all products
- HOS administration, oversight, analysis and improvement
- Clinical and preventive health initiatives, including HEDIS for all products

The team uses methodologies to systematically identify opportunities for improvement in three primary areas. The Director of Quality Improvement chairs SCIC meetings with cross organizational members that include Directors and Managers. Minutes taken are presented to CASQIC.

2. Quality and Process Improvement Department

The Quality and Process Improvement Department is a component of MHS Operations with the Vice President of Quality and Process Improvement reporting directly to the Chief Operating Officer.

3. Resources and Supports

A. Personnel dedicated to the QI program include members of the Quality and Process Improvement Department plus MHS staff with responsibilities that include:

- The Vice President of Quality and Process Improvement ensures adequate resources, support and systems to accomplish all QI functions. This individual serves as the ESC Chair, is the quality liaison to the OMPP Quality Division as a member of the Quality Strategy Committee, participates in monthly conference calls with Centene Corporate QI staff and other Health Plan QI VP's and Directors.
- The CMD chairs CASQIC and MCAAW and participates in CC,OMPP Quality Strategy Committee, Indiana State Drug Utilization Review and Therapeutics Committee, the OMPP Medical Directors collaboration group and serves as the clinical QI liaison to the MHS Senior Leadership Team.
- The Director of Quality Improvement plus Accreditation, QI and Quality of Care Managers and Senior Manager along with department staff are responsible for activities pertaining to compliance with MHS, Department of Insurance, FSSA and NCQA standards and regulations. This includes:
  - HEDIS/QRS collection and reporting
  - CAHPS/QHP/ECHO annual surveys of member medical and behavioral health experience
  - Pay for Performance (P4P) and Pay for Outcome (P4O) measures
  - Clinical QOC and quality of service (QOS) case reviews
  - Staff, member, practitioner and provider education
  - Committee and workgroup participation

- MHS Medical Directors conduct internal medical necessity reviews and actively participate in UMC and CASQIC which includes peer review.
- The Medical Management Senior VP and Senior Directors are experienced medical and behavioral healthcare clinicians. Together with their teams they identify and act on opportunities to improve quality and utilization of services in medical and utilization management programs of Case Management, Care Coordination, Prior Authorization, ER Diversion, Right Choices, etc. All are responsible for identification and referral of potential quality of care and quality of service issues.
- The Compliance Department oversees MHS-FSSA quality collaboration activities and delegation oversight. The Compliance Director chairs CLAS and leads related activities. The Manager of Grievance and Appeals oversees grievance and appeals functions, reporting type and category with resolution timeliness to MCAAW and CASQIC internally and to FSSA as required.
- The Credentialing and Provider Data Management staff perform initial credentialing and recredentialing activities, including facility assessments and reassessments. They are also responsible for credentialing delegation oversight.
- 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. They are responsible for the annual provider satisfaction survey and subsequent analysis. The Provider Data Analytics Team provides reports, analysis and communication of P4P and P4O measures.
- The Quality Outreach Team along with 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 by the Member Satisfaction Action Team and the CAHPS Workgroup.
- The Pharmacy Director oversees quality and safety of pharmaceutical 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.
- Analytical support is provided through the MHS Reporting & Business Analytics Department, Provider Network Data Analytics Team (Pay for Performance, Pay for Outcomes) and Centene Corporate Data Analysts.

B. Systems support begins with the MHS Management Information Systems (MIS) to manage the data required to support the measurement aspects of QI activities. The MIS captures and utilizes data from both internal and subcontractor sources for administration, management and other reporting requirements, submit and receive data

as well as interface with other systems.

MHS utilizes the Enterprise Data Warehouse (EDW) for the collection, integration and reporting of clinical claim/encounter data for medical, laboratory, pharmacy, behavioral health, dental, and vision, financial information, medical management information (referrals, authorizations, case management, disease management), member services information (current and historical eligibility, demographics, primary care provider, member outreach) and provider information (participation status, specialty, demographics).

The MicroStrategy reporting application is used to access the information stored in the EDW which includes internal data sources:

- Amisys is the claims processing engine that receives enrollee and provider data from MRM and PRM, service authorization information from TruCare;
- TruCare is a health management platform for collaborative care coordination, case management, disease management and utilization management. TruCare allows medical management staff to capture utilization, care and population based disease management data. An interface with clinical decision support criteria results in accurate identification and stratification of members with complex and/or high risk conditions. Members' progress, barriers and improvement interventions are documented and monitored in TruCare.
- QSI XL is an Inovalon software system used to monitor, profile and report on the treatment of specific episodes, care quality and treatment delivery patterns. QSI XL is certified by NCQA and used to integrate claim, member and provider data into a single repository for reporting HEDIS, Pay for Performance (P4P) and Pay for Outcome (P4O).
- Impact Pro is a predictive modeling and care management analytics tool to identify high risk members

C. Framework for Process Improvement

MHS utilizes 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.

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