PURPOSE

Managed Health Services (MHS) is committed to the provision of a well-designed and well-implemented Quality Program. 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 members. Whenever possible, MHS' Quality Program supports processes and activities designed to achieve demonstrable and sustainable improvement in the health status of its 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 the 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 members, the community and other key stakeholders, and regulatory and accreditation agencies, the health plan's Board of Directors has adopted the following Quality Program Description. The Program Description is reviewed and approved at least annually by the Clinical and Service Quality Improvement Committee (CASQIC) and the MHS Board of Directors.

SCOPE

The scope of the Quality Program is comprehensive and addresses both the quality and safety of clinical care and quality of services provided to all MHS members including medical, behavioral health, dental, and vision care as applicable to the health plan's benefit package. MHS incorporates all demographic groups, lines of business, benefit packages, care settings, and services in its quality management and improvement activities. Areas addressed by the Quality Program include preventive health; emergency care; acute and chronic care; population health management; health disparity reduction; behavioral health; episodic care; long-term services and supports; ancillary services; continuity and coordination of care; patient safety; social determinants of health; and administrative, member, and network services as applicable. MHS' Quality Program includes the following:

- Identification of priorities and goals aligning with Centene Corporation's mission and the health priorities defined by the CDC 6|18 Initiative, Healthy People 2020 and 2030, the National Institutes of Health, and other evidence-based sources;
- Conducting quality activities, including peer review activities, in accordance with all applicable state and federal confidentiality laws and regulations and taking conflicts of interest into consideration when conducting peer review activities;
- A focus on cultural competency and health equity, including the identification of interventions to improve health disparities based on age, race, ethnicity, sex, primary language, etc. and by key population group;
- Assessment and identification of interventions to address health disparities at a statewide and regional level, including identifying internal priorities for disparity reduction and quality measure improvement and addressing inequalities;
- A robust Quality Committee structure, including subcommittees and additional ad hoc committees and work groups as applicable to meet the needs of the health plan, members, and providers;
- Allocation of personnel and resources necessary to:
  - support the Quality Program, including data analysis and reporting;
  - meet the educational needs of members, providers, and staff relevant to quality improvement efforts; and
  - meet all regulatory and accreditation requirements;
- The technology infrastructure and data analytics capabilities to support goals for quality management and value include health information systems that provide data collection, integration, tracking, analysis, and reporting of data that reflects performance on standardized measures of health outcomes;

- An ongoing documentation cycle that includes the Quality Program Description, the Quality Work Plan, and a Quality Program Evaluation; these documents demonstrate a systematic process of quality assessment, identification of opportunities, action implementation as indicated, and ongoing evaluation;
- Collecting and submitting all quality performance measurement data per state, federal, and accreditation requirements, including robust performance management tracking and reporting such as:
  - The annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) (Qualified Health Plan (QHP) Enrollee Experience survey for the Marketplace product line, when applicable) (CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ));
  - Annual Health Outcomes Survey (HOS®); (HOS is a CMS-developed survey tool which assesses a health plan's ability to maintain or improve the physical and mental health of Medicare members over time);
  - Healthcare Effectiveness Data and Information Set (HEDIS®) results for members (HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA));
  - Developing additional standardized performance measures that are clearly defined, objective, measurable, and allow tracking over time; and/or
  - Administering an annual provider satisfaction survey and identifying improvement activities based on identified areas of provider need/dissatisfaction;
- Monitoring, assessing, and promoting patient safety including efforts to prevent, detect, and remediate quality of care and critical incidents and a peer review process that addresses deviations in the provision of health care and action plans to improve services;
- Ensuring member access to care in areas such as network adequacy, availability of services, timely appointment availability, transitions of coverage, and coordination and continuity of care,
- Encouraging providers to participate in quality initiatives and giving support to providers, including a provider analytics system that delivers frequent, periodic quality improvement information to participating providers in order to support them in their efforts to provide high quality health care, and adoption and distribution of evidence-based practice guidelines;
- Conducting and assessing quality improvement and performance improvement projects based on demonstration of need and relevance to the population served, with improvement initiatives aligned with identified health priorities and state/federal requirements and applicable member population(s);
- Develop and implement a Chronic Care Improvement Program for Medicare, focused on improving care and health outcomes for members with chronic conditions;
- Monitoring utilization patterns by performing assessment of utilization data to identify potential over- and under-utilization issues or practices using various data sources such as medical, behavioral health, pharmacy, dental, and vision claim/encounter data to identify patterns of potential or actual inappropriate utilization of services;
- A Population Health Management (PHM) Strategy focused on four key areas of member health needs (keeping members healthy, managing members with emerging health risks, patient safety/outcomes across settings and managing multiple chronic illnesses) that offers interventions to address member needs in all stages of health and across all health care settings;
- Serving members with complex health needs, including members needing complex care management and long-term services and supports (LTSS), as applicable;
- Achieving/maintaining NCQA accreditation and/or other applicable accreditations for appropriate products;
- Monitoring for compliance with all regulatory and accreditation requirements; and
- Collaboration with Compliance and other applicable departments concerning oversight of delegated functions and services, including approval of the delegate's programs, routine reporting of key performance metrics, and ongoing evaluation to determine whether the delegated activities are being carried out according to health plan and regulatory requirements and accreditation standards.

PRIORITIES AND GOALS

MHS' primary goal is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving the quality of care and services delivered. The Quality Program focuses on the health priorities defined by a combination of the CDC 6|18 Initiative, Healthy People 2020 and 2030, the National Institutes of Health, and other evidence-based sources. Performance measures are aligned to specific priorities and goals used to drive quality improvement and operational excellence.

MHS' Quality Program priorities and goals support the Centene Corporation purpose of *Transforming the Health of the Community, One Person at a Time* and the mission of *Better Health Outcomes at Lower Costs* employing the three core brand pillars: a focus on the individual; an innovative, whole-health, well-coordinated system of care; and active local and community involvement. The mission, core pillars and health priorities are outlined in the table below:

Transforming the Health of the Community, One Person at a Time		
Better Health Outcomes at Lower Costs		
Focus on Individuals	**Whole Health**	**Active Local Involvement**
Priorities	**Priorities**	**Priorities**
• Well-Coordinated, Timely, Accessible Care Delivery • Member Healthy Decisions • Home and Community Connection • Right Care, Right Place, Right Time • Member Engagement • Provider Engagement • High Value Care • Member Satisfaction with Provider and Health Plan	• Meaningful Use of Data • Prevent and Manage Top Chronic Illnesses • Manage Co-morbid Physical and Behavioral Health Diagnosis • Manage Episodic Illnesses • Manage Rare Chronic Conditions • Screen for Unmet Needs • Remove Barriers to Care; Make It Simple to Get Well/Stay Well/Be Well • Coordination of Care Across the Health Care Continuum • Behavioral Health Integration • LTSS Quality of Life	• Local Partnerships • Population Health Improvement • Preventive Health and Wellness • Maternal-Child Health Care • Prevent and Manage Obesity • Tobacco Cessation • Opioid Misuse Prevention and Treatment • Address Social Determinants of Health • Health Equity/Disparity Reduction • Multi-Cultural Health

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 goals outlined previously, as well as required additional measures. MHS reports all required measures in a timely, complete, and accurate manner as necessary to meet federal and state reporting requirements. Performance measures also include all HEDIS measures required for the NCQA Health Plan Ratings and the designated set of CMS Adult and Child Core Measures. 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 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.

The Health Outcomes Survey (HOS) is a member-reported outcomes measure used in Medicare Star Ratings. There are five (5) measures that are incorporated into the HOS survey:

- Improving and Maintaining Physical Health;
- Improving and Maintaining Mental Health;
- Falls Risk Management;
- Managing Urinary Incontinence; and
- Physical Activity in Older Adults.

PROVIDER EXPERIENCE

Provider satisfaction is assessed annually using valid survey methodology and a standardized comprehensive survey tool. The survey tool is designed to assess provider satisfaction with the network, claims, quality, utilization management, and other administrative services. Survey results are reviewed by 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 all 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. An adverse event is an event over which health care personnel could have exercised control, and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred. Although occurrence of an adverse event in and of itself is not necessarily a preventable quality of care issue, MHS monitors and tracks these occurrences for trends in type, location, etc., to monitor member safety and investigates further and/or requests a corrective action plan any time a quality of care issue is definitively substantiated.

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.

Critical incidents, for example, may include events or occurrences that cause harm to an LTSS member or indicate risk to a member's health and welfare, such as abuse, neglect, and exploitation. Other events impacting LTSS members' health and wellness, or potential risk, may be addressed through the quality of care process as noted above.

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 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 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
- Managing multiple chronic illnesses

MHS' PHM Strategy outlines how member health needs are identified and stratified for intervention; details the PHM programs and services offered to address those needs for all stages of health and across health care settings; explains how members are informed of the programs and services and their eligibility to utilize them; and describes proven prevention interventions and tactics used to promote the transition to value-based care in the health plan's network. PHM programs, activities, and outcomes are reported to CASQIC for review, recommendations, and approval.

CARE MANAGEMENT AND COORDINATION OF SERVICES

MHS ensures coordination of services for 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 members within 90 days of enrollment by performing a health risk screening which includes assessing for member risk based on social determinants of health, emerging risk, and other risks. A universal screening tool is utilized that includes questions relating to social determinants of health such as housing, food, transportation, and interpersonal violence. 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 SUPPORTS

MHS collaborates with network providers to build useful, understandable, and relevant analyses, and reporting tools to improve care and compliance with practice guidelines. These analyses are delivered in a timely manner in order to support member outreach and engagement. This collaborative effort helps to establish the foundation for practitioner and provider acceptance of results leading to continuous quality improvement activities that yield performance improvements.

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 in order to identify provider performance opportunities and assist with population health management initiatives. Provider analytics prioritizes measures based on providers' performance to help identify where to focus clinical efforts in order to optimize pay-for-performance (P4P) payouts, which may include:

- Key performance indicators;
- Cost and utilization data;
- Emergency room cost, utilization, and trending data;
- Pharmacy comparisons of brand vs. generic; and/or
- Value-Based Contracting performance summaries.

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. This engagement helps providers identify performance insights as well as identify opportunities for improvement.

Interventions may be discussed with the practitioner to address practitioners' performance that is out of range from their peers, and such interventions may include, but are not limited to, provider education, sharing of best practices and/or documentation tools, assistance with barrier analysis, development of corrective action plans, ongoing medical record reviews, and potential termination of network status when recommended improvements are not implemented.

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. National 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 particular 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' CASQIC reviews and adopts an annual Quality Program and Quality Work Plan that aligns with the health plan's strategic vision and goals and appropriate industry standards. The Quality Department implements and supports performance/quality improvement activities as required by state or federal contract, including quality improvement projects and/or chronic care improvement projects as required by state or federal regulators, and accreditation needs. Focus studies and health care initiatives also include behavioral health care issues and/or strategies.

Chronic Care Improvement Program (CCIP) – MHS conducts a CCIP, with a focus on promoting effective management of chronic disease and improving care and health outcomes for members with chronic conditions, that meets all CMS requirements for Medicare, as applicable. Effective management of chronic disease includes slowing disease progression, preventing complications and development of comorbidities, reducing preventable emergency department utilization and inpatient stays, improving quality of life, and reducing costs for both the health plan and members. CCIP interventions are developed through an analysis of a MHS target population and include activities such as care coordination, promotion of preventive screening, disease and lifestyle management programs, education and outreach to members and providers, etc.

GREIVANCE AND APPEALS SYSTEM

MHS ensures members are able to address their problems quickly and with minimal burden and as such investigates and resolves member complaints/grievances and appeals and quality of care concerns in a timely manner. 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. MHS reports on grievance and appeal processes and outcomes as required.

All member grievances and appeals are tracked and resolved, and data is analyzed and reported to 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 if 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 other 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, Quality; and Manager, Accreditation facilitate the accreditation process with support from Centene Corporation's national accreditation team. MHS received Commendable Accreditation status for Medicaid and Accredited status for Marketplace following the 2019 survey by NCQA.

SUMMARY

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 Program Description;
- Quality Work Plan; and
- Quality Program Evaluation.

At the end of the Quality Program cycle each year (calendar year, unless otherwise specified by state contract), the Quality Department facilitates the completion of the Quality Program Evaluation. This evaluation assesses both progress in implementing the quality improvement strategy and the extent to which the strategy is in fact

promoting the development of an effective Quality Program. It includes recommended changes in program strategy or administration and commitment of resources by CASQIC.

MHS provides general information about the Quality Program to members and providers on the website or member/provider materials such as the member handbook or provider manual.