2019
Managed Health Services
Quality Improvement
Program Description

2019 QI Program Description
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I. Mission/Purpose

The mission of Managed Health Services (MHS) is to promote better health outcomes at lower costs.

MHS’ culture, systems, and processes are structured around its mission to improve the health of all enrolled members. The Quality Assessment and Performance Improvement (QAPI) 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, including those with special needs. This systematic approach to quality improvement provides a continuous cycle for assessing the quality of care and services in such areas as preventive health, acute and chronic care, population health management, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services.

MHS recognizes its legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, MHS will provide for the delivery of quality care with the primary goal of improving the health status of Plan members. Where a member’s condition is not amenable to improvement, MHS will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. The QAPI Program includes identification of members at risk of developing conditions, the implementation of appropriate interventions, and designation of adequate resources to support the interventions. Whenever possible, MHS’s QAPI Program supports processes and activities designed to achieve demonstrable and sustainable improvement in the health status of its members.

In order to fulfill its responsibility to members, the community and other key stakeholders, and regulatory/accreditation agencies, MHS’s Board of Directors has adopted the following QAPI Program Description. The program description is reviewed and approved at least annually by the Quality Improvement Committee (QIC) and Board of Directors (BOD).

II. Scope

The scope of the QAPI Program is comprehensive and addresses both the quality and safety of clinical care and quality of services provided to MHS’s members including medical, behavioral health, dental, and vision care as included in MHS’s benefits. MHS incorporates all demographic groups, lines of business (Medicaid, Marketplace, Medicare and Medicare SNP), benefit packages, care settings, and services in its quality improvement activities, including preventive care, emergency care, primary care, specialty care, acute care, short-term care, (depending upon MHS’s products), and ancillary services. MHS’s QAPI Program monitors the following:

- Acute, complex and chronic care management
- Behavioral health care
- Compliance with member confidentiality laws and regulation
- Compliance with preventive health guidelines and clinical practice guidelines
- Continuity and coordination of care
- Delegated entity oversight
- Department performance and service
- Employee and provider cultural competency
- Marketing practices
- Member enrollment and disenrollment
- Member grievance and appeals system
- Member experience
- Patient safety
- Primary care provider changes
- Pharmacy
- Primary care provider after-hours telephone accessibility
- Provider appointment availability
- Provider complaints
- Provider network adequacy and capacity
- Provider experience
Selection and retention of providers (credentialing and re-credentialing)
Medical management, including population health management
Utilization management, including over- and under-utilization

Envolve, a sister company, provides utilization review services while case management is fully integrated with physical health. Quality improvement initiatives for Behavioral Health are the responsibility of MHS.

III. Goals

MHS’ primary quality improvement goal is to improve members’ health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered. MHS develops goals using the 75th percentile of performance for HEDIS measures, unless performance is already at this level. In these instances, the 90th percentile of performance is selected. For metrics with non-HEDIS benchmarks, goals are selected from comparable Centene plans or relevant data sources.

Quality Improvement goals include but are not limited to the following:
- A high level of health status and quality of life will be experienced by Plan members.
- Network quality of care and service will meet industry-accepted standards of performance; as well as State of Indiana custom measures.
- Plan services will meet industry-accepted standards of performance consistent with
  - Generally-accepted principles of professional practice and adherence to evidence-based guidelines
  - Cultural and linguistic needs/preferences of MHS members
  - MHS Medicaid LOB also performs selected Quality Improvement Projects relevant to Indiana membership
- Fragmentation and/or duplication of services will be minimized through integration of quality improvement activities across Plan functional areas;
- Member satisfaction will meet MHS’s established performance targets;
- Preventive and clinical practice guideline compliance will meet established performance targets. This includes, but is not limited to, compliance with immunizations, prenatal care, diabetes, asthma, early detection of chronic kidney disease and EPSDT guidelines (Early Periodic Screening, Diagnosis and Treatment Program). Guidelines are selected from authoritative sources per QI policy CC.QI.08. They are reviewed by practicing physicians at the CASQIC for relevance and appropriateness. They cover all age groups and populations.
- Members Rights and Responsibilities will be protected and these rights will be communicated to members, practitioners and providers.
- Safety of our membership will be ensured.
- Compliance with all applicable regulatory requirements and accreditation standards is maintained.
- Health care disparities in clinical areas will be reduced.

Annually MHS will develop a work plan that reflects ongoing progress on QI activities throughout the year (see 2019 QI Work Plan)

IV. Objectives

To meet the goals listed above, MHS’ QAPI Program objectives include, but are not limited to, the following:

A. General

- To establish and maintain a health system that promotes continuous quality improvement
- To adopt evidence-based clinical indicators and practice guidelines as a means for identifying and addressing variations in medical practice
- To select areas of study based on demonstration of need and relevance to the population served;
- To develop or utilize standardized performance measures that are clearly defined, objective, measurable, and allow tracking over time
To utilize management information systems in data collection, integration, tracking, analysis, and reporting of data that reflects performance on standardized measures of health outcomes

To allocate personnel and resources necessary to:
- support the QAPI Program, including data analysis and reporting;
- meet the educational needs of members, providers and staff relevant to quality improvement efforts;
- To seek input and work with members, providers, and community resources to improve quality of care
- To oversee peer review procedures that address deviations in medical management and health care practices and devise action plans to improve services
- To establish a system to provide frequent, periodic quality improvement information to participating providers in order to support them in their efforts to provide high quality health care
- To recommend and institute focused quality studies in clinical and non-clinical areas, where appropriate
- To serve members with complex health needs
- Ensure that effective resources and programs are in place to address clinical priorities, via the following mechanisms:
  - Adoption and distribution of preventive health and clinical guidelines
  - Provider education
  - Member education
  - Care gap/appointment outreach calls
  - Case Management including Complex Medical and OB
  - Disease Management
  - ER diversion/medical home promotion
  - Primary-Specialty care coordination
  - Medical-Behavioral Health (BH) care coordination
  - Health promotion incentive programs
  - Grievance and appeals mechanisms

To monitor trends related to service utilization and respond to identified issues
To ensure provider network adequacy/geographic distribution via systematic monitoring
To ensure appropriate appointment and after-hours access via annual monitoring of the PMP network
To ensure the availability of culturally and linguistically appropriate services through systematic monitoring and improvement activities
To ensure that the voice of the customer helps inform QI Program direction, through Member and Provider participation in QI committees
To implement focused monitoring activities to ensure that needs of Members with Special Needs and the Medically Frail are met
To conduct and report annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and Qualified Health Plan (QHP) Enrollee Experience surveys and certified Healthcare Effectiveness Data and Information Set (HEDIS®) results for Plan members [CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ); HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)];
To comply with State and Federal standards
To participate in the Office of Medicaid Policy and Planning (OMPP) Quality Strategy Committee and relevant subcommittees
To participate in the External Quality Review Organization (EQRO) initiatives developed by the OMPP
To achieve and maintain accreditation (National Committee for Quality Assurance [NCQA] and/or other applicable accreditations) for appropriate products;
To evaluate the QI program annually and modify it as necessary to achieve program effectiveness

**B. Specific**

- Achieve ≥90th percentile HEDIS for priority measure scores; achieve ≥75th percentile for remaining HEDIS rates (NCQA Quality Compass)
- Achieve ≥75th percentile rates on CAHPS / QHP EES survey measures; reach for ≥90th percentile benchmark scores
- Achieve 100% compliance with State Access and Availability standards
- Achieve 100% compliance with Culturally & Linguistically-Appropriate Services standards
- Record <1.37 Complaints/1000 member months
- Record an all-cause 30-day Readmission rate ≤ the national average rate
V. Confidentiality

Confidential information is defined as any data or information that can directly or indirectly identify a patient or provider. The Senior Executive Quality Improvement Committee (SEQIC) and its subcommittees have the responsibility to review quality of care and resource utilization, and conduct peer review activities as appropriate. The SEQIC and related peer review committees conduct such proceedings in accordance with MHS’s bylaws and applicable federal and state statutes and regulations.

As such, the proceedings of the SEQIC, its subcommittees and/or any ad hoc peer review committees are considered “Privileged and Confidential” and are treated as such. In this regard, all correspondence, worksheets, QI documents, minutes of meetings, findings, and recommendations for the programs are considered strictly confidential and therefore not legally discoverable.

Confidential quality improvement findings are accessible only to the following individuals/groups:

- Board of Directors
- President and CEO
- Chief Medical Director/Senior Executive Quality Improvement (SEQI), Vice President of Medical Management (VPMM), QI VP/Director and QI Coordinator(s)
- Peer Review Committee
- External regulatory agencies, as mandated by applicable state/federal laws
- Plan legal executives

SEQIC correspondence and documents may be made available to another health care entity's peer review committee, and/or any regulatory body as governed by law, for the purpose of carrying out or coordinating quality improvement/peer review activities. This may include a QI/Credentialing Committee of a Plan-affiliated entity or that of a contracted medical group/IPA.

MHS has adopted the following confidentiality standards to ensure that QI proceedings remain privileged. These are described as follows:

- All peer review and QI related correspondence documents are appropriately labeled "Privileged and Confidential, Peer Review " and maintained in locked files/secure electronic files;
- Confidentiality policies and procedures comply with applicable state statutes that address protection of peer review documents and information;
- Committee members and Plan employees responsible for QI, Utilization Management, Credentialing, and Pharmacy program activities are educated about maintaining the confidentiality of peer review documents;
- The QI VP/Director and designated QI Coordinators are responsible for taking minutes and maintaining confidentiality;
- For QI studies coordinated with, or provided to outside peer review committees, references to patients are coded by identification number rather than a PHI identifier such as medical record number or ID number, with references to individual providers by provider "code" number;
- Records of review findings are maintained in secured files, which are made available only as required by law or specifically authorized in writing by MHS CEO, Chief Medical Director/ Senior Executive for Quality Improvement, Plan’s Legal Counsel, VPMM or the Board Chairman; and
- All participating providers and employees of MHS involved in peer review activities or who participate in QI/QM activities or committees are required to sign confidentiality agreements.

VI. 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 decisions regarding any case in which he or she has been professionally involved in the delivery of care. Provider reviewers may not participate in decisions on cases where the provider reviewer is the consulting provider or where the provider reviewer’s partner, associate, or relative is involved in the care of the member, or cases in which the provider or other consultant has
previously reviewed the case. When a provider 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.

VII. Cultural Competence

MHS will endeavor 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 the Indiana state contract, standards from the federal Office of Minority Health (OMH) and the National Culturally and Linguistically Appropriate Services (CLAS) standards guidelines. MHS has a CLAS committee that meets regularly to assess compliance with OMH standards. Specifically, the QAPI program will identify and address clinical areas of health disparities. MHS will assure communications are culturally sensitive, appropriate, and meet federal and state requirements. Population health management initiatives will be reviewed with a view to assuring cultural issues and social determinants of health to identified populations and sub-populations.

As part of the annual program evaluation, MHS will also review member needs from a cultural competency standpoint; MHS will analyze data for cultural, ethnic, race, and linguistic issues and address identified barriers. MHS also reviews the network on a regular basis for cultural adequacy in order to meet the needs of a diverse membership.

As needed MHS will employ tools such as practitioner and provider chart reviews to understand the differences in health care provided and why outcomes may vary, conduct member-focused interviews with culturally competent materials that focus on risks specific to race, ethnicity and language and provide information, training and tools to staff and practitioners to support culturally competent communication. MHS conducts focus group through the MAC designed to elicit information from culturally or linguistic minority members to determine how best to meet their needs.

VIII. Governance

MHS Board of Directors (BOD) oversees development, implementation, and evaluation of the QAPI Program and has the ultimate authority and accountability for oversight of the quality of care and services provided to members. MHS Board of Directors supports the QAPI Program by:

- Adopting the initial and annual QAPI Program which requires regular reporting (at least annually) to the Board, and establishes mechanisms for monitoring and evaluating quality, utilization, and risk;
- Supporting SEQIC recommendations for proposed quality studies and other QI/OM initiatives;
- Providing the resources, support and systems necessary for optimum performance of QI/OM functions;
- Designating a senior practitioner as MHS’s Senior Executive for Quality Improvement (SEQI); and
- Evaluating the QAPI Program and QI Work Plan annually to assess whether program objectives were met and recommending adjustments when necessary.

The BOD delegates the operating authority of the QAPI Program to the SEQIC. Plan senior management staff, clinical staff, and network providers, who may include but are not limited to, primary, specialty, behavioral, dental, and vision health care providers, 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 BOD.

The BOD approves the annual QI program description and QI work plan. The BOD monitors the program’s effectiveness through review and discussion of the annual program evaluation.

The BOD meets a minimum of two times per calendar year and discusses MHS QI activities as an agenda item. At least one meeting is convened at a point in time where opportunity to consider any mid-course modification of the QI work plan is feasible. The Chief Medical Director (CMD), a primary care physician, serves as the program’s designated physician and provides assistance with agenda, research, and reports to review. The CMD also presents the proposed QI program description, work plan, and evaluation to the BOD for their approval.

The BOD assigns the MHS Chief Executive Officer (CEO) the authority and responsibility to establish, maintain, and support an effective program on a continuous basis. The CEO is an ex officio member of the BOD and the
chairperson of the SEQIC.

The CEO assigns the responsibility for the QI/UM program to the CMD and Sr. Vice President of Medical Management respectively. The CMD is the Chair of the Clinical and Service Quality Improvement Committee (CASQIC), and has direct oversight of all Quality functions within the health plan. The Vice President for Quality manages Quality operations.

**IX. Program Structure**

Quality is integrated throughout MHS, and represents the strong commitment to the quality of care and services for members. To this end, MHS has established various committees, subcommittees, and ad-hoc committees to monitor and support its QAPI Program.

The Board of Directors holds ultimate authority; the Senior Executive Quality Improvement Committee (SEQIC) is the senior management lead committee reporting to the Board of Directors. The SEQIC is supported by the Credentialing, the Clinical and Services Quality Improvement Committee (CASQIC), the Utilization Management Committee (UMC), the HEDIS Executive Steering Committee (ESC) and the Delegation Oversight Committee (DOC). The CASQIC provides oversight for work of the Pharmacy and Therapeutics Committee (P&T), the Member Advisory Committee (MAC), the Member Complaints & Appeals Analysis Workgroup (MCAAW) all of which report up to CASQIC. The ESC provides oversight for the work done in the HEDIS and Stars Workgroup while the DOC provides oversight for the work done in the Subcontractor Oversight Workgroup that report up to ESC and DOC respectively. There are other ad hoc work groups that receive oversight and report to their sponsor committees. The program structure is presented below.

All committee activities are documented in MHS approved meeting minute format. Minutes are taken during the
meeting and reflect attendance and participant discussion. Minutes document all committee findings and follow-up by designating "Old" and "New Business" and are used for planning subsequent agendas and meetings. Each item for discussion includes the person responsible and a timeline for completion.

The minutes are completed, dated, and distributed to the attendees for review prior to the next meeting. Minutes are approved and signed by the Committee Chair at the subsequent committee meeting and maintained in a secure area.

**Senior Executive Quality Improvement Committee (SEQIC)**

The QIC is MHS’s senior level committee accountable directly to the Board of Directors. The purpose of the QIC 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 to members. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems; the identification of opportunities to improve member outcomes; and the education of members, providers, and staff regarding the QI/QM, Utilization Management, and Credentialing programs.

The scope of the SEQIC includes:

- Oversight of the QI/QM activities of MHS to ensure compliance with contractual requirements, federal and state statutes and regulations, and requirements of accrediting bodies such as NCQA
- Annual development of MHS QAPI Program Description and Work Plan incorporating applicable supporting department goals as indicated
- Development of quality improvement studies and activities, and reporting of findings to the BOD
- Annual review and approval or acceptance of MHS Credentialing, Pharmacy, Utilization Management, and Case Management program descriptions and work plans as developed by the appointed subcommittees to facilitate alliance with strategic vision and goals
- Evaluation of the effectiveness of each departments’ activities to include analysis and recommendations regarding identified trends, follow-up, barrier analysis, and interventions required in order to improve the quality of care and/or service to members and implement corrective actions as appropriate, and act as a communication channel to the Board of Directors
- Prioritization of quality improvement efforts, facilitation of functional area collaboration, and assurance of appropriate resources to carry out QI/QM activities
- Review and establishment of benchmarks or performance goals for each quality improvement initiative and service indicator
- Review and approval of due diligence information for any potential delegated entity and the annual oversight of audit outcomes for those entities already delegated
- Adoption of preventive health and clinical practice guidelines to promote appropriate and standardized quality of care and monitoring of clinical quality indicators (such as HEDIS, adverse events, sentinel events, peer review outcomes, quality of care tracking, etc.) to identify deviation from standards of medical management; and supporting the formulation of corrective actions, as appropriate
- Ongoing evaluation of the appropriateness and effectiveness of practitioner profiling and pay-for-performance initiatives and support in designing and modifying the program as warranted

The SEQIC is composed of the CEO (Chair), the Chief Medical Director (Co-Chair) and Executive Staff (Chief Operating Officer, Sr. Vice President Medical Management, Vice President Finance, Vice President Contracting and Network Development, Director of Human Resources, Vice President Customer Experience, Vice President Quality Improvement and Vice President Compliance). The SEQIC approves policy and procedures and ensures the coordination of the QI program. The SEQIC establishes standards and criteria for care and service delivery; it also approves the QI and UM programs, work plans, and annual program evaluations, and monitors progress. The CASQIC, the Credentialing Committee (CC), the UMC, the Pharmacy & Therapeutics Committee, the ESC and the Delegation Oversight Committee (DOC) report to the SEQIC. Reports include committee minutes and verbal reports from the VPMA and corporate administrators with knowledge of practices and opportunities to improve. Invited guests may also provide reports or input.

**Meetings**

The SEQIC meets at least quarterly or more frequently as needed. A quorum for action items is no less than
three voting members, excluding the committee chairperson, 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 are not available as part of “discoverability” or other proceedings associated with litigation.

Clinical and Service Quality Improvement Committee (CASQIC)

The CASQIC is responsible for overseeing clinical and service activities that members encounter within the managed care system.

The CASQIC is composed of practitioners representing a variety of specialties and medical groups reflective of the MHS network, subcontractor representatives, community partners, consumer advocates, members, and MHS staff. The Behavioral Health Medical Director is also a member of the CASQIC and participates and advises the committee about behavioral health matters. MHS seeks to maintain a voting majority of non-plan employees on the committee. Plan associates include representatives from Network, Compliance, Operations, Medical Management and Member Services. Committee composition ensures practitioner participation in the QI program through the committee's planning, design, implementation and review functions.

The functions of the CASQIC include:
- Review information (including EPSDT, HEDIS and CAHPS audit results) for compliance with standards and criteria for delivery of care and services to the member population
- Analyze and evaluate the results of QI activities, including by conducting quantitative and causal analysis of data/trends
- Identify and prioritize needed actions
- Investigate breaches in the standard of care and recommend appropriate actions to ensure the safety of our membership
- Promote and recommend improvement in care and services
- Ensure follow-up as appropriate, and evaluate the effectiveness of improvement activities
- Review and recommend approval of Preventive Health & Clinical Practice guidelines
- Review and recommend approval of policies or policy decisions for effective operation of the QI program and achievement of QI program objectives
- Review and recommend approval of Quality Improvement Activity (QIA) reports
- Act as liaison to the medical and behavioral health providers for dissemination of QI information
- Review and discuss operational issues that have resulted in poor service to any of our customers
- Provide clinical and service related quality data as performance feedback to network providers and internal MHS departments
- Oversees analysis and evaluation of the QI program
- Review and recommend for approval the annual QI program description, annual work plan, and evaluation in order to formulate improvements to the system
- To review provider satisfaction surveys and recommend actions to address identified issues

Practitioner members of this committee may also serve as peer reviewers for clinical issues involving sentinel events, adverse outcomes, and member complaints/concerns, as appropriate.

Meetings
The CMD is Chair, with the MHS Medical Directors, participating practitioners, and community representatives. A majority of the voting membership is comprised of community physicians. The 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 committee Chair; members may be present by teleconference and vote via fax, e-mail, or in person. Decision-making is by vote or consensus. Representative staff are non-voting members of the committee, including the Sr. Director of Quality Improvement, Sr. Manager of QI and representatives from Provider Relations, Medical Management, Compliance and Member Services. Meeting minutes are taken and presented to the SEQIC.

Utilization Management Committee (UMC)

The UMC’s primary purpose is to provide oversight and operating authority of the utilization management program and associated activities and to ensure the efficient integration of utilization management (UM) and medical
management (MM) activities into all functional areas and departments. The MHS Chief Medical Officer (CMO) chairs this committee which meets a minimum of six times annually. Additional voting members include a majority participating physicians directly affected by the actions of the committee, a Behavioral Health Medical Director, CMD, MHS Medical Directors and the Senior Vice President of Medical Management. 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.

The scope of the UMC includes:
- Analysis of UM data
- Identification of trends
- Address identified issues
- Monitor appropriateness of care, over and under-utilization of services
- Review and approval of medical necessity criteria and departmental policies and procedures.
- Analysis of data to detect and correct patterns of potential or actual inappropriate under or over utilization that 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)

Credentialing Committee (CC)

The CC is the vehicle through which credentialing and re-credentialing activities are communicated to the SEQIC. The CC is responsible for the review and assessment of provider applications to participate with the Plan and establishes the qualifications of each participating provider through training, experience, and performance consistent with the standards established by the provider credentialing policies to participate as an MHS provider. A network participating physician chairs this committee which meets a minimum of six times annually. At least six providers consisting of a broad representative group of participating practitioners are voting members in addition to the Provider Network Director, the Compliance Director and the QI Manager (non-voting). Minutes are taken and presented to the SEQIC.

The functions of the CC include:
- Review of initial credentialing files with a significant deviation from the standard of practice
- Review of re-credential files when there is evidence of malpractice, Medicare/Medicaid and/or state sanctions, restrictions on licensure and/or limitations on scope of practice
- Review of member complaints regarding quality of service issues when making re-credentialing decisions.
- Make recommendations to the SEQIC to approve or deny an applicant’s participation.
- Review and approval of the annual Program Description, departmental policies and procedures.

Member Complaint and Appeals Analysis Workgroup (MCAAW)

The Member Complaint and Appeals Analysis Workgroup (MCAAW) is an internal staff committee responsible for the multi-disciplinary review and trending of member complaints, grievances, and appeals. The review and follow-up of Behavioral Health utilization management complaints is delegated to Envolve People, a wholly owned Centene subsidiary behavioral healthcare affiliate organization.

The MCAAW meets quarterly with additional meetings as deemed necessary. Membership includes Plan staff representative of areas directly related to complaints or appeals. To conduct an official meeting a quorum, 50% or more of appointed members, must be present. Minutes taken are presented to the CASQIC for consideration when making recommendations to enhance member and provider satisfaction.

Functions include
- Review aggregate member complaint and appeals data to ensure recognition of adverse trends
- Conduct quantitative and qualitative analysis including regional variances when applicable.
- Identify system improvement needs
- Recommend improvement strategies that are based on industry standards and best practices
Follow-up after PDSA cycles
Conduct ongoing monitoring with tracking/trending of findings

**Member (Consumer) Advisory Council (MAC)**

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

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

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

**HEDIS Executive Committee (HESC)**

The HESC Committee is a cross-departmental committee. It directs activities designed to raise CAHPS/QHP and HEDIS scores for all MHS products. The global objectives are to meet state P4O objectives and capture withholds, as well as meet Corporate goals, strive for and maintain “Best in State” rating, fulfill OMPP contracting requirements and achieve the benchmark 90<sup>th</sup> percentile NCQA Quality Compass for CAHPS and HEDIS scores for priority measures. The ESC provides oversight for the work done in the HEDIS-Stars Workgroup that reports to the ESC. The VP of Quality Improvement chairs the ESC that meets at least quarterly. Meeting minutes are taken and presented to SEQIC.

**Pharmacy and Therapeutics Committee (P&T)**

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

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

The functions of the P&T Committee include:
- Ensure clinical decisions are based on the strength of scientific evidence and quality standards of practice
- Formulary management through the review and potential revision of drugs listed for coverage, controls or limitations.
- Review and recommend drugs formulary management procedures such as prior authorizations, step therapies, age restrictions, quantity limits, therapeutic interchange and generic substitution.
- Ensure regulatory compliance
- Monitor drug utilization and medication safety
Review and approval of policies and procedures governing provision of drug coverage under the Medicaid and Medicare Preferred Drug List (PDL)
Review and approval of annual Pharmacy Program Description and all associated policies and procedures.

Delegation Oversight Committee (DOC)

MHS has established the DOC to provide an organized and systematic approach to assure oversight of delegated functions, including quality improvement. As part of the 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; NurseWise Nurse Advice Line), Envolve Benefit Options (dental and vision), and Envolve Pharmacy. The Vendor Oversight Compliance Manager leads the DOC with members representing departments that delegate any function to another entity or have relationships with vendors. Minutes taken are presented to the SEQIC.

Oversight functions reported to the DOC Committee 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

Creation of integrated work groups of both MHS and vendor staff to conduct collaborative discussions and activities regarding vendor reporting and quality improvement.

Culturally & Linguistically Appropriate Services Committee (CLAS)

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

Joint Oversight Committee

These committee meetings are held at least quarterly to monitor vendor performance with contractual requirements, including compliance with NCQA standards as appropriate. Meeting attendees include subcontracted vendor staff, the MHS Business Owner and staff representatives from Compliance, QI, Medical Management, Medical Affairs and Operations as appropriate.

Vendors include:
- Envolve People Care
  - NurseWise Nurse Advice Line
  - Nurtur Disease Management and Lifestyle Management
- Envolve Benefit Options
  - Envolve Vision
  - Envolve Dental
- Envolve Pharmacy Solutions
- LCP Transportation
- National Imaging Associates
- Medline DME

Meetings are facilitated by the MHS Business Owner with minutes taken and reported to the DOC. Discussion
should include:
- All products and delegated activities of 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, CC.COMP.21.02, and CC.COMP.43.02

**HEDIS and Stars Workgroup**

The Sr. Director of QI chairs the meetings with cross-organizational members that include directors and / or managers or staff of departments that impact the performance rates of HEDIS and Star measures. The minutes taken are presented to the ESC.

The objectives of this workgroup include identification and implementation of improvement initiatives for all lines of business in the areas of
- CAHPS, QHP and HOS administration, oversight and analysis
- Clinical and preventive health initiatives including HEDIS measure performance for all product lines

The workgroup uses QI methodologies to systematically identify opportunities for improvement in three primary areas:
- Data and associated processes
- Members via communication, technology, education and incentives
- Provider network P4P program assuring members receive the right care at the right time

**Other MHS Committees/Work Groups Associated with the QI Program**

MHS utilizes interdepartmental work groups, which may include representatives of affiliate partners to conduct root cause/barrier analysis and suggest improvement strategies during the QIA development process.

MHS also convenes ad hoc issue-focused practitioner advisory groups to gain the practitioner perspective on improvement strategies, pay-for-performance issues and any relevant concerns that may arise.

Communication of clinical QI activities and results to all levels of staff occur through routine employee communication processes that include manager’s meetings, departmental meetings and all staff meetings. In addition, communication of a summary of clinical and service quality improvement and utilization review activities to members and practitioners occurs at least annually via newsletter articles and web postings.

**Collaborative Programs**

MHS participates in the Indiana Perinatal Quality Improvement Committee designed to improve neonatal outcomes such as premature births and neonatal abstinence syndrome and to reduce infant mortality. The results of these collaborations are communicated back to MHSA Quality workgroups and the CASQIC for review and analysis.

MHS and Envolve People (Behavioral Health), Nutur (Disease Management) and US Script (Pharmacy Services) collaborate on quality improvement activities related to enhancing and ensuring continuity and coordination of care. MHS and each of these entities review and analyze quality data and discuss any improvement needs and plans at joint oversight committee conferences quarterly. The entities additionally provide quarterly reports to the CASQIC where additional analysis and planning may occur.

**X. QI Department Staffing**

Staffing for the QI Department is determined by Plan membership and State contract requirements and is presented below.
The staffing plan includes the following positions.

**Vice President of Quality Improvement**

The VP of Quality Improvement is a registered nurse or other qualified professional with experience in health care, data analysis, barrier analysis, and project management as it relates to improving the clinical quality of care and quality of service provided to Plan members. The QI VP reports to Chief Operating Officer and is responsible for directing the activities of MHS’ QI staff and monitoring and auditing MHS’ health care delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality, and clinical quality. The QI VP assists MHS’ senior executive staff, both clinical and non-clinical, in overseeing the activities of MHS operations to meet MHS’ goal of providing health care services that improve the health status and health outcomes of its members. Additionally, the QI VP coordinates MHS’ QIC proceedings in conjunction with the Chief Medical Director, supports corporate initiatives through participation on committees and projects as requested, reviews statistical analysis of clinical, service and utilization data, and recommends performance improvement initiatives while incorporating best practices as applicable.

**Senior Director of Quality Improvement**

The Sr. Director of QI is a registered nurse or other qualified professional with experience in data analysis, barrier analysis and project management as it relates to clinical quality of care, safety of care and quality of service provided to MHS members. The Sr. Director of QI reports to the VP of QI and is responsible for directing the activities of MHS’ QI staff and coordinating the work of the HEDIS and Stars Workgroup. Additionally, the Sr. Director of QI coordinates the activities of the HEDIS reporting cycle and the Risk Adjustment team, supports corporate initiatives through participation in committees and projects as requested, reviews statistical analysis of clinical and service data and recommends performance improvement initiatives.

**Senior Manager of Quality Improvement**
The Sr. Manager of QI is a registered nurse or other qualified professional with experience in data analysis, barrier analysis and project management and the ability to oversee the work of the Quality of Care team as well as the State QIPs. Additionally, the Sr. Manager of QI participates in site visits from the State and other OMPP initiatives including ECRO.

**HEDIS Project Manager**

The HEDIS Project Manager is a highly trained individual with significant experience in project management. This Project Manager is responsible for coordinating the work of the HEDIS workgroups and the activities of the HEDIS reporting cycle.

**NCQA Project Manager**

This Project Manager is responsible for ensuring compliance with NCQA accreditation requirements, conducting routine readiness assessments, evaluating policies and procedures, and reviewing processes and records. The Project Manager develops, implements, and leads a process for ensuring that MHS achieves and maintains NCQA accreditation. The Project Manager establishes and implements objectives, policies and strategies to maintain a continual state of accreditation readiness to achieve successful accreditation status for the Plan and supports document preparation and submission of documents for the Plan’s accreditation survey. Additionally, the Project manager supports the development of Plan performance improvement activities and may coordinate delegation vendor oversight.

**Quality of Care (QOC) Nurses**

The QOC nurses perform medical chart review for all members and/or providers that are referred to them with concerns about quality of care issues in accordance with the policy. Additionally, they document the findings of these reviews and present a summary of the necessary cases at the CASQIC for further review and action by the CASQIC voting members.

**Quality Improvement (QI) Field Nurses**

The QI Field nurses primarily collaborate with providers and practices they support to educate them about the specific HEDIS measures that apply to their members, identify gaps in service and support the providers closing these gaps.

**Quality Improvement Coordinator Nurse**

Quality Improvement (QI) Coordinators are highly trained clinical and non-clinical staff with significant experience in a health care setting; experience with data analysis and/or project management. At least one of the Plan’s QI Coordinators is a registered nurse. Their scope of work may include medical record audits, data collection for various quality improvement studies and activities, data analysis and implementation of improvement activities, and complaint response with follow up review of risk management and sentinel/adverse event issues. A QI Coordinator may specialize in one area of the quality process or may be cross-trained across several areas. The QI Coordinator collaborates with other departments as needed to implement corrective action or improvement initiatives as identified through Plan’s quality improvement activities and quality of care reviews. They also support the activities of the HEDIS reporting cycle.

**Project Entry Specialist and Data Entry Specialist**

These team members primarily support the activities of the Risk Adjustment project and also assist with the HEDIS reporting cycle.

**XI. Program Resources**
Most MHS departments actively participate in the QI program. The roles and responsibilities of each department are outlined below.

**Behavioral Healthcare:**

The MHS Staff Medical Director for Behavioral health, a board certified psychiatrist, is the designated practitioner involved in the behavioral health aspects of the MHS QI program and a member of CASQIC, DOC and specialty advisory groups as applicable.

In addition this Medical Director is a member of the UM Committee and Credentialing Committee. He advises the committee and may be asked to review data and provide recommendations regarding: use of psychopharmacological medications, behavioral health disorders and behavioral health access and appointment availability.

MHS medical management staff collaborate to support the integration of care between medical and behavioral health providers by the following:

- Quarterly: MHS sends a postcard to providers directing them to the MHS Provider Portal where they can access their members’ healthcare services and medications, including behavioral health services and medications.
- Coordination of care between BH and Medical practitioners/settings.
- MHS Behavioral Health Case Management and Envolve Behavioral Health Utilization Management staff meet weekly through inpatient rounds to assess and coordinate care for members with co-existing conditions.
- Medical Management and MHS Medical Affairs staff meet semi-weekly through medical and inpatient rounds to assess and coordinate care for members with co-existing conditions.
- MHS distribution of a depression survey to all enrolled pregnant members with responses coordinated with behavioral health case management
- Behavioral Health and Medical case management teams review and refer members to behavioral health providers when appropriate.
- Nurtur, the disease management partner coordinates medical and behavioral health co-existing conditions with MHS medical and behavioral health case management and care coordination staff.
- Upon discharge from a psychiatric inpatient facility, the behavioral health case manager faxes a discharge summary to the member’s MHS PMP
- MHS encourages medical and behavioral health providers to utilize a care coordination fax form listing the members’ services and medications

MHS monitors the outcome of efforts to improve behavioral health for its members through review of appropriate HEDIS/QRs measures such as:

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

**Medical Management:**

The Medical Management department conducts utilization and case management activities. Staff refer potential quality issues and adverse events to the QI department for investigation. Medical Management staff also implement programs to improve continuity and coordination of medical care, promote appropriate resource use and foster provider satisfaction with the health plan.

- Case Management (CM): The CM department serves as the clinical management support department for all MHS members. The CM staff perform assessments, provide care coordination and assist with gap closure based on member acuity levels.
- Utilization management (UM): The UM department provides ongoing medical necessity review of all MHS members based on State, CMS and NCQA timeframes, with the exception of behavioral health UM. This function is delegated to Envolve People Care, a wholly owned subsidiary of Centene with regular reports provided to the Sr. VP of Medical Management.

**Network Management**
The VP of Network Development and Contracting, Directors of Provider Relations and their team of QI auditors and Provider Relations Specialists orient new providers, disseminate quality information to the provider network, identify barriers and gaps in care and services, and educate providers on preventive and clinical standards to facilitate compliance through proven interventions. Network Management department conducts geographical studies to monitor the accessibility and availability of contracted practitioners on an annual basis. This department also performs an annual review and analysis of the network’s cultural preferences to ensure an adequate number of participating providers meet the cultural needs of the MHS population.

**Member Services**

Representatives conduct telephonic preventive health outreach and review care gaps at member call-in. Response to after call surveys are analyzed, trends are identified and improvement plans are implemented.

**Credentialing and Provider Data Management**

This department is responsible for the ongoing assessment and evaluation of network providers, practitioners, and facility credentials to ensure they continuously meet all state, federal and NCQA regulatory requirements. They perform initial credentialing and re-credentialing activities including facilities assessments and reassessments.

**Pharmacy**

The Sr. Director of Pharmacy oversees quality and safety of medication management including development of the Preferred Drug List (PDL) and monitoring of poly pharmacy and Class I and II drug recalls. In addition, this department coordinates with Quality to facilitate closure of HEDIS gaps in care.

**Customer Experience**

The Customer Experience team sponsors community health promotion events for members, creates and coordinates health education communication materials and presentations for members and practitioners. The MAC meetings provide members with opportunities to communicate their experiences with various aspects of the plan. Their comments and concerns, both positive and constructive, are the basis for improvement opportunities.

**Medical Directors**

Medical Directors are Indiana licensed physicians. They conduct internal medical necessity reviews and actively participate in the UMC and CASQIC which include peer review activities.

**Compliance Department**

This department oversees the MHS-Office of Medicaid Policy and Planning (OMPP) quality collaboration activities and provides delegation oversight. The Director of Compliance chairs CLAS.

**Grievance and Appeals**

The Manager of this department oversees the appeals functions and reports to the MCAAW and the CASQIC internally and to OMPP as required.

**Management Information Systems**

The management information systems supporting the QAPI Program allow key personnel the necessary access and ability to manage the data required to support the measurement aspects of quality improvement activities

- **Centelligence™** – A comprehensive family of integrated decision support and health care informatics solutions that includes Centelligence™ Insight, Centelligence™ Foresight and the Centelligence™ Enterprise Data Warehouse (EDW). The EDW is the central hub for service information that allows collection, integration, and reporting of clinical claim/encounter data (medical, behavioral health, laboratory, pharmacy, and vision), financial information, medical management information (referrals, authorizations, disease
management), member information (current and historical eligibility and eligibility group, demographics, primary care provider assignment, member outreach), and provider information (participation status, specialty, demographics) as required by the QAPI Program.

- **AMISYS Advance** - Claims processing engine with extensive capabilities for administration of multiple provider payment strategies. AMISYS Advance receives appropriate enrollee and provider data systematically from Member Relations Manager and Provider Relations Manager systems, receives service authorization information in near real time from TruCare, and is integrated with encounter production and submission software.

- **TruCare** - Enrollee-centric health management platform for collaborative care coordination, and case, behavioral health, disease, and utilization management. Integrated with Centelligence™ for access to supporting clinical data, TruCare allows medical management staff to capture utilization, care and population-based disease management data, proactively identify, stratify, and monitor high-risk enrollees, consistently determine appropriate levels of care through integration with InterQual criteria, and capture the impact of Plan programs and interventions. TruCare 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.

- **Quality Spectrum Insight - XL (QSI-XL) and INDICES** - an Inovalon software system used to monitor, profile, and report on the treatment of specific episodes, care quality, and care delivery patterns. QSI-XL produces NCQA-certified HEDIS measures; it is an NCQA-certified software; its primary use is for the purpose of building and tabulating HEDIS performance measures. QSI-XL enables the Plan to integrate claims and member, provider, and supplemental data into a single repository, by applying a series of clinical rules and algorithms that automatically convert raw data into statistically meaningful information. Additionally, the Inovalon products provide the Plan with an integrated clinical and financial view of care delivery, which enables the Plan to identify cost drivers, help guide best practices, and to manage variances in its efforts to improve performance. QSI-XL and INDICES are updated at least monthly by using an interface that extracts claims, member, provider and financial data. Data are mapped into QSI-XL and summarized. Plan staff is given access to view standard data summaries and drill down into the data or request ad-hoc queries.

**Other sources of information include but are not limited to**
- Claims and encounter data
- Member Enrollment data, including age, gender, language, race and ethnic diversity
- Authorization data
- Inter-rater Reliability testing of clinical staff through Milliman Criteria
- Member complaints and appeals information
- Medical record review data
- Pharmacy data
- Health information exchange data (Indiana Health Info. Exchange; Michiana Health Info. Exchange)
- P4P quarterly scorecards
- Member incentive data
- HEDIS/QRS and CAHPS/QHP data
- Satisfaction with CM surveys
- Effectiveness of CM via SF-12 surveys, All-Cause readmission rates and NICU admissions
- Behavioral health data
- Financial indicators
- Data from delegates and vendors
- Web site utilization data
- Translation services through language line utilization
- GeoAccess data: geographic distribution and practitioner-to-member ratios
- Practitioner satisfaction survey
- Call center average speed of answer and abandonment rate

The Plan obtains data and analytical support through the Information and Management Systems Department, Corporate QI, and Health Economics and other support resources as deemed necessary, which may include corporate and health plan resources. MHS also participates with the Indiana Health Information Exchange (IHIE) and the Michiana Health Information Network (MHIN) which are sources of member specific data such as claims
and services.

XII. Quality Partnerships

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

Healthcare Providers, Practitioners, Facilities, and Contractors

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

Member Involvement

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

Delegated Activity Providers

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

Office of Medicaid Policy and Planning (OMPP)

MHS’ QI program is designed for compliance with all applicable OMPP standards. MHS staff participate in the OMPP Quality Strategy Committee and subcommittees that currently include Neonatal and Health Services Utilization. MHS participates in External Quality Review directed by OMPP consultants. MHS submits its Quality Improvement Program Description and Work Plan to OMPP annually. Progress reports are provided quarterly. MHS collaborates with OMPP by providing information to complete the State’s annual Quality Strategy Plan.

Centene Quality Management Group

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

XIII. Documentation Cycle

The QAPI 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 QI instruments demonstrate Plan’s continuous quality improvement cycle using a pre-determined documentation flow. They are:

- QAPI Program Description
- QI Work Plan
- QAPI Program Evaluation

The QAPI 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. The Program Description and Work Plan include an assessment of quality and appropriateness of care provided to members including those with special needs, completing performance improvement projects and quality improvement projects. The QAPI Program
Description is reviewed and approved by the SEQIC and Board of Directors on an annual basis. Changes or amendments are noted in the “Revision Log”. MHS submits any substantial changes to its QAPI Program Description to the SEQIC and the State agency for review and approval if required by state contract, as applicable.

To implement the comprehensive scope of the QAPI Program, the QI **Work Plan** clearly defines the activities to be completed by each department and all supporting committees throughout the measurement year, based on the QAPI Program Evaluation of the previous year. The Work Plan is written annually after completing the Program Evaluation for the previous year, and includes all recommendations for improvements from the annual Program Evaluation. The Work Plan reflects the ongoing progress of the QI/QM activities, including:

- Yearly planned QI/QM activities and objectives for improving quality of clinical care, safety of clinical care, quality of services and member experience;
- Timeframe for each activity’s completion;
- Staff members responsible for each activity;
- Monitoring of previously identified issues; and
- Evaluation of QI Program.

The Work Plan is formally approved and accepted by the SEQIC and the BOD. The Work Plan status reports are reviewed by the SEQIC and the BOD on an annual basis and at regular intervals during the year, quarterly or as necessary. The Work Plan is a fluid document; and designated QI/QM staff make quarterly updates to document progress of the QAPI Program.

The **QAPI Program Evaluation** includes a summary of all QI/QM activities, the impact the program has had on member care, an analysis of the achievement of stated goals and objectives, and the need for program revisions and modifications. The Program Evaluation outlines the completed and ongoing activities of the previous year for all departments within the Plan, including activities regarding provider services, member services, utilization management, care management, chronic care management, disease management, and safety of clinical care. Program Evaluation findings are incorporated in the development of the annual QAPI Program Description and QI Work Plan for the subsequent year. The Senior Executive for QI and the VP QI are responsible for coordinating the evaluation process and a written description of the evaluation and work plan is provided to the SEQIC and Board of Directors for approval annually.

The annual QAPI Program Evaluation identifies outcomes and includes evaluation of the following:

- Analysis and evaluation of the overall effectiveness of the QAPI Program, including progress toward influencing network-wide safe clinical practices;
- A description of completed and ongoing QI/QM activities that address quality and safety of clinical care and quality of service;
- Trending of measures collected over time to assess performance in quality of clinical care and quality of service;
- Interventions implemented to address the issues chosen for performance improvement projects and focused studies;
- Measurement of outcomes;
- Measurement of the effectiveness of interventions;
- An analysis of whether there have been demonstrated improvements in the quality of clinical care and/or quality of services;
- Identification of limitations and barriers to achieving program goals;
- Recommendations for the upcoming year’s QI Work Plan;
- An evaluation of the scope and content of the QAPI Program Description to ensure it covers all types of services in all settings and reflects demographic and health characteristics of Plan’s member population;
- An evaluation of the adequacy of resources and training related to the QAPI Program; and
- The communication of necessary information to other committees when problems or opportunities to improve patient care involved more than one committee’s intervention.

The written description of the evaluation ad plan is provided to the BOD for approval annually.
XIV. Clinical Performance Measures

As reported by NCQA, HEDIS is one of the most widely used sets of health care performance measures in the United States. HEDIS includes measures across 5 domains of care including: Effectiveness of Care, Access and Availability, Satisfaction with the Experience of Care, Use of Services, Cost of Care, Health Plan Descriptive Information, Health Plan Stability, and Informed Health Care Choices.

HEDIS rates and state performance metrics are used by the Plan as one of the primary sources to monitor, assess, and promote patient safety and quality of care. HEDIS is a collaborative process between the Plan, Corporate QI, and several external vendors. Ultimate ownership and accountability of the HEDIS project and rates and state performance metrics are the responsibility of the Plan. The Plan reports and monitors population appropriate metrics as defined by NCQA and/or state and federal contracts.

The Plan calculates and analyzes HEDIS rates at least annually utilizing Inovalon’s NCQA-certified QSI software. HEDIS rates, analysis, and progress of the work plan are reported to the QIC and appropriate subcommittees at least annually. HEDIS rates are audited by an NCQA-certified auditor and submitted to NCQA, the Centers for Medicare and Medicaid Services (CMS), and the State as required by state and federal contracts. In order to facilitate External Quality Rev iew Organization (EQRO) analytical review to assess the quality of care and service provided to members, and to identify opportunities for improvement, the Plan supplies claims and encounter data to the appropriate EQRO and works collaboratively with the state agency and the EQRO to assess and implement interventions for improvement.

XV. Cultural Competence: Serving a Diverse Membership

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

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

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

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

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

**XVI. Promoting Safety and Quality of Care**

The QAPI 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 and improve the quality and appropriateness of care and service delivery furnished to all enrollees including those with special health care needs, as defined by the State. MHS accomplishes this through peer review, performance improvement projects (PIP), medical / case record audits, performance measures, surveys and related activities.

**Patient Safety**

Patient safety is a key focus of MHS’ QAPI Program. Monitoring and promoting patient safety is integrated throughout many activities across MHS, including through identification of potential and/or actual quality of care events. A potential quality of care 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 signals a potential sentinel event, up to and including death of a member. MHS employees (including medical management staff, member services staff, provider services staff, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, Medical Directors, or the Board of Directors may inform the QI Department of potential quality of care issues. Potential quality of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action, up to and including review by the Peer Review Committee as indicated. Potential quality of care issues received in the QI Department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

MHS 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 significant quality of care, MHS monitors and tracks these occurrences for trends in type, location, etc., to monitor patient safety and investigates further and/or requests a corrective action plan any time a quality of care issue is definitively identified.

The QAPI Program also supports patient safety initiatives in the education of practitioners, providers, and members about safe practice protocols and procedures. These initiatives include utilizing provider and member newsletter articles and mailings to communicate information regarding patient safety. MHS may incorporate the review of practitioner and provider initiatives to improve member safety.

**Access and Availability**

MHS’ SEQIC provides oversight to the provider network in order to ensure adequate numbers and geographic distribution of PCPs, specialists, and behavioral health practitioners, while taking into consideration the special and cultural needs of its members.

Practitioner availability is analyzed at least annually by the Network/Contracting or Provider Relations Department. Results are reviewed and recommendations are made to the QIC to address any deficiencies in the number and distribution of primary care, specialty, and behavioral health practitioners. Availability of hospitals, ancillary, and other provider types is also assessed per applicable state or federal contract requirements. The SEQIC sets standards for the number and geographic distribution of the above listed providers in accordance with state or federal requirements, and consider clinical safety and if the standards are realistic for the applicable service area.

MHS’ QI Department analyzes practitioner appointment accessibility (primary, specialty, and behavioral health care practitioners) and Plan’s Member Services telephone accessibility at least annually. Results are reviewed by the QIC as part of the annual QI Program Evaluation to ensure compliance with contractual, regulatory, and accreditation requirements and to maintain appropriate appointment access and availability.
Member and Provider Experience

MHS supports continuous ongoing measurement of clinical and non-clinical effectiveness and member and provider experience by monitoring member and provider complaints and appeals, member and provider satisfaction surveys, and member and provider call center performance. MHS collects and analyzes data at least annually to measure its performance against established benchmarks or standards and identifies and prioritizes 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 solicits feedback from members, medical consenters, and caregivers to assess satisfaction using a range of approaches, such as the CAHPS and QHP member satisfaction surveys, monitoring member complaints, and direct feedback from the Member Advisory Committee. The QI Department is responsible for coordinating the CAHPS and QHP surveys, aggregating and analyzing the findings and reporting the results. Survey results are reviewed by the SEQIC, with specific recommendations for performance improvement interventions or actions. The Member Advisory Committee or other member focus group may also review survey results.

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. The Provider Communications/Network Development departments are responsible for coordinating the provider satisfaction survey, aggregating and analyzing the findings, and reporting the results to appropriate committees. Survey results are reviewed by the SEQIC, with specific recommendations for performance improvement interventions or actions.

Member Grievances and Provider Complaints

The Grievance and Appeals department collaborates with QI to investigate and resolve member quality of care concerns/grievances. Member grievances related to quality of care and service are tracked, classified according to severity, reviewed by MHS Medical Directors, categorized and analyzed and reported on a routine basis to the MCAAW.

All member grievances are tracked and resolution is facilitated by the Grievance and Appeal Manager. Data are also reported to the SEQIC on a regular basis to identify trends and to recommend performance improvement activities as appropriate.

All provider complaints are tracked and resolution is facilitated by the Provider Services Department. Data are reported to and analyzed by the QIC on a regular basis to identify trends and to recommend performance improvement activities as appropriate. Provider complaint reports are submitted to the QIC, along with recommendations for quality improvement activities based on results.

Practice Guidelines

Preventive health and clinical practice guidelines (CPGs) assist practitioners, providers, members, medical consenters, and caregivers in making decisions regarding health care in specific clinical situations. Guidelines are adopted in consultation with network practitioners/providers (including behavioral health as indicated) and based on the health needs and opportunities for improvement identified as part of the QAPI Program, valid and reliable clinical evidence or a consensus of health care professionals in the particular field, the needs of the members and in accordance with Policy CC.CPC.03. These include preventive acute conditions, chronic conditions, behavioral health conditions, perinatal care, care for children and care for adults. Clinical and preventive health guidelines are updated upon significant new scientific evidence or change in national standards. Guidelines are distributed to providers via the Provider Manual, website, and/or provider newsletters. Chronic care guidelines are foundational for Case and Care Management programs.

Practitioner adherence to MHS’ adopted preventive and clinical practice guidelines may be encouraged in the following ways: new provider orientations include the practice guidelines section of the Provider Manual with discussion of Plan expectations; measures of compliance are shared in provider newsletter articles available on the provider web site; targeted mail outs that include guidelines relevant to specific provider types underscore the
importance of compliance; and Plan’s Provider Profiling program, as discussed later in this document, also work to promote compliance with practice guidelines.

MHS uses applicable HEDIS measures to monitor practitioner compliance with adopted guidelines. If performance measurement rates fall below MHS/state/accreditation goals, MHS implements interventions for improvement as applicable. Monitoring outcomes and analysis is presented to SEQIC at least annually.

**Continuity and Coordination of Care**

This is assessed through several different activities. Data from each activity are aggregated, reported, and reviewed annually. MHS also has in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees as applicable. The following are examples of MHS activities that monitor continuity and coordination of care:

**Medical Care**
- Surveying PCPs to assess their satisfaction with feedback from referred providers, including medical/surgical specialists, and organizational providers.
- Conducting PCP office record review to assess the adequacy of consultant reports, discharge summaries, and home health reports from referred providers.
- Assessing the effectiveness of discharge planning via member survey and medical record review.
- Assessing, through medical record review, the quality of the information exchange between medical providers, including the protection of privacy.
- Reviewing claims data to determine utilization patterns for specialty care referrals.
- Assessment of care between care settings for LTSS members and a comparison of services received with those set forth in the member’s treatment plan.

**Between Medical and Behavioral Health Care**
- Assessing, through medical record review, the quality of the information exchange between medical and behavioral health providers.
- Utilizing pharmaceutical reports to assess the appropriateness of psychopharmacological medications prescribed by primary care providers.
- Reviewing primary care providers’ guidelines for assessment for behavioral health disorders in at-risk individuals (i.e., eating disorders in adolescent girls or depression in the elderly) and referral to behavioral health providers.
- Surveying PCPs to assess their satisfaction with feedback from referred behavioral health providers.
- Reviewing claims data to determine utilization patterns for behavioral health referrals.

**Medical Record Documentation Standards**

As required by state contract, MHS monitors its practitioners for maintenance of medical records in a current, detailed, and organized manner which permits effective and confidential patient care and quality review. The minimum standards for practitioner medical record keeping practices, which include medical record content, medical record organization, ease of retrieving medical records, and maintaining confidentiality of patient information, are outlined in MHS Provider Manual. Additionally, MHS may conduct medical record reviews for purposes including, but not limited to, utilization review, quality management, medical claim review, or member complaint/appeal investigation. Providers must meet 80% of the requirements for medical record keeping; elements scoring below 80% are considered deficient and in need of improvement. MHS works with providers who score less than 80% to develop an action plan for improvement. Medical record review results are filed in the QI/QM Department and shared with the Credentialing Department for consideration at the time of re-credentialing.

**Monitoring Utilization Patterns**

To ensure appropriate care and service to members, MHS’ Medical Management Committee performs at least an annual assessment of utilization data to identify potential under- and over-utilization issues or practices. Data analysis is conducted using various data sources such as medical, behavioral health, pharmacy, dental, and vision encounter data reporting to identify patterns of potential or actual inappropriate utilization of services. The
UM Department works closely with the Chief Medical Director, Sr. VP Medical Management, and Medical Directors to identify problem areas and provide improvement recommendations to the SEQIC for approval. Once approved, the MM departments implement approved actions to improve appropriate utilization of services.

Preventive Health Reminder Programs

These are population-based initiatives that aim to improve adherence to recommended preventive health guidelines for examinations, screening tests, and immunizations promoting the prevention and early diagnosis of disease. These programs utilize various member and provider interventions and activities to improve access to these services and member compliance. Examples of preventive health reminder programs include, but are not limited to:

- General and supportive member and provider education such as articles in member and provider newsletters, face-to-face interactions, and written education provided to members at health fairs, diaper distribution events, etc.
- Targeted telephonic and/or written outreach to member/parents/guardians to remind of applicable preventive health screenings and services due or overdue and assistance with scheduling appointments and transportation to the appointments as needed.
- Targeted written and/or face-to-face education and communication to providers identifying assigned members due or overdue for preventive health screenings such as EPSDT, immunizations, lead testing, cervical cancer screening, breast cancer screening, etc.

Chronic Care and Complex Care Management

MHS provides care and disease management for members identified at risk, intervenes with specific programs of care, and measures clinical and other health-related outcomes. Decision support encourages informed health care decisions by providing members with educational materials about their conditions and treatment options, and by supporting members to make informed treatment decisions in collaboration with their providers. MHS’ disease management programs help members understand their diagnoses, learn self-care skills, and adhere to treatment plans. All clinical management programs include the use of general awareness and targeted outreach and educational interventions, including but not limited to, newsletter articles, advertising, direct educational/informational mailings, and care management. Programs also include written communication to providers informing them of members on their panel with chronic conditions such as diabetes and/or hypertension and reminding them about appropriate screening and monitoring tests as recommended by evidenced-based practice guidelines.

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

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

Medical Management identifies candidates by mining data from multiple sources, comprehensive assessment (including but not limited to medical and behavioral health status/functional status/psychosocial needs/CLAS preferences/resources), care planning, stratification and care coordination. Further details are available for review in the MHS Medical Case Management policy/procedure.

The Children with Special Needs Program additionally provides case management services to members with chronic conditions such as neurological disorders, developmental disorders, HIV/AIDS, blood diseases and musculoskeletal disorders. This approach also includes appropriate client identification, stratification, intervention and documentation. A plan of care is developed with actions, interventions and treatment goals designed to educate, inform and maximize quality of life.

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

Population Health Management
MHS has implemented a cohesive strategy to address member needs across the continuum of care. The strategy is 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

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

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

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

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

**Credentialing and Re-Credentialing**

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 re-credentialing 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.

**On-Site Office Evaluation and Medical Record Review**

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

**Health Needs Screening**

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

**XVII. Performance Improvement Activities**

MHS’ SEQIC reviews and adopts an annual QAPI Program and QI Work Plan that aligns with MHS’s strategic vision and goals and appropriate industry standards. The QI/QM Department implements and supports Performance / quality improvement activities as required by the state or federal contract, including quality improvement projects and/or chronic care improvement projects as required by the state or federal regulators, and accreditation needs. Focus studies and health care initiatives also include behavioral health care issues and/or strategies. MHS participates in the State’s Quality Improvement Programs (QIPs) and submits reports to the State about its performance and activities in these projects at least quarterly. As a Medicare Advantage Organization (MAO), MHS conducts a Quality Improvement Project (QIP) and a Chronic Care Improvement Program (CCIP) for each contract as part of its QI Program.

MHS utilizes traditional quality/risk/utilization management approaches to identify activities relevant to MHS programs or a specific member population and that describe an observable, measurable, and manageable issue. Initiatives are identified through analysis of key indicators of care and service based on reliable data which indicate the need for improvement in a particular clinical or non-clinical area. Baseline data may come from:
performance profiling of contracted providers, mid-level providers, ancillary providers and organizational providers; provider office site evaluations; focus studies; utilization information (over-and under-utilization performance indicators); sentinel event monitoring; trends in member complaints, grievances and/or appeals; issues identified during care coordination; and/or referrals from any source indicating potential problems, including those identified by affiliated hospitals and contracted providers. Census, National and state level data is used for population analysis and for prevalence of disease conditions. Centene sister plans can be source of benchmarked desired results. Other initiatives may be selected to test an innovative strategy or as required by state or federal contracts. Projects and focus studies reflect the population served in terms of age groups, disease categories, and special risk status.

The SEQCQIC assists in prioritizing initiatives focusing on those with the greatest need or expected impact on health outcomes and member experience. Performance improvement projects, focused studies, and other QI/QM initiatives are designed to achieve and sustain, through ongoing measurements and interventions, significant improvement over time in clinical and non-clinical care areas in accordance with principles of sound research design and appropriate statistical analysis. The SEQCIC helps to define the study question and the quantifiable indicators, criteria, and goals to ensure the project is measureable and able to show sustained improvement. Evidence-based guidelines, industry standards, and contractual requirements are used as the foundation for developing performance indicators, setting benchmarks and/or performance targets, and designing projects and programs that assist providers and members in managing their health. If data collection is conducted for a random sample of the population, baseline and follow-up sampling is conducted using the same methodology and a sample size based on a 90% or more confidence level.

The SEQCIC or other subcommittee may also assist in barrier analysis and development of interventions for improvement. Data are re-measured at predefined intervals to monitor progress and make changes to interventions as indicated. Once a best practice is identified, control monitoring reports are implemented to monitor for changes in the process and need for re-intervention. Improvement that is maintained for one (1) year is considered valid and may include, but is not limited to, the following:

- The achievement of a pre-defined benchmark level of performance; (such as NCQA Quality Compass percentiles)
- The achievement of a reduction of at least 10% in the number of members who do not achieve the outcome defined by the indicator (or, the number of instances in which the desired outcome is not achieved); and
- The improvement is reasonably attributable to interventions undertaken by Plan.

MHS develops a corrective action plan(s) using the plan, do, study, act (PDSA) cycle to bring performance to at least the minimum level established.

**Plan**
- Document the evaluation results and barriers of interventions
- Document reasons why the interventions have not achieved the desired effects
- Identify new interventions for implementations shown to be effective in the same/similar population

**Do**
- Allocation of administrative resources to improve performance rates for the measures or service areas
- Identify staff positions responsible for implementing/overseeing interventions
- Specific timeframes for implementation

**Study**
- Provide means for re-measurement of new interventions frequently

**Act**
- Refine interventions based on the results until the desired effect meets or exceeds the goals set by QAPI.

**XVIII. Communicating to Members and Providers**

At least annually, MHS provides information, including a description of the QAPI Program and a report on MHS’s progress in meeting QAPI Program goals, to members. At a minimum, the communication addresses how to
request information about QAPI Program goals, processes, and outcomes as they relate to member care and service which includes Plan-specific data results such as HEDIS, CAHPS, and results of performance improvement projects. Information about how to obtain a hard copy description of the program and/or program outcomes is included on the website and/or in the Member Handbook and Provider Manual Information available to members and providers and may include full copies of the QI Program Description and/or QI Program Evaluation (when requested), or summary documents. Member materials are written at an appropriate reading level or as mandated by state contract and monitored for compliance. Members requiring/requesting receipt of information in an alternative format are identified at MHS, either through a direct request or through normal member service and/or medical management functions, taking into consideration the member’s special needs, including those who are visually impaired, have limited reading proficiency or cultural differences. MHS communicates the need to the Corporate Communications Department who works with external vendors to create the alternative format on an as needed basis.

XIX. 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 MHS functional areas utilize standards/guidelines from these sources and those promulgated by national and state medical societies or associations, the Centers for Disease Control, and the federal government. The QI/QM Department maintains a schedule of relevant QI reporting requirements for all applicable state and federal regulations and accreditation requirements, and submits reports in accordance with all requirements. This includes any federal/state requirements that apply to joint contract (e.g., dual eligible Special Needs Plans, Financial Alignment Demonstrations, etc.) Additionally, MHS’s QAPI Program and Plan departments fully support every aspect of the federal privacy and security standards, MHS’ Business Ethics and Integrity Program, MHS’ Compliance Plan, and MHS’ Waste, Fraud and Abuse Plan.

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 Re-credentialing
- 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.
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 Q4.

**Indiana Office of Medicaid Policy and Planning (OMPP)**

MHS’ Medical Director is responsible for the coordination and implementation of the Quality Management and Improvement Program. As part of the Quality Management and Improvement Program, MHS will participate in OMPP’s annual performance improvement program. 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.

In accordance with State contractual requirements, MHS will monitor, evaluate and take effective action to identify and address any needed improvements in quality of care delivered to members in the Hoosier Care Connect (HCC), Healthy Indiana Plan (HIP), Hoosier Healthwise (HHW) programs. This includes submitting quality improvement data to the State, including data that meets the HEDIS standards for reporting and measuring outcomes and the status and results of performance improvement projects. Additionally, MHS will submit the information requested by FSSA/OMPP to complete the State’s Annual Quality Assessment and Improvement Strategies Report to CMS for the HCC and HIP programs respectively. MHS will also comply with the details of the quality management program as defined in Exhibit 1.F (7.1); Exhibit 2.B (9.1) and Exhibit 1.B (6.1) of the HCC, HIP and HHW programs respectively.

**Medicare and Marketplace Products**

In accordance with federal requirements, MHS will develop and comply with the Model of Care for its Medicare product lines (Allwell from MHS) and the reporting requirements for both its Medicare (Allwell from MHS) and its marketplace (Ambetter from MHS) product lines.

**XX. Delegated Services**

The SEQIC may authorize participating provider entities such as independent practice associations or hospitals, or organizations such as disease management companies or managed behavioral health organizations (MBHO) to perform Plan activities (such as UM, credentialing, or QI) on MHS’ behalf. The DOC evaluates each delegated entity’s capacity to perform the proposed delegated activities prior to the execution of a delegation agreement. A mutually agreed upon delegation agreement, signed by both parties, includes, but is not limited to, the following elements:

- Responsibilities of MHS and the delegate
- Specific activities being delegated
- Frequency and type of reporting (i.e. minimum of semiannual reporting)
- The process by which MHS evaluates the delegate’s performance
- Explicit statement of consequences and corrective action process if the delegate fails to meet the terms of the agreement, up to and including revocation of the delegation agreement
If the delegation arrangement includes the use of protected health information (PHI) the delegation agreement also includes PHI provisions, typically accomplished in the form of a Business Associate Agreement signed by the delegated entity.

MHS retains accountability for any functions and services delegated, and as such monitors the performance of the delegated entity through annual approval of the delegate’s programs (e.g. Credentialing, UM, QI/QM, etc.), routine reporting of key performance metrics, and annual or more frequent evaluation to determine whether the delegated activities are being carried out according to Plan standards and Program requirements. The DOC and/or Compliance designee(s) in conjunction with Centene Corporate Compliance designee conducts an annual evaluation and documentation review to include the delegate’s program, applicable policies and procedures, applicable file reviews, and review of meetings minutes for compliance with Plan, state and federal requirements and/or accreditation standards. MHS retains the right to reclaim the responsibility for performance of delegated functions, at any time, if the delegate is not performing adequately.

Envolve is a sister company for provision of Behavioral Health, Disease Management, and Pharmacy services. ExactCare is a vendor that supports the pharmacy adherence program for MHS members and Home Access is an MHS vendor for direct-to-member diabetic and colorectal test kits. Other MHS vendors provide dental care, vision services transportation, and nurse hotline services.
# Appendix A
- QI Delegation Inventory -

<table>
<thead>
<tr>
<th>Quality Management and Improvement Functions</th>
<th>Envolve People Care (Nurtur)</th>
<th>Envolve Pharmacy</th>
<th>Envolve Vision</th>
<th>Envolve Dental</th>
<th>National Imaging Association (NIA)</th>
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<tbody>
<tr>
<td><strong>A. QI Program Structure</strong></td>
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<td>Clinical Programs</td>
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<td><strong>C. Behavioral Health Programs</strong></td>
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<tr>
<td><strong>D.</strong> A &amp; B. Submit Quality Management Program Description, Quality Management Work Plan, Quality Management Program Evaluation, &amp; all applicable Quality Management policies &amp; procedures annually.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<td><strong>E. Program Operations</strong></td>
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<td>F. A-B. Maintains functional QI Committee</td>
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<td><strong>Health Services Contracting</strong></td>
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<td>Use Appropriate Provider Contracts</td>
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<td>A. Practitioner Contracts (including allowable use of performance data)</td>
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<td>B. Affirmative Statement</td>
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<td>C. Provider Contracts (including allowable use of performance data)</td>
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<td><strong>G. Availability of Practitioners</strong></td>
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<td>Provides &amp; Monitors Appropriate Availability of Practitioners, as applicable</td>
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<td>Pharmacies</td>
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<td>H. Cultural Needs &amp; Preferences</td>
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<td>I. Practitioners Providing Primary Care</td>
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<td>J. Practitioners Providing Specialty Care</td>
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<td>K. Practitioners Providing BH Care</td>
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<td>L. Quality Management and Improvement Functions</td>
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<td><strong>N. Accessibility of Services</strong></td>
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<td>Provides &amp; Monitors Appropriate</td>
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<td>Accessibility of Practitioners, as applicable</td>
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<td>A. Assessment Against Access Standards</td>
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<td>B. BH Access Standards</td>
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<td>C. BH Telephone Access Standards</td>
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<td><strong>P. Member Experience</strong></td>
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<td>A &amp; B. Measures &amp; Promotes Member</td>
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<td>Satisfaction– physical health</td>
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<td>Q. C &amp; D Measures &amp; Promotes</td>
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<td>Member Satisfaction– behavioral health</td>
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<td><strong>S. Complex Case Management</strong></td>
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<tr>
<td>A. Population Assessment</td>
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<td>B. Program Description</td>
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<tr>
<td>C. Identifying Members for Case Management</td>
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<td>D. Access to Case Management</td>
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<td>A - C. Collaborates with BH practitioners to monitor &amp; facilitate continuity &amp; coordination of care</td>
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