EXECUTIVE SUMMARY OF MHS' ANNUAL QUALITY MANAGEMENT & IMPROVEMENT PROGRAM CY2024

PURPOSE

MHS is committed to the provision of a well-designed and well-implemented Medicaid Quality Program. The health plan's culture, systems, and processes are structured around the purpose and mission to improve the health of all enrolled Medicaid members which includes a focus on health outcomes as well as healthcare process measures, and member and provider experience.

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

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

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

SCOPE

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

PRIORITIES AND GOALS

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

In alignment with the Office of Medicaid Policy & Planning's (OMPP) commitment to improving the lives of Hoosiers to reach their greatest emotional, mental, and physical well-being, MHS has adopted OMPP's Five Pillars of Well Being for 2024. The goals and objectives for each pillar are measurable, take into consideration the health status of all populations in the state served by the MCEs, and were determined based on review of quality metrics (e.g., HEDIS®), P4Os, external quality review, consumer surveys (e.g., CAHPS), and trends in health care data within the state.

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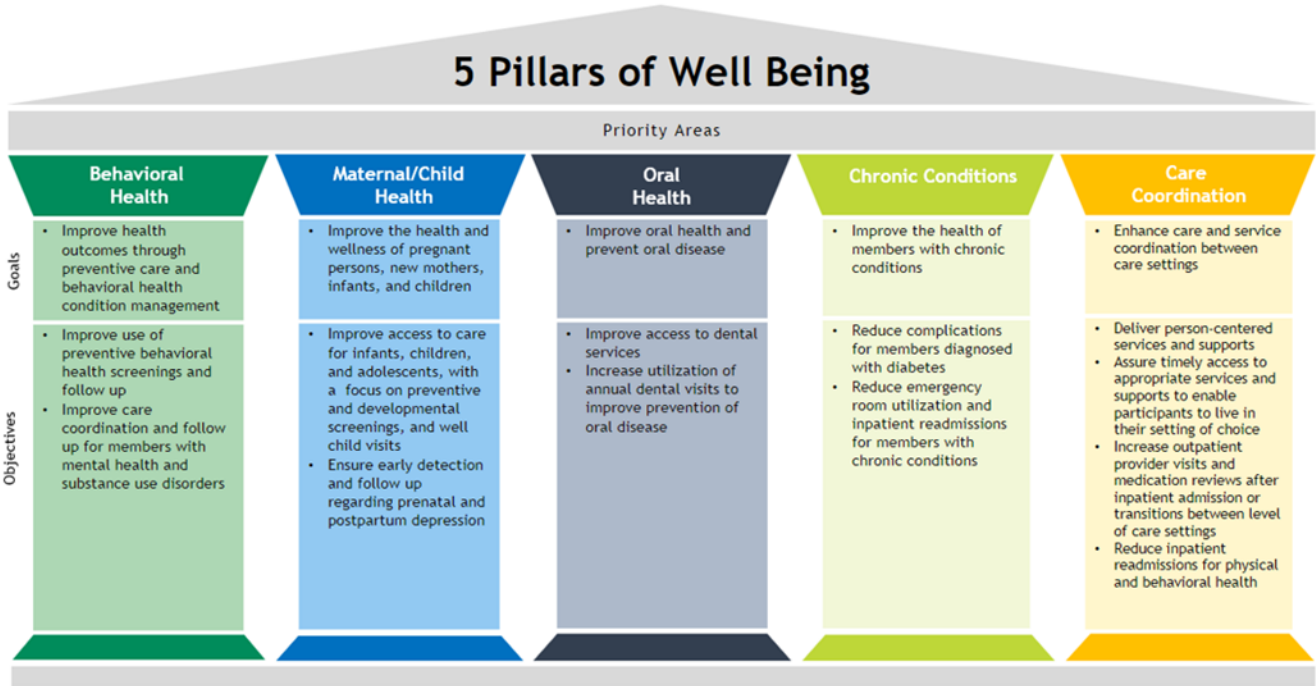


MHS has included the following focus measures for each Medicaid program to align with OMPP's performance targets.

Strategic Objectives for Quality Improvements for 2024

Objective Description	Process and Outcomes Quality Measures	Measure Source	Medicaid Program		
			HHW	HIP	HCC
Goal 1: Improve health outcomes through preventive care and behavioral health condition management					
Improve care coordination and follow up for members with behavioral health and substance use disorders	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)	HEDIS	X	X	X
	Follow-Up after Hospitalization for Mental Illness (FUH)	HEDIS	X	X	X
	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS	X	X	X
	Initiation and Engagement of Alcohol and other Drug (IET)	HEDIS	X	X	X
	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	HEDIS	X	X	X
Improve the use of preventive behavioral health screenings and follow up to screenings	Metabolic Monitoring for Children and Adolescents on Antipsychotic (APM)	HEDIS	X	X	X
	Diabetes Screening for Persons with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications (SSD)	HEDIS	X	X	X
	Cardiovascular Monitoring for Persons with Cardiovascular Disease and Schizophrenia (SMC)	HEDIS	X	X	X

Objective Description	Process and Outcomes Quality Measures	Measure Source	Medicaid Program		
			HHW	HIP	HCC
	Diabetes Monitoring for Persons with Diabetes and Schizophrenia (SMD)	HEDIS	X	X	X
Goal 2: Improve the health and wellness of pregnant persons, new mothers, infants, and children					
Ensure early detection and follow up regarding prenatal and postpartum depression	PPC: Timeliness of Prenatal Care	HEDIS	X	X	
	PPC: Postpartum Care	HEDIS	X	X	
Improve access to care for infants, children, and adolescents, with a focus on preventive and developmental screenings, and well child visits	Well-Child Visits in the First 30 Months of Life (W30)◊	HEDIS	X		
	Child and Adolescent Well-Care Visits (WCV)◊	HEDIS	X		
	Childhood Immunization Status (CIS)◊	HEDIS	X		
	Immunizations for Adolescents (IMA)◊	HEDIS	X		
Goal 3: Improve oral health and prevent oral disease					
Prevent oral disease	Oral Evaluation, Dental Services (OED)	HEDIS	X	X	X
Improve access to dental services	Dentists and Oral Surgeons Network Adequacy	OMPP	X	X	X
Goal 4: Improve the health of members with chronic conditions					
Improve the health and reduce complications for members diagnosed with diabetes	CDC: HbA1c Testing	HEDIS	X	X	X
	HBD: Hemoglobin A1c Control for Patients with Diabetes - Poor HbA1c Control	HEDIS	X	X	X
	HBD: Hemoglobin A1c Control for Patients with Diabetes*	HEDIS	X	X	X
Reduce emergency room utilization and inpatient readmissions for members with chronic conditions	Adults' Access to Preventive/Ambulatory Health Services (AAP)	HEDIS	X	X	X
	Acute Hospital Utilization (AHU)	HEDIS	X	X	X
	Emergency Department Utilization (EDU)	HEDIS	X	X	X
Goal 5: Improve care coordination across the entire service continuum					
Reduce the number of inpatient readmissions for physical and behavioral health	Plan All-Cause Readmissions (PCR)	HEDIS	X	X	X
Ensure smooth transitions between level of care settings	Completion of Initial Health Needs Screening within 30 days or 90 Days of MCE Enrollment based on care program	OMPP	X	X	X

In addition to these measures of focus within specific Medicaid programs, MHS has adopted these NCQA Medicaid Health Plan Ratings Scorecard measures for improvement with the goal of performing at or above 75th percentile of the 2024 NCQA Quality Compass.

2024 Medicaid Initiatives	
Measure	**Methodology***
MEMBER EXPERIENCE	
Getting Needed Care (Usually + Always)	CAHPS
Getting Care Quickly (Usually + Always)	CAHPS
Rating of Personal Doctor (9 + 10)	CAHPS
Rating of Specialist (9 + 10)	CAHPS
Rating of Health Plan (9 + 10)	CAHPS
Rating of All Health Care (9 + 10)	CAHPS
Customer Service (9 +10)	CAHPS
PREVENTION AND EQUITY	
Children and Adolescent Well-Care	
CIS Childhood Immunization Status—Combination 10	HEDIS
IMA Immunizations for Adolescents—Combination 2	HEDIS
WCC Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	HEDIS
Women's Reproductive Health	
PPC Prenatal and Postpartum Care—Timeliness of Prenatal Care Prenatal and Postpartum Care—Postpartum Care	HEDIS
PRS-E Prenatal Immunization Status —Combination Rate	HEDIS
Cancer Screening	
BCS-E Breast Cancer Screening	HEDIS
CCS Cervical Cancer Screening	HEDIS
Equity	
RDM Race/Ethnicity Diversity of Membership	HEDIS
Other Preventive Services	
CHL Chlamydia Screening in Women—Total	HEDIS
MSC Medical Assistance with Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit	CAHPS
AIS-E Adult Immunization Status-Influenza; Td/ Tdap; Zoster; Pneumococcal	HEDIS
TREATMENT	
Respiratory	
AMR Asthma Medication Ratio—Total	HEDIS
CWP Appropriate Testing for Pharyngitis—Total	HEDIS
URI Appropriate Treatment for Upper Respiratory Infection—Total	HEDIS
AAB Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	HEDIS
PCE Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	HEDIS
Diabetes	
BPD Blood Pressure Control (<140/90) for Patients With Diabetes	HEDIS
EED Eye Exam for Patients With Diabetes	HEDIS
HBD Hemoglobin A1c Control for Patients With Diabetes — HbA1c Control (<8%)	HEDIS

SPD Statin Therapy for Patients with Diabetes— Received Statin Therapy Statin Therapy for Patients with Diabetes—Statin Adherence 80%	HEDIS
KED Kidney Health Evaluation for Patients with Diabetes	HEDIS
SPC Statin Therapy for Patients with Cardiovascular Disease—Received Statin Therapy—Total Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%—Total	HEDIS
CBP Controlling High Blood Pressure	HEDIS
Behavioral Health—Care Coordination	
FUH Follow-Up After Hospitalization for Mental Illness— 7 days—Total	HEDIS
FUM Follow-Up After Emergency Department Visit for Mental Illness—7 days—Total	HEDIS
FUA Follow-Up After Emergency Department Visit for Substance Use—7 days—Total	HEDIS
FUI Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	HEDIS
Behavioral Health—Medication Adherence	
SAA Adherence to Antipsychotic Medications for Individuals With Schizophrenia	HEDIS
POD Pharmacotherapy for Opioid Use Disorder—Total	HEDIS
AMM Antidepressant Medication Management— Effective Continuation Phase Treatment	HEDIS
Behavioral Health—Access, Monitoring and Safety	
APM Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	HEDIS
ADD Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	HEDIS
SSD Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	HEDIS
APP Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	HEDIS
IET Initiation and Engagement of Substance Use Disorder—Engagement of SUD Treatment—Total	HEDIS
Risk-Adjusted Utilization	
PCR Plan All-Cause Readmissions—Observed-to Expected Ratio—18-64 years	HEDIS
Other Treatment Measures	
LBP Use of Imaging Studies for Low Back Pain	HEDIS

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

CULTURAL COMPETENCY AND HEALTH EQUITY

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

care. As such, MHS has developed a health equity approach that identifies and hotspots disparities, prioritizes projects and collaborates across the community to reduce disparities by targeting member, provider, and community interventions. Disparity analysis includes analyzing HEDIS and utilization data by eligibility category, race, ethnicity, limited English proficiency, disability, age, gender, and geography to identify priority populations and interventions for targeting disparity reduction.

AUTHORITY

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

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

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

The Chief Medical Director, or as designated by the MHS President/CEO, serves as the senior quality executive and is responsible for:

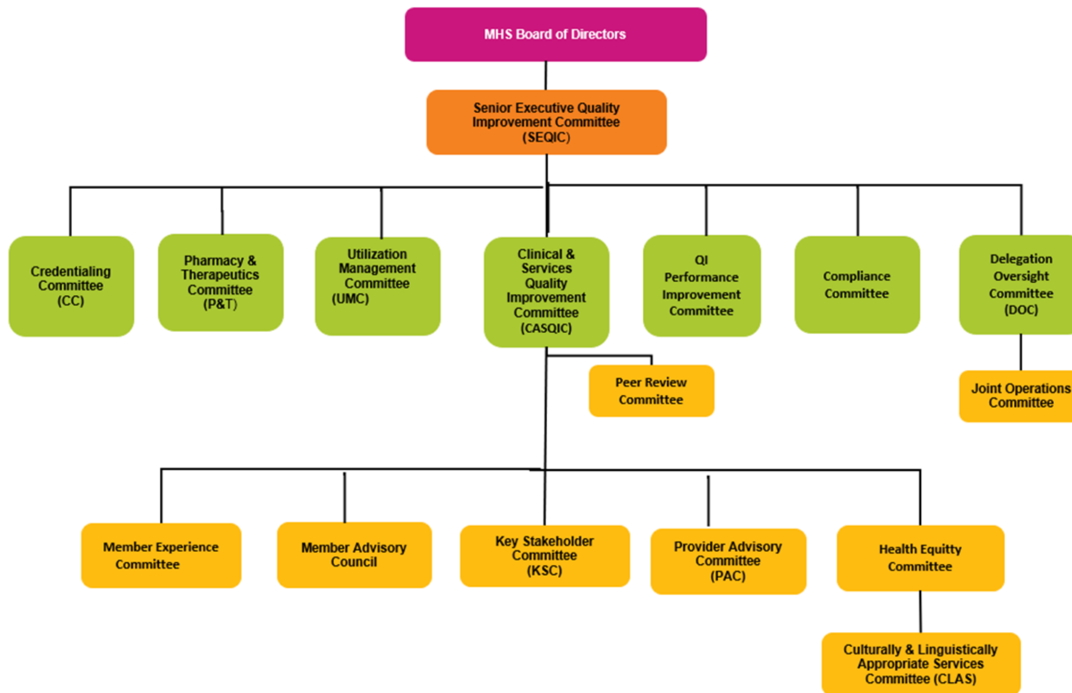
- Compliance with state, federal, and accreditation requirements and regulations;
- Chairing the CASQIC, or designating an appropriate alternate chair, and participating as appropriate;
- Monitoring and directing quality activities among personnel and among the various subcommittees reporting to the CASQIC;
- Coordinating the resolution of outstanding issues with the appropriate leadership staff, pertaining to CASQIC recommendations, subcommittee recommendations, and/or other stakeholder recommendations;
- Being actively involved in the MHS' Quality Program including activities such as: recommending quality study methodology, formulating topics for quality studies as they relate to accreditation and regulatory requirements and state and federal law, promoting participating practitioner compliance with medical necessity criteria and clinical practice and preventive health guidelines, assisting in ongoing patient care monitoring as it relates to population health management programs, pharmacy, diagnostic-specific case reviews, and other focused studies, and directing credentialing and re-credentialing activities in accordance with MHS' policies and procedures; and
- Reporting the Quality Program activities and outcomes to the Board of Directors at least annually.
- The Behavioral Health Medical Director, or other appropriate behavioral health practitioner (i.e., a medical doctor or a clinical PhD or PsyD who may be a medical director, clinical director, or a participating practitioner from the organization or behavioral healthcare delegate), is the designated practitioner responsible for the behavioral health aspects of the Quality Program and is responsible for:
    - Compliance with state, federal, and accreditation requirements and regulations related to behavioral health;

- Participating in the CASQIC and various subcommittees reporting to the CASQIC, as applicable to behavioral health;
- Monitoring and directing behavioral health quality activities among personnel and among the various subcommittees reporting to the CASQIC; and,
- Providing oversight of the behavioral health aspects of care to ensure appropriateness of care delivery and improve quality of service.

QUALITY PROGRAM STRUCTURE

Quality is integrated throughout MHS and represents the strong commitment to the quality of care and services for members. The Board of Directors is the governing body designated for oversight of the Quality Program and has delegated the authority and responsibility for the development and implementation of the Quality Program to the SEQIC and CASQIC.

The SEQIC is the senior management lead committee accountable directly to the Board of Directors and reports Quality Program activities, findings, recommendations, actions, and results to the Board of Directors no less than annually. MHS ensures ongoing member, provider, and stakeholder input into the Quality Program through a strong SEQIC and CASQIC and subcommittee structure focused on member and provider experience. The MHS SEQIC and CASQIC structure is designed to continually promote information, reports, and improvement activity results, driven by the Quality Work Plan, throughout the organization and to providers, members, and stakeholders. The SEQIC serves as the umbrella committee through which all subcommittee activities are reported and approved. The SEQIC directs subcommittees to implement improvement activities based on performance trends, and member, provider and system needs. Additional committees may also be included per health plan need, including regional level committees as needed based on distribution of membership. These committees assist with monitoring and supporting the Quality Program. The MHS committee structure is outlined below:



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

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

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

QUALITY PROGRAM RESOURCES: INFRASTRUCTURE AND DATA ANALYTICS

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

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

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

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

Enterprise Data Warehouse (EDW) – The foundation of MHS' Centelligence proprietary data integration and reporting strategy is the EDW, powered by high performance Teradata technology. The EDW systematically receives, integrates, and transmits internal and external administrative and clinical data, including medical,

behavioral, and pharmacy claims data, as well as lab test results and health screening/assessment information. EDW supplies the data needed for all of Centelligence' s analytic and reporting applications while orchestrating data interfaces among core applications. Housing all information in the EDW allows MHS to generate standard and ad-hoc quality reports from a single data repository.

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

TruCare – Member-centric health management platform for collaborative care management, care coordination and behavioral health, condition, and utilization management. Integrated with Centelligence for access to supporting clinical data, TruCare allows Population Health and Clinical Operations (PHCO) and Quality department staff to capture utilization, care, and population health management data, to proactively identify, stratify, and monitor high-risk enrollees, to consistently determine appropriate levels of care through integration with InterQual® medical necessity criteria and clinical policies, and capture the impact of 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, and a quality-of-care module to track and report potential quality of care incidents and adverse events.

Certified HEDIS Engine – a software system used to monitor, profile, and report on the treatment of specific episodes, care quality, and care delivery patterns. The HEDIS Engine is certified by NCQA and produces NCQA-certified HEDIS measures; its primary use is for the purpose of building and tabulating HEDIS, and other state required performance measures. The Engine enables the health 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 system provides an integrated clinical and financial view of care delivery, which enables the health plan to identify cost drivers, help guide best practices, and to manage variances in its efforts to improve performance. Data is updated at least monthly by using an interface that extracts claims, member, provider, and financial information and then summarized with access for staff to view standard data summaries and drill down into the data or request ad-hoc queries.

Scorecards - Centene Quality Analytics produces monthly scorecards for ratings systems such as Medicare Stars, Marketplace Quality Rating System, and Medicaid NCQA Health Plan Rating System. In addition, scorecards are produced for any quality-related Pay for Performance programs outlined in contracts between states and health plans. Scorecards contain the most up-to-date HEDIS, CAHPS, and operational rates, where applicable, from our source-of-truth HEDIS engine, certified CAHPS vendor, and CMS HPMS and Complaint Tracker Module, and Acumen pharmacy data. Additional data points provided are source-of-truth rates from prior year final rates, prior year current month, and star or rating assignment (1-5) at the measure level. Domain and overall-level roll-up ratings are estimated using calculations modeled from CMS or NCQA Technical Specifications. Roll-up overall stars are estimated for current rates, and final overall star ratings from prior year are provided for comparison. Month-over-month and year-over-year graphs are provided to show trending performance across current and prior measurement year. Finally, most current available benchmarks are provided, and current numerator and denominator, where relevant, are provided at the measure level to show health plans the benchmark currently achieved and distance, in numerator hits, to all remaining benchmarks not met.

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

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

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

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

DOCUMENTATION CYCLE

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

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

Quality Assessment & Performance Improvement (QAPI) Program Description – The Quality Assessment & Performance Improvement Program Description is a written document that outlines MHS' structure and process to monitor and improve the quality and safety of clinical care and the quality of services provided to members. The QAPI includes the following at minimum: the scope and structure of the Quality Program, including the behavioral health aspects of the program; the specific role, structure, function, and responsibilities of the CASQIC and subcommittees/work groups, including meeting frequency and accountability to the governing body; a description of dedicated Quality Program staff and resources, including involvement of a designated physician and behavioral health care practitioner; the behavioral health aspects of the program, and how the health plan serves a diverse membership. No less than annually, ideally during the first quarter of each calendar year, the designated quality department team prepares, reviews, and revises the QAPI as needed. The QAPI is reviewed and approved by the CASQIC, 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 to CASQIC and SEQIC and appropriate state agency for review and approval as required by state contract, if applicable.

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

The Work Plan is developed annually after completing the Quality Program Evaluation for the previous year and includes the recommendations for improvements from the annual Program Evaluation. The Work Plan reflects the ongoing progress of the quality activities, including:

- Yearly planned quality 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;

- Business owners responsible for each activity;
- Monitoring of previously identified issues; and,
- Evaluation of Quality Program.

MHS annually reviews the existing Work Plan and confirms compliance with the health plan's current needs, accreditation requirements, and current state and/or federal requirements and deliverables related to the Quality Program, as applicable. Work Plan status reports are reviewed by the CASQIC on a regular basis (e.g. at least quarterly and usually monthly). The Work Plan is a fluid document; designated Quality Department staff make frequent updates to document progress of the Quality Program throughout the year.

Quality Program Evaluation – The Quality Program Evaluation includes an annual summary of all quality 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 health plan, including activities regarding provider services, member services, utilization management, care management, complex case management, condition management, and safety of clinical care. Program Evaluation findings are incorporated in the development of the annual Quality Assessment & Performance Improvement Program Description and Quality Work Plan for the subsequent year. The senior quality executive and Quality VP and Sr. Director are responsible for coordinating the evaluation process and a written description of the evaluation and work plan is provided to the CASQIC, SEQIC and Board of Directors for approval annually.

MHS provides general information about the Quality Program to members and providers on the website or member/provider materials such as the member handbook or provider manual. If required, communication includes how to request specific information about Quality Program goals, processes, and outcomes as they relate to member care and services and may include results of performance measurement and improvement projects. Information available to members and providers may include full copies of the Quality Assessment & Performance Improvement Program Description and/or Quality Program Evaluation, or summary documents.

PERFORMANCE MEASUREMENT

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

MHS focuses monitoring efforts on the priority performance measures that align with the mission and goals outlined previously, as well as required additional measures. MHS reports all required measures in a timely, complete, and accurate manner as necessary to meet federal and state reporting requirements. Performance measures also include all HEDIS measures required for the NCQA Health Plan Ratings and the designated set of CMS Adult and Child Core measures. HEDIS includes measures across six (6) domains of care including: Effectiveness of Care, Access and Availability of Care, Experience of Care, Utilization and Risk Adjusted Utilization, Health Plan Descriptive Information, and Measures Collected Using Electronic Clinical Data Systems.

HEDIS is a collaborative process between MHS, the Centene Corporate Quality Department, and several external vendors. MHS calculates and reports HEDIS rates utilizing an NCQA-certified software. HEDIS rates are audited by an NCQA-certified auditor and submitted to NCQA as required. As applicable, in order to facilitate External Quality Review Organization (EQRO) analytical review to assess the quality of care and service provided to members, and to identify opportunities for improvement, MHS supplies claims and encounter data to the appropriate EQRO and works collaboratively to assess and implement interventions for improvement.

Member Experience: MHS supports continuous ongoing measurement of member experience by monitoring member inquiries, complaints/grievances, and appeals; member satisfaction surveys; member call center

performance; and direct feedback from member focus groups and other applicable committees. The Quality Department analyzes findings related to member experience and presents results to the CASQIC and appropriate subcommittees.

The Consumer Assessment of Healthcare Providers and Systems Plan Survey (CAHPS) assesses patient experience in receiving care. CAHPS results are reviewed by the CASQIC and applicable subcommittees, with specific recommendations for performance improvement interventions or actions. In addition to any federal or state required CAHPS measures, MHS focuses on the following measures required for the NCQA Health Plan Ratings:

- Getting Care Quickly;
- Getting Needed Care;
- Coordination of Care;
- Customer Service;
- Rating of Health Plan;
- Rating of All Health Care;
- Rating of Personal Doctor; and,
- Rating of Specialist Seen Most Often

Provider Experience - Provider satisfaction is assessed annually using valid survey methodology and a standardized comprehensive survey tool. The survey tool is designed to assess provider satisfaction with the network, claims, quality, utilization management, and other administrative services. The Provider Engagement and 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 CASQIC, with specific recommendations for performance improvement interventions or actions. Provider experience may also be assessed through monitoring of provider grievances and appeals as well as point-in-time provider surveys following call center and in-person interactions. Provider surveys, monitoring of provider grievances and appeals, and input from various quality committees and advisory workgroups provide ongoing data to the Performance Improvement Team and CASQIC, with operational process improvements and service performance improvement projects based on formal analysis of identified areas of provider need/dissatisfaction.

PROMOTING MEMBER SAFETY AND QUALITY OF CARE

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

Member safety is a key focus of the MHS Quality Program. Monitoring and promoting member safety is integrated throughout many activities across the health plan, including through identification of potential and/or actual quality of care events and critical incidents, as applicable. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of member 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. Employees (including population health staff, member services staff, provider services staff, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, state partners, Medical Directors, or the Board of Directors may inform the Quality Department of potential quality of care issues and/or critical incidents. 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 and critical incidents received in the Quality Department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

In addition, the health plan monitors for quality of care and/or adverse events through claims-based reporting mechanisms. An adverse event is an event over which health care personnel could have exercised control, and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention

occurred. Although occurrence of an adverse event in and of itself is not necessarily a preventable quality of care issue, MHS monitors and tracks these occurrences for trends in type, location, etc., to monitor member safety and investigates further and/or requests a corrective action plan any time a quality of care issue is definitively substantiated.

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

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

MHS also ensures initial and re-credentialing of all network practitioners/providers complies with state and accreditation requirements, and performs ongoing monitoring of the provider network, including screening of providers against all applicable Exclusion Lists (e.g. System for Award Management [SAM], List of Excluded Individuals/Entities [LEIE], etc.).

Medical Record Documentation Standards – MHS promotes 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 member information, are outlined in the Provider Manual. 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 specific requirements for medical record keeping; elements scoring below a determined benchmark are considered deficient and in need of improvement.

MEMBER ACCESS TO CARE

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

POPULATION HEALTH MANAGEMENT

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

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

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

MHS provides care coordination, care management, and condition/disease management for members identified at risk, intervenes with specific programs of care, and measures clinical and other health-related outcomes. MHS attempts to assess all new members within 90 days of enrollment by performing a health risk screening which includes assessing for member risk based on social determinants of health, emerging risk, and other risks. A universal screening tool is utilized that includes questions relating to social determinants of health such as housing, food, transportation, and interpersonal violence. Decision support encourages informed health care decisions by providing members with education about their condition(s) and treatment options, and by supporting members to make informed treatment decisions in collaboration with their providers. MHS' condition management and population health 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 regarding available programs, direct educational/informational mailings, and care management. Programs also include written communication to primary care providers informing of members on their panel with chronic conditions such as diabetes and/or hypertension and reminders on appropriate screening and monitoring tests as recommended by evidenced-based practice guidelines.

Behavioral Health Services - Behavioral health is integrated in the overall care model with guidance from Behavioral Health Medical Directors. The goals and objectives of the behavioral health activities are congruent with the Population Health Solutions health model and are incorporated into the overall care management model program description, which involve efforts to monitor and improve behavioral healthcare.

PROVIDER SUPPORT

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

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

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

Provider Analytics - MHS offers a quality, cost and utilization tool designed to support providers who participate in a value-based program to identify provider performance opportunities and assist with population health

management initiatives. Through these supporting platforms, MHS works to keep providers engaged in the delivery of value-based care by promoting wellness and incentivizing the prudent maintenance of chronic conditions.

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

PERFORMANCE IMPROVEMENT ACTIVITIES

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

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

2024 Quality Improvement Projects (QIP)		
QIP Topic	**QIP Aim**	**QIP Intervention**
Maternal and Infant Mortality	Reduction in Maternal and Infant Mortality	Increase enrollment of pregnant members in the Start Smart for Baby (SSFB) program Reduce the rate of hospital admissions of high-risk OB members in the SSFB program
Member Experience	Increase Medicaid CAHPS Survey Composite Rating of Health Plan	The percentage of grievances aggregated in the NCQA required categories (Quality of Care, Access, Attitude and Service, Billing and Financial Issues, and Quality Practitioner Office) for the measurement year. The percentage of appeals aggregated in the NCQA required categories (Quality of Care, Access, Attitude and Service, Billing and Financial Issues, and Quality Practitioner Office) for the measurement year.
Diabetes	Increase rate of members with diabetes receiving a retinal eye exam and/or whose blood pressure is controlled	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year. (Source: HEDIS MY2024 Technical Specifications) The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam. (Source: HEDIS M2024 Technical Specifications)

GREIVANCE AND APPEALS SYSTEM

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

All member grievances and appeals are tracked and resolved, and data is analyzed and reported to the CASQIC and applicable subcommittees on a regular basis to identify trends and to recommend performance improvement activities as appropriate. In addition, member grievances associated with specific practitioners and/or providers and related to quality of care and service are tracked, classified according to severity, and reviewed by the Medical Director if needed. Member grievances by associated practitioner/provider are analyzed and reported on a routine basis to the CASQIC and applicable subcommittees (including the Credentialing Committee and Peer Review Committee as appropriate) for identification of specific improvement activities or corrective action as needed.

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

REGULATORY COMPLIANCE AND REPORTING

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

NCQA HEALTH PLAN ACCREDITATION

MHS adheres to the belief that NCQA Health Plan Accreditation demonstrates a health plan's commitment to delivering high-quality care and service for members and thus strives for a continual state of accreditation readiness. The MHS Chief Medical Director, VP of Quality Sr. Director of Quality and Medicaid Program Manager III facilitate the accreditation process with support from Centene Corporation's national accreditation team.

Centene has achieved NCQA Health Plan Corporate Accreditation for specific elements, which reduces the burden for affiliate health plans to become accredited. In addition, MHS sister organizations have also achieved NCQA accreditations which allow MHS to receive auto-credit for specific elements within the NCQA standards and decrease the accreditation burden for the health plan.

SUMMARY

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

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