EXECUTIVE SUMMARY OF MHS' ANNUAL QUALITY MANAGEMENT & IMPROVEMENT PROGRAM CY2022

PURPOSE

MHS is committed to the provision of a well-designed and well-implemented Quality Program to improve the experience and health outcomes of MHS' Indiana Medicaid members.

The Quality Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of health care provided to all its Medicaid members. Whenever possible, MHS' Quality Program supports processes and activities designed to achieve demonstrable and sustainable improvement in the health status of its Medicaid members. This systematic approach to quality improvement provides a continuous cycle for assessing the quality of care and services by addressing both medical and non-medical drivers of health and promoting health equity.

MHS provides for the delivery of quality care with the primary goal of improving the health status of its Medicaid members. When a member's condition is not amenable to improvement, the health plan implements measures to prevent any further decline in condition or deterioration of health status or provides for comfort measures as appropriate and requested by the member.

In order to fulfill its responsibility to its Medicaid members, the community and other key stakeholders, and regulatory and accreditation agencies, the health plan's Board of Directors reviews and approves the MHS Quality Program, Quality Evaluation and Quality Work Plan at least annually.

SCOPE

The scope of MHS' Quality Program is comprehensive and addresses both the quality and safety of clinical care and quality of services provided to its Medicaid members including medical, behavioral health, dental, and vision care as applicable to the health plan's benefit package. MHS incorporates all demographic groups, benefit packages, care settings, and services in its quality management and improvement activities for its members in the Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC) programs. Areas addressed by the Quality Program include preventive health including children and adolescent preventive care, ambulatory care; emergency care; acute and chronic care; population health management; health disparity reduction; behavioral health; episodic care; ancillary services; utilization management; continuity and coordination of care; patient safety; social determinants of health; prenatal and postpartum health outcomes and administrative, member, and network services as applicable.

AUTHORITY

MHS Board of Directors has authority and oversight for the development, implementation, and evaluation of the Quality Program and is accountable for oversight of the quality of care and services provided to its Medicaid members. The Board of Directors supports the Quality Program by:

- Adopting the initial and annual Quality Program which requires regular reporting (at least annually) to the Board of Directors, and establishes mechanisms for monitoring and evaluating quality, utilization, and risk;
- Supporting SEQIC (Senior Executive Quality Improvement Committee) and CASQIC (Clinical and Service Quality Improvement Committee) recommendations for proposed quality studies and other quality initiatives and actions taken;
- Providing the resources, support, and systems necessary for optimum performance of quality functions;
- Designating a senior staff member as the health plan's senior quality executive;
- Designating a behavioral health professional to provide oversight of the behavioral health aspects of care to ensure appropriateness of care delivery and improve quality of service; and,
- Evaluating the QAPI (Quality Assessment & Performance Improvement) and Quality Work Plan annually to assess whether program objectives were met and recommending adjustments when necessary.

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The Board of Directors delegates the operating authority of the Quality Program to the SEQIC. MHS senior management staff, clinical staff, and network practitioners, who may include but are not limited to, primary, specialty, behavioral, dental, and vision health care practitioners, are involved in the implementation, monitoring, and directing of the relative aspects of the quality improvement program through the SEQIC, which is directly accountable to the Board of Directors.

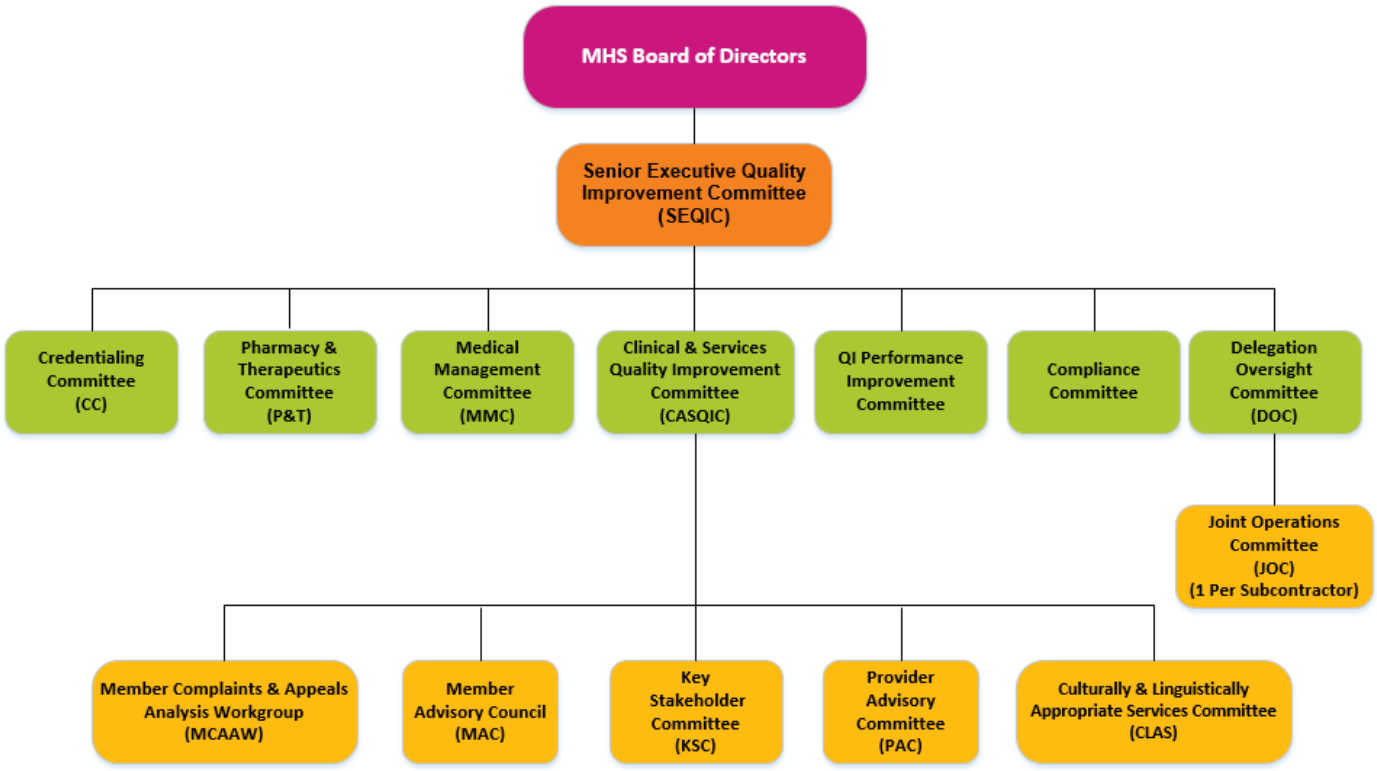
The Chief Medical Director, or a senior executive as designated by the MHS President/Chief Executive Officer, serves as the senior quality executive.

The Behavioral Health Medical Director, or other appropriate behavioral health practitioner (i.e., a medical doctor or a clinical PhD or PsyD who may be a medical director, clinical director, or a participating practitioner from the organization or behavioral healthcare delegate), is the designated practitioner responsible for the behavioral health aspects of the Quality Program.

GOVERNANCE AND LEADERSHIP

Quality is integrated throughout MHS and represents its strong commitment to the quality of care and services for its Medicaid members.

The SEQIC is the senior management lead committee accountable directly to the Board of Directors and reports Quality Program activities, findings, recommendations, actions, and results to the Board of Directors no less than annually. MHS ensures ongoing member, provider, and stakeholder input into the Quality Program through a strong SEQIC, CASQIC and subcommittee structure focused on member and provider experience. The MHS SEQIC and CASQIC structure is designed to continually promote information, reports, and improvement activity results, driven by the Quality Work Plan, throughout the organization and to providers, members, and stakeholders. The MHS committee structure is outlined below:



EXECUTIVE SUMMARY OF MHS' ANNUAL QUALITY MANAGEMENT & IMPROVEMENT PROGRAM CY2022

In addition to this internal program oversight, OMPP monitors MHS' compliance with contractual requirements. MHS submits reports to OMPP on a monthly, quarterly and annual basis. OMPP also conducts a monthly on-site meeting with MHS to discuss focus areas and see demonstrations of MHS' processes. MHS shares its performance data and improvement strategy with OMPP at the quarterly Quality Strategy Committee meetings.

There is an annual External Quality Review Organization analysis of MHS' managed care program that includes an annual review of the Quality Improvement Projects (QIPs).

As required by its state contract, MHS is also accredited by NCQA, an independent, non-profit organization. This industry-leading accreditation is a rigorous assessment of the health plan's structure and process, clinical quality and patient satisfaction. NCQA evaluates health plans on the quality-of-care patients receive, how happy patients are with their care, the health plans' efforts to keep improving, and then rates plans based on their combined HEDIS, CAHPS and NCQA Accreditation standards scores. MHS receives an annual Medicaid Health Plan Scorecard Rating from NCQA based on this assessment.

GOALS AND OBJECTIVES

In alignment with the Office of Medicaid Policy & Planning (OMPP), MHS has adopted four global aims in support of OMPP's Quality Strategic Plan. These are:

1) Quality: Monitor quality improvement measures and strive to maintain high standards

2) Prevention: Foster access to primary and preventive care services with a family focus

3) Cost: Ensure medical coverage in a cost-effective manner

4) Coordination/Integration: Encourage the organization of patient care activities to ensure appropriate care

In alignment with OMPP's initiatives for 2022 specific to each program , MHS has included these measures of focus specific to each program.

Hoosier Healthwise Strategic Objectives for Quality Improvements for 2022

2022 Hoosier Healthwise Initiatives		
Objective	**Methodology**	**Goal**
1. Improvements in children and adolescents' well-care - Percentage of members with well-child visits during first 21 years of life. HEDIS measures well-child visits in the first 30 months of life and child and adolescent well-care visits for ages 3-21 using hybrid data.	NCQA HEDIS methodology	Achieve at or above the 90th percentile of the NCQA 2022 Quality Compass improvements in children and adolescent well-child W30 and WCV HEDIS measures.
2. Improvements in childhood immunization status – Combination 10	NCQA HEDIS methodology	Achieve at or above the 50th percentile of the NCQA Quality Compass for member childhood immunization status (Combination 10) during the measurement year.
3. Completion of health needs screening (>65%)	Administrative reporting	Achieve at or above the 65% for all new members completing the health needs screening within 90 days of enrollment.
4. Annual dental visit	NCQA HEDIS methodology for members, aged 2-20 years	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for member dental visits during the measurement year.
5. Lead screening in children	NCQA HEDIS methodology	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for lead screening in children.
6. Asthma medication ratio	NCQA HEDIS methodology for members, aged 5-11 years	Achieve at or above the 90th percentile of the NCQA 2022 Quality Compass for asthma medication ratio.
7. Prenatal depression screening in pregnant members	NCQA HEDIS methodology	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for prenatal depression screening.
8. Increase in COVID-19 vaccination rate	Administrative reporting	Achieve at or above 70% of eligible membership fully vaccinated.

Healthy Indiana Plan Strategic Objectives for Quality Improvements for 2022

2022 Healthy Indiana Plan Initiatives		
Objective	**Methodology***	**Goal**
1. POWER Account rollover (HEDIS AAP). HIP members who obtain a preventive exam during the measurement year receive power account rollover. Only codes and code combinations listed in the categories 'Preventive Care Counseling Office Visit' and 'Alternative Preventive Care Counseling Visit' apply to this measure.	NCQA HEDIS methodology	Achieve rate at or above the 75th percentile of the NCQA 2022 Quality Compass of members who received a preventative exam
2. Prenatal depression screening in pregnant members	NCQA HEDIS methodology	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for prenatal depression screening.
3. Timeliness of ongoing prenatal care	NCQA HEDIS methodology	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for the timeliness of prenatal care.
4. Frequency of post-partum care	NCQA HEDIS methodology	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for the Frequency of postpartum.
5. Completion of health needs screening (>65%)	Administrative reporting	Achieve at or above the 65% for all new members completing the health needs screening within 90 days of enrollment.
6. Follow-up after emergency department visit for alcohol and other drug abuse dependence - 7 day	NCQA HEDIS methodology using administrative data	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass.
7. Follow-up after emergency department visit for alcohol and other drug abuse dependence - 30 day	NCQA HEDIS methodology using administrative data	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass.
8. Increase in COVID-19 vaccination rate	Administrative reporting	Achieve at or above 70% of eligible membership fully vaccinated.

Hoosier Care Connect Strategic Objectives for Quality Improvements for 2022

2022 Hoosier Care Connect Initiatives		
Objective	**Methodology***	**Goal**
1. Adult preventative care (HEDIS)	Adult preventive care NCQA HEDIS methodology	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for members 20 years and older who had a preventive care visit.
2. Completion of health needs screen (>65%)	Administrative reporting	Achieve completion of a Health Needs Screening for > 65% of all members during the first 90 days of completion.
3. Completion of comprehensive health assessment tool	Administrative reporting	Achieve completion of a comprehensive health assessment for >79% for all members who are stratified into complex case management or the Right Choice Program following the initial screening, during the first 150 days of enrollment.
4. Annual dental visit.	NCQA HEDIS methodology for members, aged 2-20 years	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass for member dental visits during the measurement year.
5. Follow-up after emergency department visit for alcohol and other drug abuse dependence - 7 day	NCQA HEDIS methodology using administrative data	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass.
6. Follow-up after emergency department visit for alcohol and other drug abuse dependence 30 - day	NCQA HEDIS methodology using administrative data	Achieve at or above the 75th percentile of the NCQA 2022 Quality Compass.
7. Increase in COVID-19 vaccination rate	Administrative reporting	Achieve at or above 70% of eligible membership fully vaccinated.

In addition to these measures of focus within specific Medicaid programs, MHS has adopted these NCQA Medicaid Health Plan Ratings Scorecard measures for improvement, with the goal of performing at or above 75th percentile of the 2023 NCQA Quality Compass.

2022 Medicaid Initiatives	
Measure	**Methodology***
PATIENT EXPERIENCE	
Getting Needed Care (Usually + Always)	CAHPS
Getting Care Quickly (Usually + Always)	CAHPS
Rating of Personal Doctor (9 + 10)	CAHPS
Rating of Specialist Seen Most Often (9 + 10)	CAHPS
Coordination of Care (Usually + Always)	CAHPS
Rating of Health Plan (9 + 10)	CAHPS
Rating of All Health Care (9 + 10)	CAHPS
PREVENTION AND EQUITY	
Children and Adolescent Well-Care	
ADV Annual Dental Visit—Total	HEDIS
CIS Childhood Immunization Status—Combination 10	HEDIS
IMA Immunizations for Adolescents—Combination 2	HEDIS
WCC Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	HEDIS
Women's Reproductive Health	
PPC Prenatal and Postpartum Care—Timeliness of Prenatal Care Prenatal and Postpartum Care—Postpartum Care	HEDIS
PRS-E Prenatal Immunization Status —Combination Rate	HEDIS
Cancer Screening	
BCS Breast Cancer Screening	HEDIS
CCS Cervical Cancer Screening	HEDIS
Equity	
RDM Race/Ethnicity Diversity of Membership	HEDIS
Other Preventive Services	
CHL Chlamydia Screening in Women—Total	HEDIS
FVA Flu Vaccinations for Adults Ages 65 and Older	CAHPS
MSC Medical Assistance with Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit	CAHPS
TREATMENT	
Respiratory	
AMR Asthma Medication Ratio—Total	HEDIS
CWP Appropriate Testing for Pharyngitis—Total	HEDIS
URI Appropriate Treatment for Upper Respiratory Infection—Total	HEDIS
AAB Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	HEDIS
PCE Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	HEDIS

Diabetes	
BPD Blood Pressure Control (<140/90) for Patients With Diabetes	HEDIS
EED Eye Exam for Patients With Diabetes	HEDIS
HBD Hemoglobin A1c Control for Patients With Diabetes — HbA1c Control	HEDIS
SPD Statin Therapy for Patients with Diabetes— Received Statin Therapy Statin Therapy for Patients with Diabetes—Statin Adherence 80%	HEDIS
KED Kidney Health Evaluation for Patients with Diabetes	HEDIS
Heart Disease	
SPC Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy—Total Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%—Total	HEDIS
CBP Controlling High Blood Pressure	HEDIS
Behavioral Health—Care Coordination	
FUH Follow-Up After Hospitalization for Mental Illness— 7 days—Total	HEDIS
FUM Follow-Up After Emergency Department Visit for Mental Illness—7 days—Total	HEDIS
FUA Follow-Up After Emergency Department Visit for Substance Use—7 days—Total	HEDIS
FUI Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	HEDIS
Behavioral Health—Medication Adherence	
SAA Adherence to Antipsychotic Medications for Individuals With Schizophrenia	HEDIS
POD Pharmacotherapy for Opioid Use Disorder—Total	HEDIS
AMM Antidepressant Medication Management— Effective Continuation Phase Treatment	HEDIS
Behavioral Health—Access, Monitoring and Safety	
APM Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	HEDIS
ADD Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	HEDIS
SSD Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	HEDIS
APP Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	HEDIS
IET Initiation and Engagement of Substance Use Disorder—Engagement of SUD Treatment—Total	HEDIS
Risk-Adjusted Utilization	
PCR Plan All-Cause Readmissions—Observed-to Expected Ratio—18-64 years	HEDIS
Overuse of Opioids	
HDO Use of Opioids at High Dosage	HEDIS
UOP Use of Opioids from Multiple Providers—Multiple Prescribers and Multiple Pharmacies	HEDIS
COU Risk of Continued Opioid Use—31-day rate—Total	HEDIS
Other Treatment Measures	
LBP Use of Imaging Studies for Low Back Pain	HEDIS

*HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). (Healthcare Effectiveness Data and Information Set-HEDIS)
*CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). (Consumer Assessment of Healthcare Providers and Systems-CAHPS)

QUALITY PROGRAM RESOURCES: INFRASTRUCTURE AND DATA ANALYTICS

MHS has the technology infrastructure and data analytics capabilities to support goals for quality management and value. MHS' health information systems collect, analyze, integrate, and report encounter data and other types of data to support utilization, complaints/grievances and appeals, care management/coordination, and all quality activities related to its Medicaid membership. The IT infrastructure integrates data for monitoring, analysis, evaluation, and improvement of the delivery, quality and appropriateness of health care furnished to all members, including those with special health care needs. MHS IT systems and informatics tools support advanced assessment and improvement of both quality and value, including collection of all quality performance data, with the ability to stratify data at the regional level, across provider types, and across member populations. These systems capture, store, and analyze data from internal, subcontractor, and external sources and for effective use through a suite of data informatics and reporting solutions.

Centelligence – Internal monitoring processes are supported by Centelligence, a family of integrated decision support and health care informatics solutions that facilitates use of data by collecting, integrating, storing, analyzing, and reporting data from all available sources. Centelligence also powers the MHS provider practice patterns and provider clinical quality and cost reporting information products. Centelligence includes a suite of predictive modeling solutions incorporating evidence-based, proprietary care gap/health risk identification applications that identify and report significant health risks at population, member, and provider levels.

The Centelligence platform receives, integrates, and continually analyzes large amounts of transactional data, such as medical, behavioral, and pharmacy claims; lab test results; health screenings and assessments; service authorizations; member information (e.g., current and historical eligibility and eligibility group; demographics including race and ethnicity, region, and primary care provider assignment; member outreach), and provider information (e.g., participation status; specialty; demographics; languages spoken). The Centelligence analytic and reporting tools provide MHS the ability to report on all datasets in the platform, including HEDIS and EPSDT, at the individual member, provider, and population levels. These analytic resources allow key quality personnel the necessary access and ability to manage the data required to support the measurement aspects of the quality improvement activities and to determine intervention focus and evaluation.

Through Centelligence, MHS develops defined data collection and reporting plans to build custom measures and reports, as applicable. MHS analyzes population demographics, including disease prevalence and healthcare disparities, at the state and regional level, to identify opportunities for improvement and trends that indicate potential barriers to care that can potentially affect the results of interventions and initiatives. Demographic analysis is used to appropriately design quality improvement projects and interventions and to evaluate the results of performance measures, analyzing population results by gender, age, race/ethnicity, geographic region, etc.

Enterprise Data Warehouse (EDW) – The foundation of MHS' Centelligence proprietary data integration and reporting strategy is the EDW, powered by high performance Teradata technology.

AMISYS Advance – AMISYS provides claims processing with extensive capabilities for administration of multiple provider payment strategies. AMISYS Advance receives appropriate health plan member and provider data systematically from Member Relations Manager and Provider Relations Manager systems; receives service authorization information in near real time from TruCare, the clinical documentation and authorization system; and is integrated with encounter production and submission software.

TruCare – This is a member-centric health management platform for collaborative care management, care coordination and behavioral health, condition, and utilization management that is integrated with Centelligence for access to supporting clinical data. It allows Medical Management and Quality department staff to capture utilization, care, and population health management data, to proactively identify, stratify, and monitor high-risk enrollees, to consistently determine appropriate levels of care through integration with InterQual® medical necessity criteria and clinical policies, and to capture the impact of programs and interventions. It also houses an integrated appeals management module, supporting the appeals process from initial review through to resolution, and reporting on all events along the process, and a quality-of-care module to track and report potential quality of care incidents and adverse events.

NCQA Certified HEDIS Engine – a software system used to monitor, profile, and report on the treatment of specific episodes, care quality, and care delivery patterns. It supports NCQA-certified HEDIS measures reporting; its primary use is for the purpose of building and tabulating HEDIS and other state-required performance measures. Data is updated at least monthly by using an interface that extracts claims, member, provider, and financial information and then summarized with access for staff to view standard data summaries and drill down into the data or request ad-hoc queries.

Scorecards - Centene Quality Analytics produces monthly scorecards for ratings systems like the NCQA Medicaid Health Plan Rating System. In addition, scorecards are produced for the quality-related Pay-for-Performance programs outlined in the FSSA HHW, HIP and HCC contracts. Roll-up overall stars are estimated for current rates, and final overall star ratings from prior year are provided for comparison. Month-over-month and year-over-year graphs are provided to show trending performance across current and prior measurement year. Finally, the most current available benchmarks are provided, at the measure level to show health plans the benchmark currently achieved and the gap to all remaining benchmarks not met.

Predictive Analytics – MHS' predictive analytics engine examines large data sets daily, providing a comprehensive array of targeted clinical and quality reports. This includes the regular re-computation and interpretation of a member's clinical data, delivering actionable insights for HEDIS, Pay-for-Performance, and Risk Adjustment scores, as well as enhanced drug safety and quality of care metrics. The predictive analytics tool applies clinical predictive modeling rules, supplying care teams, Quality staff, providers, and members with actionable, forward-thinking care gap and health needs information to guide decisions and program development.

Clinical Decision Support – State-of-the-art predictive modeling software is used to identify members who may be at risk for high future utilization through risk score assignment. The Clinical Decision Support application is a multi-dimensional, episode-based predictive modeling and Care Management analytics tool that allows the Quality and Care Management teams to use clinical, risk, and administrative profile information obtained from medical, behavioral, and pharmacy claims data and lab value data to identify high risk members. The EDW updates the Clinical Decision Support system bi-weekly with data, including eligibility, medical, behavioral and pharmacy claims data, demographic data, and lab test results to calculate and continuously update each member's risk score. The application supports the Quality team in identifying target populations for focused improvement intervention based on risk score and need.

Customer Relationship Management (CRM) Platform – The Customer Relationship Management (CRM) platform enables MHS to identify, engage, and serve members, providers, and federal/state partners in a holistic and coordinated fashion across the wellness, clinical, administrative, and financial matters. The CRM platform captures, tracks, and allows MHS staff to manage complaints, grievances, and appeals for all required reporting.

MHS obtains data and analytical support through the Information and Management Systems Department, Corporate Quality, Health Economics, and other support resources as necessary.

DOCUMENTATION CYCLE

The Quality Program incorporates an ongoing documentation cycle that applies a systematic process of quality assessment, identification of opportunities, action implementation as indicated, and evaluation. Several key quality instruments demonstrate MHS' continuous quality improvement cycle using a predetermined documentation flow such as the:

- Quality Assessment & Performance Improvement (QAPI) Program Description;
- Quality Work Plan; and
- Quality Program Evaluation.

Quality Assessment & Performance Improvement (QAPI) Program Description – The Quality Assessment & Performance Improvement Program Description is a written document that outlines MHS' structure and process to monitor and improve the quality and safety of clinical care and the quality of services provided to its Medicaid

members. The QAPI includes the following at minimum: the design and scope of the Quality Program, the governance and leadership for the approval, implementation and evaluation of the quality program, the data systems that support systematic and ongoing monitoring of performance, as well as systematic analysis to inform data-driven action, and the measures of focus and performance improvement projects for the current year.

Quality Work Plan – The Quality Work Plan clearly defines the activities to be completed by each department and all supporting committees throughout the program year, based on the Quality Program Evaluation of the previous year to meet the goals and objectives identified in the Quality Program.

The Work Plan is developed annually after completing the Quality Program Evaluation for the previous year and includes the recommendations for improvements from the annual Program Evaluation.

Quality Program Evaluation – The Quality Program Evaluation includes an annual summary of all quality activities, the impact the program has had on MHS' Medicaid member care, an analysis of the achievement of stated goals and objectives, and the need for program revisions and modifications. Program Evaluation findings are incorporated in the development of the annual Quality Assessment & Performance Improvement Program Description and Quality Work Plan for the subsequent year.

PERFORMANCE MEASUREMENT

MHS continually monitors and analyzes data to measure performance against established benchmarks and to identify and prioritize improvement opportunities. Specific interventions are developed and implemented to improve performance and the effectiveness of each intervention is measured at specific intervals, applicable to the intervention.

MHS focuses monitoring efforts on the priority performance measures that align with the mission and the objectives and goals previously outlined. MHS reports all required measures in a timely, complete, and accurate manner as necessary to meet federal and state reporting requirements.

HEDIS includes measures across six (6) domains of care including:

- Effectiveness of Care
- Access and Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information
- Measures Collected Using Electronic Clinical Data Systems.

Member Experience: MHS supports continuous ongoing measurement of member experience by monitoring member inquiries, complaints/grievances, and appeals; member satisfaction surveys; member call center performance; and direct feedback from member focus groups and other applicable committees. The Quality Department analyzes findings related to member experience and presents results to the CASQIC and appropriate subcommittees.

The Consumer Assessment of Healthcare Providers and Systems Plan Survey (CAHPS) assesses patient experience in receiving care. MHS focuses on the following measures required for the NCQA Health Plan Ratings:

- Getting Care Quickly;
- Getting Needed Care;
- Coordination of Care;
- Customer Service;
- Rating of Health Plan;

- Rating of All Health Care;
- Rating of Personal Doctor; and
- Rating of Specialist Seen Most Often.

CULTURAL COMPETENCY AND HEALTH EQUITY

MHS endeavors to meet the needs of all members with sensitivity to cultural needs and the impact of cultural differences on health services and outcomes. MHS is guided by requirements set by each respective state/federal contract and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) developed by the Office of Minority Health. MHS assures communications are culturally sensitive, appropriate, and meet federal and state requirements. Information provided to members promotes the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities and regardless of gender, sexual orientation, or gender identity. Population health management initiatives are reviewed to assure cultural issues and social determinants of health are identified, considered, and addressed. Additionally, MHS is committed to improving disparities in care as an approach to improving HEDIS measures, reducing utilization costs and delivering locally tailored, culturally relevant care.

PROVIDER EXPERIENCE

Provider satisfaction is assessed annually using valid survey methodology and a standardized comprehensive survey tool to assess provider satisfaction with the network, claims, quality, utilization management, and other administrative services. Survey results are reviewed by the CASQIC, with specific recommendations for performance improvement interventions or actions. Provider experience may also be assessed through monitoring of provider grievances and appeals as well as point-in-time provider surveys following call center and in-person interactions.

PROMOTING MEMBER SAFETY AND QUALITY OF CARE

The Quality Program is a multidisciplinary program that utilizes an integrated approach to monitor, assess, and promote patient safety and quality of care. MHS has mechanisms to assess the quality and appropriateness of care furnished to its Medicaid members including those with special health care needs, as defined by the State. These activities are both clinical and non-clinical in nature and address physical health, behavioral health, and social health services.

Member safety is a key focus of the MHS Quality Program. Monitoring and promoting member safety is integrated throughout many activities across the health plan, including through identification of potential and/or actual quality of care events and critical incidents, as applicable. Potential quality of care issues and critical incidents received in the Quality Department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

In addition, the health plan monitors for quality of care and/or adverse events through claims-based reporting mechanisms.

MHS' critical incident management processes comply with all health, safety and welfare monitoring and reporting of critical incidents as required by state and federal statutes and regulations and meets all accreditation requirements. Management of critical incidents safeguards the health, safety, and welfare of members by establishing protocols, procedures, and guidelines for consistent monitoring and trend analysis for all critical incidents as defined by state and federal regulations and accreditation requirements.

MHS also ensures initial and re-credentialing of all network practitioners/providers complies with state and accreditation requirements, and performs ongoing monitoring of the provider network, including screening of

providers against all applicable Exclusion Lists (e.g., System for Award Management [SAM], List of Excluded Individuals/Entities [LEIE], etc.).

MEMBER ACCESS TO CARE

MHS ensures Medicaid member access to care in areas such as network adequacy, availability of services, timely appointment availability, transitions of coverage, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization. MHS ensures the availability and delivery of services in a culturally and linguistically competent manner to all members, including those with limited English proficiency and literacy and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, gender identity, etc. MHS also ensures all network providers deliver physical access, reasonable accommodations, and accessible equipment for beneficiaries with physical or mental disabilities. Numerous methods and sources of data are utilized to assure appropriate member access to care, including practitioner/provider availability analysis, practitioner office site surveys, member inquiries and complaints/grievances/appeals, and review of CAHPS survey findings related to member experience of availability and access to services. MHS also ensures members have access to accurate and easy to understand information about network providers. MHS' provider directory is available in online and in hard copy, as needed, and meets all regulatory and accreditation requirements. The directory is updated in a timely manner upon receipt of updated information from providers and assessment of the accuracy of the directory is completed on an ongoing basis.

POPULATION HEALTH MANAGEMENT

MHS' Population Health Management (PHM) strategy includes a comprehensive plan for managing the health of its Medicaid enrolled population, improving health outcomes, and controlling health care costs, and is coordinated with activities addressed in this program description. The PHM Strategy is closely aligned with the Quality Program priorities and goals with PHM goals and objectives focused on four key areas of member health needs:

- Keeping members healthy;
- Managing members with emerging health risk;
- Patient safety/outcomes across settings; and
- Managing multiple chronic illnesses.

CARE MANAGEMENT AND COORDINATION OF SERVICES

MHS ensures coordination of services for its Medicaid members, including between settings of care, such as appropriate discharge planning for hospital and institutional stays. When members experience changes in enrollment across health plans or FFS Medicaid, MHS coordinates with the applicable payer source to ensure continuity and non-duplication of services.

MHS provides care coordination, care management, and condition/disease management for members identified at risk, intervenes with specific programs of care, and measures clinical and other health-related outcomes. MHS attempts to assess all new Medicaid members within 90 days of enrollment by performing a health risk screening, using an approved tool, that includes assessing for member risk based on social determinants of health, emerging risk, and other risks. MHS' condition management and population health management programs help members understand their diagnoses, learn self-care skills, and adhere to treatment plans. Programs also include written communication to primary care providers informing of members on their panel with chronic conditions such as diabetes and/or hypertension and reminders on appropriate screening and monitoring tests as recommended by evidenced-based practice guidelines.

The Care Management Program Description further outlines MHS' approach to addressing the needs of members with complex health issues, which may include physical disabilities, developmental disabilities, chronic conditions, and severe and persistent mental illness.

PROVIDER SUPPORT

MHS collaborates with network providers to build useful, understandable, and relevant analyses, and reporting tools to improve care and compliance with practice guidelines and delivers these in a timely manner to support member outreach and engagement.

The health plan offers a population health management tool designed to support providers in the delivery of timely, efficient, and evidence-based care to members. Claims data is used to create a detailed profile of each member with the ability to organize members by quality measures and disease conditions. This provider analytics tool includes:

- Disease registries;
- Care gap reporting at member and population levels;
- Claims-based patient histories; and
- Exportable patient data to support member outreach.

PROVIDER ANALYTICS – MHS offers a quality, cost and utilization tool designed to support providers who participate in a value-based program to identify provider performance opportunities and assist with population health management initiatives. Through these supporting platforms, MHS works to keep providers engaged in the delivery of value-based care by promoting wellness and incentivizing the prudent maintenance of chronic conditions.

PRACTICE GUIDELINES

Preventive health and clinical practice guidelines assist practitioners, providers, members, medical consenters, and caregivers in making decisions regarding health care in specific clinical situations. Nationally recognized guidelines are adopted/approved by MHS' Senior Executive Quality Improvement Committee (SEQIC) and Clinical and Service Quality Improvement Committee (CASQIC), in consultation with network practitioners/providers and/or feedback from board-certified practitioners from appropriate specialties, as needed. Guidelines are based on the health needs of members and opportunities for improvement identified as part of the Quality Program, valid and reliable clinical evidence, or a consensus of health care professionals in the field and needs of the members. Clinical and preventive health guidelines are updated upon significant new scientific evidence or change in national standards, or at least every two (2) years. Guidelines are distributed to providers via the Provider Manual, the MHS website, and/or provider newsletters and are available to all members or potential enrollees upon request.

PERFORMANCE IMPROVEMENT ACTIVITIES

MHS' SEQIC reviews and adopts the annual Quality Program and Quality Work Plan for Medicaid members, that aligns with the health plan's strategic vision and goals, OMPP's Quality Strategy Plan and appropriate industry standards. The Quality Department implements and supports performance/quality improvement activities as required by state or federal contract, including continuous quality improvement.

As required by OMPP, MHS has developed individualized Quality Management and Improvement Work Plans (QMIP) for each of MHS' Medicaid lines of business and has implemented these two Quality Improvement Plans (QIPs).

2022 Quality Improvement Projects (QIP)			
QIP Topic	**QIP Aim**	**QIP Intervention**	**Line of Business**
Health Needs Screening (HNS)	Increase the rate of timely completion of HNS for eligible members	• Increase completion of HNS via telephonic outreach and digital image via email • Increase use of Pursuant Health Kiosks at Walmart and CVS stores utilizing geo-fence technology • Include paper copy of HNS in each new member welcome packet • Promote member use of web portal for completion • Use of weekly email reminders • Member incentives	HHW HIP HCC
Follow-up and care coordination after emergency department visit for SUD	Increase the speed and rate of engagement with care coordination and follow-up after an emergency department visit for substance use disorder	• Member outreach via the ED Diversion Team • Member incentives	HHW HIP HCC

EXECUTIVE SUMMARY OF MHS' ANNUAL QUALITY MANAGEMENT & IMPROVEMENT PROGRAM CY2022

GREIVANCE AND APPEALS SYSTEM

MHS ensures that Medicaid members can address their problems quickly and with minimal burden. MHS investigates and resolves member complaints/grievances and appeals and quality of care concerns in a timely manner. Medicaid members may file a complaint/grievance to express dissatisfaction with any issue that is not related to an adverse benefit determination (e.g., concerns regarding quality of care or behavior of a provider or MHS employee) or file a formal appeal of an adverse benefit determination, or upon exhaustion of the internal appeal process, request further appeal as applicable.

All member grievances and appeals are tracked and resolved, and data is analyzed and reported to the CASQIC and applicable subcommittees on a regular basis to identify trends and to recommend performance improvement activities as appropriate. In addition, member grievances associated with specific practitioners and/or providers and related to quality of care and service are tracked, classified according to severity, and reviewed by the Medical Director as needed.

REGULATORY COMPLIANCE AND REPORTING

MHS departments perform required quality of service, clinical performance, and utilization studies throughout the year based on contractual requirements, requirements of state and regulatory agencies and those of applicable accrediting bodies such as NCQA. All functional areas utilize standards/guidelines from these sources and those promulgated by national and state medical societies or associations, the Centers for Disease Control, the federal government, etc. The Quality Department maintains a schedule of relevant quality reporting requirements for all applicable state and federal regulations and accreditation requirements and submits reports in accordance with these requirements. Additionally, the Quality Program and all health plan departments fully support every aspect of the federal privacy and security standards, Business Ethics and Code of Conduct, Compliance Plan, and Waste, Fraud and Abuse Plan.

NCQA HEALTH PLAN ACCREDITATION

MHS adheres to the belief that NCQA Health Plan Accreditation demonstrates a health plan's commitment to delivering high-quality care and service for members and thus strives for a continual state of accreditation readiness. The MHS Chief Medical Director, VP/Director of Quality, and Sr. Director of Quality and Member Experience facilitate the accreditation process with support from Centene Corporation's national accreditation team. MHS is accredited by NCQA for its Medicaid line of business and will complete a re-accreditation survey in August 2022.

SUMMARY

Quality is integrated throughout MHS and represents its strong commitment to the quality of care and services for its Medicaid members.

MHS provides general information about the Quality Program to members and providers on the website by posting the Executive Summary of its Annual Quality Management & Improvement Program Plan Summary report.