Magnolia Health MississippiCAN Quality Improvement Program Description

2018

Quality Improvement Program Description 2018
MississippiCAN

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PURPOSE

Magnolia Health (Magnolia) is committed to the provision of a well-designed and well-implemented Quality Assessment and Performance Improvement (QAPI) Program. Magnolia's culture, systems, and processes are structured around its mission to improve the health of all enrolled members. The 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 management, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services.

Magnolia recognizes its legal and ethical obligations 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, Magnolia will provide for the delivery of quality care with the primary goal of improving the health status of Magnolia members. Where the member's condition is not amenable to improvement, Magnolia will implement measures to prevent any further decline in condition or deterioration of health status, or will provide for comfort measures as appropriate and as requested by the member. This will include the identification of members at risk of developing conditions, the implementation of appropriate interventions, and the designation of adequate resources to support these interventions. Whenever possible, Magnolia's QAPI supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its members.

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

SCOPE

The scope of the QAPI Program is comprehensive and addresses both the quality and safety of clinical care and the quality of services provided to Magnolia's members, including medical, behavioral health, dental, and vision care. Magnolia incorporates all demographic groups, lines of business, benefit packages, care settings, and services in its quality improvement (QI) activities, including but not limited to preventive care, inpatient hospitalization, emergency care, primary care, specialty care, acute care, and ancillary services. Magnolia's QAPI Program monitors the following:

- Acute and chronic care management
- Inpatient acute care hospitalizations and discharge planning
- Behavioral health care
- Compliance with member confidentiality laws and regulations
- 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 Complaint Process
- Member Appeals
- Member Satisfaction
- Quality of Care Issues
- Patient Safety
- Primary Care Physician (PCP) changes
- Pharmacy
- Provider and Magnolia after-hours telephone accessibility
- Provider appointment availability
- Provider Complaint, Grievance and Appeal Process
- Provider network adequacy and capacity
- Provider Satisfaction
- Health Care Disparities (including but not limited to : Sickle Cell, Flu, Primary Care visits, Pre and Post-partum visits)
- Newborn tracking
- Selection and retention of providers (credentialing and re-credentialing)
- Utilization Management, including over- and under-utilization

GOALS

Magnolia's primary quality improvement goal is to improve members' health status through a variety of activities implemented across all care settings and aimed at enhancing the level of care and services delivered.

Quality Improvement goals include, but are not limited to, the following:

- Magnolia members will experience a higher level of health status and quality of life.
- Network quality of care and service will meet industry-accepted standards of performance.
- Magnolia services will meet industry-accepted standards of performance.
- Fragmentation and/or duplications of services will be minimized through integration of quality improvement activities across Magnolia's functional areas.
- Member satisfaction will meet Magnolia's established performance targets.
- Preventive and clinical practice guideline compliance will meet established performance targets (i.e. HEDIS® Quality Compass, state contract goals). This includes, but is not limited to, compliance with Immunizations, Prenatal Care, Diabetes, Asthma, EPSDT (Early and Periodic Screening, Diagnostic and Treatment) and Pediatric Preventive Health Guidelines. Magnolia will annually measure provider compliance with the implementation of preventive and clinical practice guidelines.
- Compliance with all applicable regulatory requirements and accreditation standards will be maintained.

Magnolia's Quality Improvement Program objectives include, but are not limited to, the following:

- Establish and maintain a health system that promotes continuous quality improvement.
- Adopt evidence-based clinical indicators and practice guidelines as a means for identifying and addressing variations in medical practice.
- Select areas of study based on demonstration of need and relevance to the population served.
- Develop standardized performance measures that are clearly defined, objective, measurable, and allow for tracking over time.
- Utilize internal management information systems in data collection, integration, tracking, analysis, and reporting of data that reflect performance on standardized measures of health outcomes.
- Allocate personnel and resources necessary to:
  - Support the quality improvement program, including data analysis and reporting;
  - Meet the educational needs of members, providers, and staff, relevant to quality improvement efforts.
- Seek input and work with members, providers, and community resources to improve quality of care.
- Oversee peer review procedures that will address deviations in medical management and health care practices and devise action plans to improve services.
- 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.
- Recommend and institute "focused" quality studies in clinical and non-clinical areas, where appropriate.

CONFIDENTIALITY

Confidential information is defined as any data that can directly or indirectly identify a patient or physician. The Quality Improvement Committee (QIC) and its subcommittees have the responsibility to review quality of care and resource utilization, and conduct peer review activities as appropriate. The QIC and related Peer Review Committee (PRC) conduct such proceedings in accordance with Magnolia's bylaws and applicable federal and state statutes and regulations.

As such, the proceedings of the QIC, 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:

- The Board of Directors (BOD)
- The President and the Chief Executive Officer (CEO)
- The Vice President of Medical Affairs
- The Senior Executive for Quality Improvement (SEQI), the Chief Medical Director (CMD), and the QI Designee
- Peer Review Committee (PRC)

- External regulatory agencies, as mandated by applicable state/federal laws
- Magnolia legal executives

QIC 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 the QI/Credentialing Committee of a Magnolia affiliated entity or that of a contracted medical Group/Independent Practice Associations (IPA).

Magnolia 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 "Confidential and Privileged, Peer Review" and maintained in locked files.
- Confidentiality policies and procedures comply with applicable state statutes that address the protection of peer review documents and information.
- Committee members and Magnolia employees responsible for QI, Utilization Management (UM), Credentialing, and Pharmacy & Therapeutics (P&T) program activities are educated about maintaining the confidentiality of peer review documents.
- The QI Designee is responsible for taking minutes and maintaining confidentiality.
- For QI studies coordinated with, or provided to, outside PRC, references to patients are coded by identification number rather than a PHI identifier, such as medical record number or identification (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 the Magnolia CEO, CMD, Director of Quality Improvement, Magnolia's Legal Counsel, or the Board Chairman.
- All participating providers and employees of Magnolia involved in peer review activities or who participate in QI activities or committees are required to sign confidentiality agreements.

CONFLICT OF INTEREST

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

CULTURAL COMPETENCE

Magnolia provides services to people of all cultures, races, ethnic and religious backgrounds, and languages in a manner that recognizes values, affirms and respects the worth of the individual members, and protects and preserves the dignity of each. To that end, Magnolia has developed a Cultural Competency Plan based on three frameworks: individual state definitions of cultural competency, the National Standards for Culturally and Linguistically Appropriate Services in

Health and Health Care (CLAS), and the Georgetown University National Center for Cultural Competence (NCCC) model framework. Magnolia's program defines its values and principles, and demonstrates behaviors, attitudes, policies, and structures that enable employees and providers to work effectively across cultures. Magnolia's QI Program actively supports the goals and objectives of the Cultural Competency Plan.

AUTHORITY

The Magnolia BOD has the ultimate authority, responsibility, and accountability for quality of care and services provided to members. The BOD oversees development, implementation, and evaluation of the QI Program. The BOD then 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 quality improvement activities as an agenda item. At least one meeting is convened at a point in time when the opportunity to consider any mid-course modification of the QI Work Plan is feasible. The CEO serves as the lead Magnolia staff member and provides assistance with agenda, research, and reports to be reviewed. The Sr. Director of Quality Improvement presents the proposed QI Program Description, QI Work Plan, Annual Evaluation and Quality activities.

SENIOR EXECUTIVE RESPONSIBILITY

The BOD assigns the 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 Board of Directors. The CEO may assign the responsibility for the QI Program to the CMD, as well as responsibility for overall oversight for the medical components of the QI Program. The CMD is the chairperson of the Quality Improvement Committee.

PROGRAM STRUCTURE/ORGANIZATION/COMMITTEE

Quality is integrated throughout Magnolia, and represents the strong commitment to quality of care and services for members. To this end, Magnolia has established various committees, subcommittees, and ad hoc committees to monitor and support its QAPI Program. The Magnolia BOD approves the QI Program and maintains the ultimate authority for overseeing its management and direction. The BOD supports the authority and responsibility for development and implementation of effective management of the QI Program to the CEO, CMD, and Sr. Director of Quality Improvement who are responsible for reporting quality management activities, findings, and actions to the BOD.

All committee activities are documented in meeting minutes, which are recorded using an approved minute format. Minutes are reviewed and shall document all committee findings and follow-ups, by designating them via "Old" and "New Business", and shall be used for planning subsequent agendas and meetings. Each item for discussion includes the person(s) responsible and a timeline for completion.

Minutes are taken during the meeting and reflect attendance and participant discussion. The minutes are completed, dated, and distributed to the attendees within thirty business days following the meeting. Minutes

are approved and signed by the Committee Chair at the subsequent committee meeting and maintained in a secure area.

Magnolia Health Committee Structure for 2018

Quality Improvement Committee

The Quality Improvement Committee (QIC) is Magnolia's senior level committee accountable directly to the BOD. The objectives of the QIC are to perform oversight of all Magnolia quality activities, to assess the appropriateness of care delivered, and to continuously enhance and improve the quality of services provided to members. These targets are met in the following ways:

- Comprehensive system of ongoing, objective, and systematic monitoring
- The identification, evaluation, and resolution of process problems
- The identification of opportunities to improve member outcomes
- The education of members, providers, and staff regarding the Quality Improvement program

The QIC establishes standards and criteria for delivery of care and service. The Credentialing Committee (CC), the Pharmacy and Therapeutics (P&T) Committee, the Utilization Management Committee (UMC), the Performance Improvement Team (PIT), the Quality Task Force (QTF), Joint Oversight Committee (JOC) and the Peer Review Committee (PRC) report to the QIC. Reports include committee minutes and verbal reports from the Medical Directors and corporate administrators with knowledge of practices and opportunities to improve. Invited guests may also provide reports or input.

The scope of the QIC includes:

- Oversight of the Quality Improvement activities of Magnolia to ensure compliance with contractual requirements, federal and state statutes and regulations, and

requirements of Annual development of the Magnolia QAPI Program Description and Work Plan, incorporating applicable supporting department goals as indicated

- Development of quality improvement studies and activities and reporting of those findings to the BOD
- Annual review and approval of Case Management and Utilization 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 department's 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 to implement corrective actions as appropriate, and to act as a communication channel to the BOD
- Prioritization of quality improvement efforts, facilitation of functional area collaboration, and assurance of appropriate resources to carry out QI 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 audit outcomes for those entities already delegated
- Adoption of clinical practice guidelines and preventive health guidelines to promote appropriate and standardized quality of care; monitoring of clinical quality indicators such as Healthcare Effectiveness Data and Information Set (HEDIS), adverse events, sentinel events, peer review outcomes, quality of care tracking, etc., to identify deviation from standards of medical management; and assistance in the formulation of corrective action(s), as appropriate
- Ongoing evaluation of the appropriateness and effectiveness of practitioner profiling and Pay for Performance (P4P) initiatives and assistance in designing and modifying the program as warranted

The QIC is a senior level management committee and actively involves participating network practitioners in its quality activities, as available, and to the extent that there is not a conflict of interest. The QIC will include at least two network physicians representing the range of practitioners within the network and across the regions in which it operates (i.e. Family Practice, Internal Medicine, OB/GYN, Pediatrics, Behavioral Health, Vision/Dental, and other high-volume specialists as appropriate). At least one committee member will be a Behavioral Health Practitioner. Physician members of this committee may also serve as peer reviewers for clinical issues, as appropriate. To remain in good standing, a committee member must attend at least seventy-five percent (75%) of all scheduled committee meetings.

Meetings

The QIC meets at least quarterly or more frequently as needed. A quorum for action items is no less than five voting members, including three plan staff and two external physician representatives, who are present by teleconference, e-mail, or in person. Decisions may be reached by consensus.

QI Minutes

The Quality Improvement designee maintains detailed records and minutes of all QIC meetings, activities, program statistics, and recommendations made by the Committee. The QIC submits meeting minutes, as well as a written summary regarding the outcomes and effectiveness of the QAPI program, to the BOD at least annually. Signatures will be obtained, decisions will be made, and actions of the committees will be documented. Time frames and responsible parties for the actions will be included in the minutes of the meetings. Minutes and reports are considered confidential and available only to the QI Committees, the BOD, and Officers. The minutes are not available as part of "discoverability" or other proceedings associated with litigation.

Credentialing Committee

The Credentialing Committee (CC) is a standing subcommittee of the QIC and is responsible for oversight and operating authority of the Credentialing Program. Credentialing activities will be communicated to the BOD by way of the QIC.

The CC is responsible for development and annual review of the Credentialing Program Description and the program's associated policies and procedures. The CC is responsible for the review and assessment of provider applications to participate in the network, and establishes that each participating provider is qualified by training, experience, and performance consistent with the standards established by the provider credentialing policies to participate as a Magnolia provider. The CC shall verify and certify to the Division of Medicaid (DOM) that all plan providers, and any outside providers to whom enrollees may be referred, are properly licensed in accordance with all applicable state laws and regulations, are eligible to participate in the Medicaid program, and have in effect appropriate policies of malpractice insurance as may be required by Magnolia and the DOM. The CC has final authority for review and appropriate approval of licensed physicians, other licensed healthcare professionals, and certain facilities who have an independent relationship with Magnolia.

The CC meets monthly, but no less than ten times per year, and actively involves participating network practitioners in credentialing review activities as available and to the extent that there is not a conflict of interest. The Credentialing Committee (CC) is a statewide committee with regional representation as indicated, and includes representation from a range of practitioners to include the specialty and types of practitioners it reviews. The Committee is chaired by the CMD and facilitated by the Corporate Credential liaison. The Corporate Credentialing Designee, Provider Relations designee, and QI designee are standing members of the Committee. Additional executive leadership and/or staff may be included in CC meetings as appropriate. A quorum for action items is no less than fifty percent (50%) of voting members who are present by teleconference, e-mail, or in person. Decisions may be reached by consensus.

The Credentialing program scope and processes, including delegation of specific credentialing activities, are further outlined in the Credentialing Program Description.

Pharmacy and Therapeutics Committee

The Pharmacy & Therapeutics (P&T) Committee is a subcommittee of the QIC and is responsible for any ad hoc P&T activities that requires a vote for external Pharmacy.

The P&T Committee meets on an ad hoc basis to review pharmacy utilization data, prescribing practice patterns, and the plan's formulary compliance with the State's Uniform Preferred Drug List, and to discuss any needed changes. Additionally, the P&T Committee may assist with oversight of Magnolia's Pharmacy Benefit Manager (PBM) and review of complaints/grievances regarding pharmacy issues.

The P&T Committee is a multidisciplinary team that includes representation from a range of network physicians (including at least one behavioral health practitioner), participating network pharmacist(s), and clinical pharmacist(s). At least one physician on the committee will be a Behavioral Health Care provider. Magnolia executive leadership, QI staff, and Pharmacy staff may also attend the P&T Committee meetings as non-voting members.

The Committee is chaired by the CMD and facilitated by the Pharmacy Director. A quorum for action items is no less than fifty percent (50%) of voting members who are present by teleconference, e-mail, or in person. P&T committee meets on an ad hoc basis.

The Pharmacy program scope and processes, including delegation of specific pharmacy benefit management activities, are further outlined in the Pharmacy Program Description.

Utilization Management Committee

The Utilization Management Committee (UMC) is a standing subcommittee of the QIC and has oversight and operating authority of utilization management activities. The QIC is the vehicle through which utilization management activities will be communicated to the BOD. The UMC's primary functions are to monitor the appropriateness of care and to guard against over- and under-utilization of health care services provided to our members. The committee is responsible for the analysis of UM data, the identification of trends, and the addressing of identified issues.

The UMC approves the UM Program Description, Care Management Program Description, Care Management Evaluation, Pharmacy Program Description, and the annual UM Program Evaluation. The Committee is responsible for the review and appropriate approval of medical necessity criteria, protocols, and utilization management policies and procedures. Additionally, the UMC monitors and analyzes UM and Pharmacy data to identify trends and address identified issues, including patterns of potential or actual inappropriate over- or under-utilization, which may impact health care services, as well as member and practitioner satisfaction with the UM process.

The CMD chairs the Committee, which meets at least quarterly, or more often as need arises. The CMD is a standing member of the Committee. Additional Magnolia leadership and staff attend the UMC as appropriate. A quorum for action items is no less than fifty percent (50%) of voting members who are present by teleconference, e-mail, or in person. Decisions may be reached by consensus. To remain in good standing, a committee member must attend at least seventy-five percent (75%) of all scheduled committee meetings.

The UM program scope and processes, including delegation of specific UM activities, are further outlined in the UM Program Description.

Quality Task Force (QTF)

The QTF is responsible for monitoring, evaluating, and improving HEDIS outcomes. The Taskforce reports directly to the Quality Improvement Committee (QIC). The QTF is responsible for the review of at-risk measures, state critical elements, HEDIS aggregate rates, CHIPRA performance measure rates, and rate trending. The QTF provides recommendations to the Quality Improvement Department regarding HEDIS rates, initiatives, state requirements and HEDIS issues. QTF meets monthly, but no less than ten times a year, and includes representation from each functional department area. Membership should include employees who conduct or directly supervise the day-to-day activities of the department (i.e. Case Management, Contracting, Member/Provider Services, Network Development, Prior Authorization, Provider Relations, Quality Improvement, or other members as determined by the topic under discussion). A Medical Director serves as chair. A quorum for action items is no less than fifty percent (50%) of voting members, who are present by teleconference, fax, e-mail, or in person. Decisions are made by consensus.

Peer Review Committee (PRC)

The Peer Review Committee (PRC) is an ad hoc committee of the QIC and is responsible for reviewing inappropriate or aberrant service by a provider, including alleged quality of care concerns, adverse events, and sentinel events where initial investigation indicates a significant potential or a significant, severe adverse outcome has occurred, or other cases as deemed appropriate by the CMD. The PRC is expected to use their clinical judgment in assessing the appropriateness of clinical care and recommending a corrective action plan that will best suit the particular provider's situation.

All cases are reviewed by a physician of the same or similar specialty as the provider and/or issue under review. As such, the PRC shall include the Vice President of Medical Affairs (VPMA) CMD/Medical Director as appropriate, the Quality Improvement Director, and peer physicians of same/similar specialty. Network physician members are not standing members of the committee and their attendance may change based on the types of cases being reviewed. Network physician members are considered consultants for Magnolia and shall complete the applicable Physician Consultant Agreement and sign a Business Associate Agreement prior to sitting on the PRC. The Committee is chaired by the CMD, and meets on an as-needed basis. A quorum for action items is no less than fifty percent (50%) of voting members who are present by teleconference, e-mail, or in person. Decisions may be reached by consensus. To remain in good standing, a committee member must attend at least seventy-five (75%) of all scheduled committee meetings.

The network physicians serving on this committee may or may not be the same external physicians serving on the QIC or the CC. If the same physicians are used, the QIC/CC meeting should be adjourned, and the Peer Review meeting should be started as an independent meeting with an independent agenda and minutes. The CMD, VPMA and Quality Director are the only Magnolia staff to sit on the PRC. The QI Director will be the secretary of the meeting, assuring necessary documents are available for the meeting, facilitating the attendee sign-in sheet, and recording minutes of the meeting.

As previously stated, PRC meeting minutes are confidential and will be maintained in a secure area with limited access. If the PRC assessment results in recommendation for termination of the practitioner, the recommendation will be presented to the CC for final determination. Reviews

resulting in the reduction, suspension, or termination of a provider's participation will be reported to the National Practitioner Data Bank (NPDB) as indicated and outlined in the Practitioner Disciplinary Action and Reporting Policy and Procedure. This information is also forwarded to the Division of Medicaid (DOM).

Complete documentation will be maintained in the QI Department files and will be reviewed at least quarterly for trends and repeat occurrences. This information is incorporated into re-credentialing and other QI processes. Aggregate reporting of PRC activities is reported to the QIC at least quarterly.

Performance Improvement Team (PIT)

The Performance Improvement Team (PIT) is an internal, cross-functional quality improvement team that facilitates the integration of a culture of quality improvement throughout the organization. The PIT is responsible for gathering and analyzing performance measures, performing barrier and root cause analysis for indicators falling below desired performance, and making recommendations regarding corrective actions/interventions for improvement. The PIT is also responsible for overseeing the implementation of recommended corrective actions/interventions from the QIC and/or its supporting subcommittees, monitoring the outcomes of those improvement efforts, and reporting back to the designated committee. The PIT also reviews grievance and appeals statistics and makes recommendations to the Grievance and Appeals team regarding interventions for improvement or educational opportunities.

The PIT meets monthly, but no less than ten times per year and includes representation from each functional department area. Membership should include employees who conduct or directly supervise the day-to-day activities of the department (i.e. Case Management, Contracting, Member/Provider Services, Network Development, Prior Authorization, Provider Relations, Quality Improvement, or other members as determined by the topic under discussion). A Medical Director serves as the committee chair. A quorum for action items is no less than fifty (50%) of voting members, who are present by teleconference, e-mail, or in person. Decisions may be reached by consensus. To remain in good standing, a committee member must attend at least seventy-five (75%) of all scheduled committee meetings. The PIT reports directly to the QIC.

Delegate Vendor Oversight/Joint Oversight Committee (JOC)

The Joint Oversight Committee (JOC) has the responsibility of monitoring the performance of Magnolia's sister companies and vendors to whom Magnolia has delegated the authority to perform various delegated functions (Disease Management, Quality Improvement, Utilization Management , After Hours Coverage). The JOC oversees the delegates' activities to ensure contractual compliance, as well as compliance with federal and state laws, and NCQA accreditation standards. The JOC meets quarterly but no less than twice a year. The Joint Operative Committee (JOC) will continue to provide the direct oversight of each vendor/sister company and report to JOC through dashboards and meeting minutes. The JOC reports directly to the QIC.

Member Advisory Committee

The Member Advisory Committee (MAC) is an advisory subcommittee of the PIT with a goal of soliciting member input for the Quality Improvement Program. The scope of the MAC is to act as a focus group to facilitate member perspective on the quality of care and services offered by Magnolia and to offer recommendations for improvement.

MAC responsibilities may include:
- Review of member satisfaction survey results
- Review of Member Services telephone performance levels
- Review of member education materials for relevance, understanding, and ease of use
- Discussion of other topics as defined by the PIT or other QI Committees

The MAC meets at least two times per year and includes members, parents/foster parents/ guardians of children who are members, and applicable department staff, as appropriate. The Vice President of Operations or the Director of Marketing and Communications shall chair the committee. Members and their family members may volunteer for the MAC or may be suggested by staff. This is not a voting committee and has no quorum requirements.

Magnolia notifies its members about the MAC at least once annually in the Member Newsletter. Members may also receive information about the MAC in the Member Handbook and through member contacts at community events. Members can also learn about volunteering for the MAC through the Magnolia website.

Community Advisory Committee

The Community Advisory Committee (CAC) is an advisory subcommittee of the PIT with representation from key community stakeholders, such as church leaders, and local representatives from advocacy groups and other community-based organizations.

Responsibilities of the CAC include:
- Providing feedback regarding Magnolia performance from a community-based perspective
- Making recommendations related to program enhancements based on the needs of the local community
- Helping to identify key issues related to the state programs that may directly impact specific community groups
- Providing community input on potential Magnolia service improvements, effective approaches for reaching or communicating with members, or other issues related to its member population.

The Director of Marketing and Communications serves as chair of the CAC and works with the SEQI and the CEO to determine committee members, frequency of meetings, and agenda items. This is a non-voting committee and has no quorum requirements. The CAC meets on an ad hoc basis.

Specialty Advisory Groups

Magnolia recognizes the essential role of specialty-specific input when dealing with clinical issues of concern to providers. Magnolia has established two advisory groups to address concerns of its hospital network and its physician network, such as medical management

processes, special clinical needs of the population, clinical challenges, and clinical issues of concern to certain specialty groups. These advisory groups do not report to the BOD.

(1) The Hospital Advisory Committee (HAC): The HAC is an advisory group made up of key administrative hospital leaders and Magnolia staff, whose purpose is to address concerns of the hospital networks with regard to prior authorization, concurrent review, discharge planning, and coordination of care and payment. This committee meets annually and has neither voting privileges nor quorum requirements.

(2) The Provider Advisory Committee (PAC): PAC will be held to communicate Magnolia's programs and processes to its provider network, allowing for immediate and face-to-face discussion with the providers. The Committee represents, primary care, behavioral health and specialty practitioners.

The Hospital Advisory Committee and Provider Advisory Committee both meet on an ad hoc basis. The Vice President of Contracting/Network Management serves as chair of both the HAC and the PAC and works with committee members and internal departmental staff to set meeting frequency and agenda items. This committee meets annually and has neither voting privileges nor quorum requirements.

QI DEPARTMENT STAFFING

Staffing for the QI Department is determined based on membership and state contract requirements and will include, at a minimum, the following positions:

Director, Quality Improvement

The Director, Quality Improvement (QI) is a healthcare professional responsible for the direction, coordination, and oversight of activities for the Quality Improvement Department, including but not limited to appeals, grievances, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), and all clinical quality of care and quality of service provided to Magnolia members. The Director of QI reports to the Chief Executive Officer (CEO) and works in conjunction with management staff in monitoring the health care delivery of internal processes and procedures, provider network(s), and service and clinical quality, while assisting the executive staff, both clinical and non-clinical, in overseeing the activities of Magnolia operations to meet state contract requirements, NCQA standards, and Magnolia's goal of providing health care services that improve the health status and health outcomes of its members.

Quality Improvement Manager(s)

The Quality Improvement Managers are responsible for the facilitation of Quality Improvement activities throughout Magnolia. The QI Managers have significant experience working in health care settings involving project management and data analysis and dissemination. The scope of responsibility includes, but is not limited to, medical record audits, data collection for various quality improvement studies and activities, data analysis, implementation of improvement activities, grievances and complaints follow-up, and review of risk management and sentinel/adverse event issues. The QI Managers report to the Director of Quality Improvement and collaborate with other departments as needed to implement corrective actions or improvement initiatives as identified through Magnolia's Quality Improvement Program. Additionally, the QI Managers coordinate the documentation, collection, and reporting of HEDIS measures to both NCQA and the State, as required by

contract. The QI Managers are subject matter experts and are credentialed as Registered Nurses (RN).

PROGRAM RESOURCES

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 the QI activities.

Magnolia's management information systems utilize an Oracle-based Enterprise Data Warehouse (EDW) that allows for the collection, integration, and reporting of clinical claim/encounter data (medical, laboratory, pharmacy, behavioral health, dental, and vision as included in Magnolia benefits), financial information, medical management information (referrals, authorizations, case management, disease management), member services information (current and historical eligibility, demographics, primary care provider, member outreach) and provider information (participation status, specialty, demographics) as required by Magnolia's QAPI Program and other contractual requirements. Magnolia captures and utilizes data from both internal and subcontractor sources for administration, management, and other reporting requirements, and can also submit and receive data and interface with other systems as necessary.

The MicroStrategy reporting application is used to access the information stored in the EDW. By housing all of the information in the EDW, analysts are able to generate standard and ad hoc reports using standard query tools. Reports can also be generated directly from the data being produced and housed in Clinical Documentation Systems (CDS). Amisys Advance data is refreshed nightly in the EDW to allow for analysis of the most current data available. Reports can also be generated directly from the data being produced and housed in CDS. Many fields in the CDS clinical system are date- and time-stamped. Internal data sources for Magnolia's management information systems include:

Amisys
Amisys is a claims payment system maintains datasets indefinitely, whether online or stored at an off-site facility. Data set structures are built to maintain history for claims, members, providers, authorizations and many other transactions. Retroactive adjustments to each of the datasets are kept online for historical review. Amisys uses a date spanning process to capture historical records such as provider contracting arrangements. Amisys has a separate data set built just for auditing purposes. This dataset is built for redundancy and transactional tracking purposes.

Clinical Documentation System (CDS)
CDS is a clinical decision support criteria and documentation system related to Utilization Management and Care Management. The CDS has an interface for both inbound and outbound processes with Amisys. The inbound data interface (from Amisys to the CDS) supplies updated

provider and membership information for the quality and medical management staff. This update occurs on a daily basis and is an automated process. The outbound interface (from the CDS to Amisys) updates the claims system with authorization records. These records are mapped and loaded into the authorization dataset for adjudication purposes. Records are clearly separated by product, based on the member's linkage (i.e. Supplemental Security Income (SSI), Foster Care,

and Temporary Assistance for Needy Families). The CDS allows the Medical Management group to: integrate behavioral health, utilization, and case and disease management efforts; proactively identify, stratify, and monitor their high-risk populations; consistently determine appropriate levels of care and efficiently document the impact of Magnolia's programs and targeted interventions. The CDS combines Utilization and Care Management into a seamless process and improves communications among Case Managers. CDS houses a member's care plan, including all authorizations and clinical member contacts. All Magnolia clinical personnel (medical and behavioral) will have access to the CDS, which facilitates a holistic approach to each member and allows for monitoring and expeditious authorization of additional needed services. The expected results are improved clinical outcomes and medical-loss ratios, the elimination of redundant data entries, and access to data that helps evaluate and improve case management operations.

Quality Spectrum Insight® (QSI)

QSI is a Catalyst Technologies/MedAssurant Solution product, which supports performance measurement and QI reporting. QSI is an NCQA Certified Software system that produces results for HEDIS, state specific measures, P4P measures, internally designed QI studies, and Provider Reporting studies. QSI enables us to integrate claim, member, and provider 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 QSI suite of products provides Magnolia with an integrated clinical and financial view of care delivery, which enables Magnolia to identify cost drivers, help guide best practices, and to manage variances in its efforts to improve performance.

The QSI server and database is maintained internally at the corporate level and data is updated on at least a monthly basis by using an interface that extracts claims, member, provider and financial data and maps it to the QSI preferred data format. The software also allows for import of external, non-standard data, such as immunization registry, lab value data, and vision/dental encounter data. Magnolia staff is given access to view standard data summaries, or in some instances, drill down into the data or create ad hoc queries.

Magnolia obtains data and analytical support through the Information Systems Department and other support resources as deemed necessary, which may include corporate and health plan resources.

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 Magnolia'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 Magnolia's structure and processes of monitoring and improving the quality and safety of clinical care and the quality of services. The QI Program Description includes at least the following: specific roles, structure, and functions of the QI Committee and other committees, including meeting frequency; accountability to the governing body; a description of resources that are devoted to the QI Program Description; behavioral health care involvement; and patient safety.

The QAPI Program Description is reviewed on an annual basis. Changes or amendments made will be noted in the 'Revision Log'. Magnolia will submit the Program Description to the DOM at least annually, or upon request.

To implement the comprehensive scope of the QAPI Program, the QI Work Plan clearly defines the activities that must be completed by each department and all supporting committees throughout the measurement year. The annual QI Work Plan specifies the activities, the person(s) responsible for the activities, the dates of expected task completion, and the monitoring techniques that will be used to ensure completion within the established time frame. The QI Work Plan is approved by the QIC and the Magnolia Board of Directors on an annual basis. The QI Work Plan is reviewed at regular intervals throughout the year and as needed.

The QAPI Program Evaluation includes a summary of all QI activities, the impact the program has had on members' care, an analysis of the achievement of stated goals and objectives, and the need for program revisions and modifications. Program evaluation findings are used in developing an annual QAPI Program Description and QI Work Plan for the subsequent year. The SEQI and QI designee are responsible for coordinating the annual evaluation process. A written description of the evaluation is submitted to DOM annually. The Program Evaluation is reviewed and approved by the QIC and BOD at least annually.

The annual program evaluation identifies outcomes and includes, but is not limited to, the following:

- An evaluation of the overall effectiveness of the QI Program, including progress toward influencing network-wide safe clinical practices and effectiveness of case management
- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service provided to members with special health care needs
- Trending of measures collected over time to assess outcomes, effectiveness, and ongoing performance
- Interventions implemented to address the issues chosen for performance improvement projects and focused studies
- An analysis of whether there have been demonstrated improvements in the quality of clinical care and/or quality of services
- Identification of health care disparities and limitations or barriers to achieving program goals
- Recommendations for the upcoming year's QI Work Plan
- An evaluation of the scope and content of the QI Program Description to ensure that it covers all types of services in all settings and reflects demographic and health characteristics of Magnolia's member population
- An evaluation of resources and training related to the QI Program, and

- The communication of necessary information to other committees when problems or opportunities to improve patient care involve the intervention of more than one committee

CLINICAL PERFORMANCE MEASURES

As reported by NCQA, "HEDIS is one of the most widely used set of health care performance measures in the United States. HEDIS includes 70+ measures and five domains of care including: Effectiveness of Care, Access/Availability of Care, Experience of Care, Utilization and Relative Resource Use, and Health Plan Descriptive Information."

HEDIS rates are used by Magnolia as one of the primary sources to monitor, assess, and promote patient safety and quality of care. HEDIS is a collaborative process between Magnolia, Corporate QI, and several external vendors. Ultimate ownership and accountability of the HEDIS project and rates is the responsibility of the QI Department. Magnolia will report and monitor population-appropriate HEDIS measures as defined by NCQA and state contracts.

Magnolia will calculate and analyze HEDIS rates at least annually, utilizing Catalyst's NCQA certified Quality Spectrum Insight (QSI) software. HEDIS rates, analysis, and progress of work plan will be reported to the appropriate QI committee/subcommittee at least annually. HEDIS rates will be audited by an NCQA Certified Auditor and submitted to NCQA and the State of Mississippi, as required by state contract.

Magnolia will adopt non-HEDIS clinical performance measures as directed by the MS Division of Medicaid. Magnolia will calculate and analyze non-HEDIS rates at least annually, utilizing QSI software. Non-HEDIS rates, analysis, and progress of work plan will be reported to the appropriate QI committee/subcommittee at least annually. Non-HEDIS rates will be audited and submitted to the State of Mississippi, as required by state contract.

PROMOTING PATIENT 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. These activities will be both clinical and non-clinical in nature and include, but are not limited to the following:

Patient Safety

A key focus of the QAPI program, monitoring and promoting patient safety is integrated throughout many activities across the plan, primarily through identification of potential and/or actual quality of care events. A potential Quality of Care (QOC) issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care, or that signals a potential sentinel event (up to and including death of a member). Magnolia staff (including medical management, member services, provider services, grievance and appeal coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, Medical Directors or the BOD may advise the QI Department of potential quality of care issues. Adverse events may also be identified through claims based reporting. 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.

Magnolia routinely monitors for 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, and which results in one of the following injuries: death; brain or spinal damage; the performance of a surgical procedure on the wrong patient; the performance of a wrong surgical procedure; the performance of a wrong-site surgical procedure; the performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition; the surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage was not a recognized specific risk, as disclosed to the patient *and* documented through the informed-consent process; the performance of procedures to remove unplanned foreign objects remaining from a surgical procedure. Although the occurrence of an adverse event is not necessarily a significant quality of care issue, Magnolia monitors and tracks these occurrences for trends in type, location, etc., to monitor patient safety and may investigate further and/or request a corrective action plan at any time it feels there is a quality of care issue identified. These adverse events, also called Never Events, are reported to the DOM on a quarterly basis.

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

Access and Availability
The QIC provides oversight to the provider network in order to ensure adequate numbers and geographic distribution of PCPs, specialists, hospitals, and other providers, while taking into consideration the special and cultural needs of its members.

Provider availability is analyzed at least annually by the 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 Physicians (PCPs), specialty, behavioral health, dental, hospital, pharmacy, and ancillary providers. The QIC sets standards for the number and geographic distribution of PCPs, specialists, dental providers, hospitals, and pharmacies are in accordance with state contract requirements and action is taken if the standards are not met.

The QI Department analyzes practitioner appointment accessibility (Primary Care and Behavioral Health Care providers) at least annually, and Magnolia's Member Services (telephone accessibility). Results are reviewed by the QIC annually, as part of the QI Program Evaluation (to ensure compliance with contractual, regulatory, and accreditation requirements), as well as on a regular basis, in order to maintain appropriate appointment access and availability. Action is taken if standards are not met.

Member and Provider Satisfaction

Magnolia supports the ongoing measurement of clinical and non-clinical effectiveness and member and provider satisfaction, by monitoring complaints and provider call center performance. Magnolia 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, depending upon the intervention.

Magnolia solicits feedback from members or authorized designees, to assess satisfaction using a range of approaches, such as NCQA's Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction survey, monitoring member complaints, and direct feedback from the MAC. Magnolia will conduct the member satisfaction survey annually. The Quality Department is responsible for coordinating the CAHPS surveys, aggregating and analyzing the findings, and reporting the results. Survey results are reviewed by QI with reports presented to the QIC with specific recommendations for performance improvement interventions or actions. Member satisfaction with behavioral health services will be assessed by administering an annual member satisfaction survey using a valid survey methodology and standardized comprehensive survey tool. Behavioral Health survey results and action plans derived from these results will be reported to QIC.

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. Magnolia also uses another approach to obtain more real-time data related to new provider satisfaction. Provider Services Representatives conduct a ninety day post-enrollment survey with new providers to assess satisfaction, educate providers about operational matters, correct any misunderstandings related to Magnolia operations, and obtain prompt feedback if new providers are experiencing problems. Magnolia conducts a similar post-enrollment survey with new behavioral health providers.

Member Grievances and Appeals

The QI Department investigates and resolves all member quality of care concerns/grievances and member appeals. All grievances related to quality of care and service are tracked, classified according to severity, reviewed by the CMD, categorized by the QI Department, and reported and analyzed on a routine basis by the QIC. The QIC will recommend specific physician/provider improvement activities.

All administrative member complaints and grievances are tracked, and resolutions are facilitated by the Grievance designee. Data is reported to and analyzed by the QIC on a regular basis to identify trends and to recommend performance improvement activities as appropriate. Grievance reports are

submitted to the QIC at least quarterly, along with recommendations for QI activities, based on the results.

Provider Complaints and Appeals

All provider complaints are tracked and resolution is facilitated by the Provider Relations Department. Data is reported to and analyzed by the QIC on a regular basis, to identify trends and to recommend performance improvement activities as appropriate. Provider Appeals are facilitated at the Centene Corporate office and are reported to and analyzed by the QIC on a regular basis, to identify trends and to recommend performance improvement activities as appropriate.

Clinical Practice Guidelines and Preventive Health Guidelines

Clinical Practice Guidelines (CPG) and Preventive Health Guidelines (PHG) assist providers, members, authorized designees, and caregivers in making decisions regarding health care in specific clinical situations. Guidelines will be adopted in consultation with network providers

(including behavioral health as indicated) and will be 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 professions in the particular field; and needs of the members. Magnolia adopts clinical practice guidelines for at least two non-preventive acute or chronic medical conditions and at least two behavioral health conditions (preventive or non-preventive) relevant to the target population. At least two of the adopted CPGs must directly correspond with two disease management programs offered by Magnolia. Clinical and preventive health guidelines are updated at least annually or upon significant change or new scientific evidence. Guidelines are distributed to affected providers and, upon request, to members, potential members, authorized designees, and caregivers. Additionally, a listing of adopted clinical practice and preventive health guidelines is maintained on Magnolia's website, with the links and/or full guidelines available to print and a notation that hard copies are available upon request.

Practitioner adherence to Magnolia's adopted preventive and clinical practice guidelines is encouraged in the following ways: new provider orientations will include the practice guidelines section of the Provider Manual with discussion of Magnolia's expectations; measures of compliance will be shared in provider newsletter articles and on the provider website; targeted mailings that include guidelines relevant to specific provider types will underscore the importance of compliance; and Magnolia's Physician Profiling program, as discussed later in this document, will also work to promote compliance with CPGs.

At least annually, Magnolia measures practitioner compliance with at least two of its adopted clinical guidelines and preventive health guidelines. The analysis can be either population or practice based. Whenever possible, Magnolia will use applicable HEDIS measures to monitor practitioner compliance with adopted CPGs. If an appropriate HEDIS measures does not exist, the analysis methodology must allow Magnolia to aggregate results and analyze areas or parts of the guidelines that are not being used. If the performance measurement rates fall below set goals, Magnolia shall implement interventions for improvement as applicable. Outcomes of monitoring and analysis are presented to the QIC at least annually.

Continuity and Coordination of Care

Data is assessed from multiple varying activities then aggregated, reported, and reviewed annually. The following are examples of activities that monitor continuity and coordination of care, include but are not limited to:

Medical Care

1) Surveying Primary Care Physicians (PCP)s to assess their satisfaction with feedback from referred providers, including medical/surgical specialists, and other organizational providers
2) Assessing the effectiveness of inpatient discharge planning by monitoring re-admissions within 30 days of discharge
3) Assessing the quality of information via medical record review, including the exchange of information among medical providers including privacy protection
4) Conducting PCP office record reviews to assess the adequacy of consultant reports, discharge summaries, and home health reports from referred providers

Inpatient Acute Care Medical

1) Monitoring of the inpatient program and reporting to the QIC quarterly
2) Monitoring of the UM turnaround times and Care Management effectiveness
3) Assessing all member and provider grievances, appeals, and quality of care issues related to inpatient
4) Monitoring of provider-preventable conditions by referrals, claims data, member and provider complaints, medical record review, and utilization management activities
5) Monitoring of all unplanned acute readmissions within thirty days of discharge and monitoring of discharges that have a follow up PCP visit within seven days of discharge
6) Reviewing of complex members and members with long lengths-of-stay by the interdisciplinary discharge planning team

Between Medical and Behavioral Health Care

1) Assessing, through medical record review, the quality of the information exchange between medical and behavioral health providers
2) Reviewing PCPs' 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
3) Surveying PCPs to assess their satisfaction with feedback from referred behavioral health providers

Physician/Provider Profiling

Magnolia will systematically profile the quality of care delivered by high-volume PCPs to improve provider compliance with Clinical Practice Guidelines (CPG) and/or clinical performance measures.

Magnolia will build useful, understandable, and relevant analyses and reporting to improve care and compliance with performance measures. This effort helps to establish the foundation for physician acceptance of results leading to continuous quality improvement activities that yield performance improvements. Profiles will include a multidimensional assessment of a PCP or provider's performance using clinical and administrative indicators of care that are accurate,

measurable, and relevant to the target population. Additional assessment, at Magnolia's discretion, may include such elements as availability of extended office hours, member complaint rates, and compliance with medical record standards.

Physicians will receive an annual profile report with an individual score for each measure and a weighted composite score. Scores will be benchmarked per individual measure and compositely to the average of like-network providers and as applicable, to the then available NCQA Medicaid Mean. PCPs that meet or exceed established performance goals and demonstrate continued excellence, or significant improvement over time, may be recognized by Magnolia in publications such as newsletters, bulletins, press releases, and Magnolia Provider Directories.

Interventions will be implemented to address the performance of practitioners who are out of range (outliers) from their peers, and such interventions may include, but are not limited to, provider education, sharing of best practices and/or documentation tools, assistance with barrier analysis, development of corrective action plans, ongoing medical record reviews, and potential termination of network status when recommended improvements are not made. Providers who are identified as significantly outside the norm will be reassessed at six months.

Monitoring Utilization Patterns

To ensure appropriate care and service to members, the UMC performs an annual assessment of utilization data to identify potential over- and under-utilization issues or practices. Data analysis is conducted using various data sources such as medical service encounter data, pharmacy, and dental and vision encounter reporting, to identify patterns of potential or actual inappropriate utilization of services. The QI Department works closely with the UM Department, CMD, VPMM, and regional Medical Directors to identify problem areas and provide improvement recommendations to the QIC for approval. Once approved, the QI and UM departments will implement approved actions to improve appropriate utilization of services.

Preventive Health Reminder Programs

Population-based initiatives that aim to improve the 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 both 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 or face-to-face 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 them about 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 Early and Periodic Screening, Diagnostic and Treatment (EPSDT), immunizations, lead screening, cervical cancer screening, breast cancer screening, etc.

Chronic Care and Complex Care Management

As further defined in the Care Management (CM) Program description, Magnolia provides Care Management (Physical and Behavioral) and Disease Management for members identified as at risk, intervenes with specific programs of care, and measures clinical and other health related outcomes. These programs help members with complex health issues, which may include: physical disabilities, developmental disabilities, chronic conditions, and severe mental illness, by providing them with educational materials about their conditions and treatment options, and encouraging and supporting them in making informed treatment decisions about their health care in collaboration with their providers. Magnolia's Disease Management Program helps 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/or enrollment into Care Management. Programs also include written communications to providers, informing them of members on their panels with chronic conditions (such as diabetes and/or hypertension) and reminding them about appropriate screening and monitoring tests, as recommended per evidenced-based clinical practice guidelines. Magnolia's clinical management programs include, but are not limited to: asthma, obesity, sickle cell, diabetes, lead poisoning, inpatient transition of care, behavioral health, and high risk obstetrics management.

PERFORMANCE IMPROVEMENT ACTIVITIES

The QIC reviews and adopts an annual QI Program Description, QI Evaluation, and QI Work Plan that aligns with Magnolia's strategic vision and goals and managed Medicaid appropriate industry standards. The QI Department will implement at least four quality improvement activities on topics prevalent and significant to the population served, with a minimum of one focused on obesity. When relevant, the Performance Improvement Team incorporates behavioral health care providers in committees and decision-making.

Magnolia utilizes traditional quality/risk/utilization management approaches to identify activities that are relevant to Magnolia programs or a specific member population and that describe an observable, measurable and manageable issue. Most often, initiatives are identified through analysis of key indicators of care and service, based on reliable data, which indicates the need for improvement in a particular clinical or non-clinical area. Baseline data may come from: performance profiling of contracted physicians, 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. Other initiatives may be selected to test an innovative strategy or as required by state contract. Projects and focus studies reflect the population served in terms of age groups, disease categories, and special risk status.

The PIT will help to prioritize identified initiatives, focusing on those with the greatest need or expected impact on health outcomes and member satisfaction. Performance Improvement projects and other QI 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 committee will help to define the study question and the quantifiable indicators, criteria, and goals to ensure the project is measureable and able to show sustained improvement over time. 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 physicians and members in managing their health. If data collection is conducted for a random sample of the population, baseline and follow-up sampling shall be conducted using the same methodology and shall be statistically significant, with a ninety percent (90%) or more confidence level.

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

- A pre-defined benchmark level of performance is achieved.
- The improvement is reasonably attributable to interventions undertaken by Magnolia.

COMMUNICATING TO MEMBERS AND PROVIDERS

At least annually, Magnolia provides information, including a description of the QI Program and a report on Magnolia's progress in meeting QAPI Program goals, to members and providers. At a minimum, the communication shall include information about QI program goals, processes, and outcomes, as they relate to member care and service, and must include plan-specific data results such as HEDIS, CAHPS, and results of Performance Improvement Projects. The primary distribution sources are the Member Newsletter, the Provider Newsletter, and the Magnolia website. Information about obtaining a hard copy description of the program is included on the website.

REGULATORY COMPLIANCE AND REPORTING

Magnolia adheres to all federal, state, and local rules and regulations as applicable. Magnolia departments perform required quality of service, clinical performance, and utilization studies throughout the year, based on contractual requirements, requirements of other state and regulatory agencies, and those of applicable accrediting bodies such as NCQA. All Magnolia functional areas utilize standards/guidelines from these sources and those promulgated by national and state medical societies or associations, the Center for Disease Control, and the federal government.

The QI Department maintains a schedule of relevant QI reporting requirements for all applicable state and federal regulations and submits reports in accordance with all requirements. Magnolia will maintain and make available to the Division, CMS, Office of Inspector General (OIG), the Medicaid Fraud Control Unit, and state and federal auditors, all studies, reports, protocols, standards, work plans, work sheets, committee minutes, committee reports to the BOD, medical records, and such further documentation as may be required by the DOM, concerning quality activities and corrective actions.

DELEGATED SERVICES

Magnolia may contract with outside entities such as Independent Practice Associations (IPA), hospitals, Managed Behavioral Health Organizations (MBHO), or Pharmacy Benefit Manager (PBM) to perform select activities (such as UM, credentialing, or claims payment) on Magnolia's behalf. Magnolia will evaluate 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, shall include, but is not limited to, the following elements:

- Responsibilities of Magnolia and the delegate
- Specific activities being delegated
- Frequency and type of reporting
- The process by which Magnolia evaluates the delegate's performance, which includes reporting at least twice annually
- 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 shall also include PHI provisions typically accomplished in the form of a Business Associate Agreement signed by the delegated entity.

Behavioral Health

Management of behavioral health utilization program is delegated to Envolve People Care Behavioral Health (EPC BH). The following activities, as further clarified and defined in the associated delegation agreement, have been delegated to EPC BH:

- Utilization Management and Appeals (member and provider)

Magnolia, in collaboration with EPC BH, will collect data, monitor, and evaluate improvements on Utilization Management outcomes resulting from behavioral health services

Dental Services

Management of dental care services is delegated to Envolve Dental. The following activities, as further clarified and defined in the associated delegation agreement, have been delegated:

- Benefit Management
- Provider Network Development and Maintenance
- Credentialing and Re-credentialing
- Claims Processing and Payment
- Utilization Management

Magnolia, in collaboration with Envolve, will collect data, monitor, and evaluate improvements on Utilization Management outcomes resulting from dental services. Care Management and Quality Improvement Program activities are not delegated to Envolve Dental.

Disease Management Services

Envolve People Care Disease Management (EPC DM) administers the disease management programs for select disease types. EPC DM is accredited by NCQA for Disease Management.

The following activities, as related to disease management and as further clarified and defined in the associated delegation agreement, have been delegated to EPC DM:

- Development of DM programs
- Program Staffing
- Member Identification, Assessment, and Engagement in DM programs
- Targeted Member Outreach and Education
- Select Quality Improvement Activities

Magnolia, in collaboration with EPC DM, will collect data, monitor, and evaluate improvements on Disease Management outcomes.

24-Hr Nurse Advice Line

Management of a 24-Hour Nurse Advice line is delegated to Envolve People Care. The following activities, as further clarified and defined in the associated delegation agreement, have been delegated to EPC:

- 24-hour nurse advice and emergency triage
- After-Hours/Emergency-Outage Member and Provider services hotline
- Select Outbound Member call campaigns

Magnolia, in collaboration with EPC, will collect data, monitor, and evaluate improvements on the 24 hr Nurse Advice Line.

Pharmacy Management Services

Envolve Pharmacy Solutions (Envolve Rx) serves as Magnolia's Pharmacy Benefit Manager (PBM). The pharmacy benefit aspects of the following activities, as further clarified and defined in the associated delegation agreement, have been delegated to Envolve Rx:

- Select Utilization Management
- Network Development and Maintenance
- Claims Processing and Payment
- Rebate Administration

Magnolia, in collaboration with EPC DM, will collect data, monitor, and evaluate improvements on pharmacy outcomes.

Vision Care Services

Management of routine vision care services is delegated to Envolve Vision. The following activities, as further clarified and defined in the associated delegation agreement, have been delegated to Envolve Vision:

- Benefit Management
- Utilization Management
- Provider Network Development and Maintenance
- Credentialing and Re-credentialing
- Claims Processing and Payment

Magnolia, in collaboration with Envolve Vision, will collect data, monitor, and evaluate improvements on vision outcomes. Care Management and Quality Improvement Program activities are not delegated to Envolve Vision.

Magnolia retains accountability for any functions and services delegated, and as such will monitor the performance of the delegated entity through: annual approval of the delegate's program (Credentialing, UM, QI, 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 Magnolia standards and program requirements. UM, QI and/or Compliance designee(s) in conjunction with Centene Corporate Quality Improvement designee(s), will conduct an annual evaluation and documentation review to include the delegate's program, applicable policies and procedures, applicable file reviews, and review of meeting minutes for compliance with Magnolia and/or NCQA standards. Magnolia retains the right to reclaim the responsibility for performance of delegated functions, at any time, if the delegate is not performing adequately.

Magnolia Health Quality Improvement Committee has reviewed and adopted this document, including the QI Work Plan (Program Approval Signature on file within the QI Department).

ENDORSEMENT OF THE QI Program Description

The 2018 QI Program Description has been revised and endorsed by the Board effective this ___ day of ___, 2018.

__________________ Signature on File ______________________________
Board Chairman Date

___________________ Signature on File ____________________________
Senior Executive of Quality Improvement Date

This signature page shall be signed by the Magnolia Health Plan Board of Directors Chairman, and SEQI, as appropriate, once approved.