2021
MississippiCAN Quality Management Program Description

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PURPOSE

Magnolia Health is committed to the provision of a well-designed and well-implemented Quality Program. The health plan's culture, systems, and processes are structured around its mission to improve the physical and behavioral health of all enrolled members. The Quality Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of health care provided to all members, including those with special needs. This systematic approach to quality improvement provides a continuous cycle for assessing the quality of care and services in such areas as preventive health; acute and chronic care; population health management; behavioral health; over- and under-utilization; continuity and coordination of care; patient safety; and administrative, member, and network services.

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

In order to fulfill its responsibility to members, the community and other key stakeholders, and regulatory and accreditation agencies, the health plan's Board of Directors has adopted the following Quality Program Description. The Quality Improvement Committee and Magnolia Health's Board of Directors review and approve the QI program description at least annually.

SCOPE

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

Magnolia's Quality Program includes the following:

- Identification of priorities and goals aligning with Centene Corporation's mission and the health priorities defined by the CDC 6|18 Initiative, Healthy People 2020 and 2030, the National Institutes of Health, and other evidence-based sources;
- Conducting quality activities, including peer review activities, in accordance with all applicable state and federal confidentiality laws and regulations and taking conflicts of interest into consideration when conducting peer review activities;

- A focus on cultural competency and health equity, including the identification of interventions to improve health disparities based on age, race, ethnicity, sex, primary language, etc. and by key population group;
- Assessment and identification of interventions to address health disparities at a statewide and regional level, including identifying internal priorities for disparity reduction and quality measure improvement and addressing inequalities;
- A robust Quality Committee structure, including subcommittees and additional ad hoc committees as applicable, to meet the needs of the health plan, members, and providers;
- Allocation of personnel and resources necessary to:
  - support the Quality Program, including data analysis and reporting;
  - meet the educational needs of members, providers, and staff relevant to quality improvement efforts; and
  - meet all regulatory and accreditation requirements;
- The technology infrastructure and data analytics capabilities to support goals for quality management and value include health information systems that provide data collection, integration, tracking, analysis, and reporting of data that reflects performance on standardized measures of health outcomes;
- An ongoing documentation cycle that includes the Quality Program Description, the Quality Work Plan, and a Quality Program Evaluation; these documents demonstrate a systematic process of quality assessment, identification of opportunities, action implementation as indicated, and ongoing evaluation;
- Collecting and submitting all quality performance measurement data per state, federal, and accreditation requirements, including robust performance management tracking and reporting such as:
  - The annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) (Qualified Health Plan [QHP] Enrollee Experience survey for the Marketplace product line, when applicable) (CAHPS is a registered trademark of the Agency for Healthcare Research and Quality [AHRQ]);
  - Annual Health Outcomes Survey (HOS®); (HOS is a CMS-developed survey tool which assesses a health plan's ability to maintain or improve the physical and mental health of Medicare members over time);
  - Healthcare Effectiveness Data and Information Set (HEDIS®) results for members (HEDIS is a registered trademark of the National Committee for Quality Assurance [NCQA]);
  - Developing additional standardized performance measures that are clearly defined, objective, measurable, and allow tracking over time; and/or
  - Administering an annual provider satisfaction survey and identifying improvement activities based on identified areas of provider need/dissatisfaction;
- Monitoring, assessing, and promoting patient safety including efforts to prevent, detect, and remediate quality of care and critical incidents and a peer review process that addresses deviations in the provision of health care and action plans to improve services;
- Ensuring member access to care in areas such as network adequacy, availability of services, timely appointment availability, transitions of coverage, coordination and continuity of care, etc.;
- Encouraging providers to participate in quality initiatives and giving support to providers, including a provider analytics system that delivers frequent, periodic quality improvement information to participating providers in order to support them in their

efforts to provide high quality health care, and adoption and distribution of evidence-based practice guidelines;

- Conducting and assessing quality improvement and performance improvement projects based on demonstration of need and relevance to the population served, with improvement initiatives aligned with identified health priorities and state/federal requirements and applicable member population(s);
- Monitoring utilization patterns by performing assessment of utilization data to identify potential over- and under-utilization issues or practices using various data sources such as medical, behavioral health, pharmacy, dental, and vision claim/encounter data to identify patterns of potential or actual inappropriate utilization of services;
- A Population Health Management (PHM) Strategy focused on four key areas of member health needs (keeping members healthy, managing members with emerging health risk, patient safety/outcomes across settings, and managing multiple chronic illnesses) that offers interventions to address member needs in all stages of health and across all health care settings;
- Serving members with complex health needs, including members needing complex care management and long-term services and supports (LTSS), as applicable;
- Achieving/maintaining NCQA accreditation and/or other applicable accreditations for appropriate products;
- Monitoring for compliance with all regulatory and accreditation requirements; and
- Collaboration with Compliance and other applicable departments concerning oversight of delegated functions and services, including approval of the delegate's programs, routine reporting of key performance metrics, and ongoing evaluation to determine whether the delegated activities are being carried out according to health plan and regulatory requirements and accreditation standards.

PRIORITIES AND GOALS

Magnolia Health's 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.

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

Transforming the Health of the Community, One Person at a Time		
Better Health Outcomes at Lower Costs		
Focus on Individuals	**Whole Health**	**Active Local Involvement**

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

CONFIDENTIALITY

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

The proceedings of the QIC, its subcommittees, work groups, and/or any ad hoc peer review committees are considered "Privileged and Confidential" and are treated as such. In this regard, all correspondence, worksheets, quality documents, minutes of meetings, findings, and recommendations for the programs are considered strictly confidential and therefore not legally discoverable.

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

- Board of Directors
- President and Chief Executive Officer (CEO)
- Chief Medical Director, Vice President of Medical Management (VPMM), Vice President/Director of Quality, and designated Quality Department staff
- Peer Review Committee
- External regulatory agencies, as mandated by applicable state/federal laws
- Plan legal executives
- Compliance leadership

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 a Quality

and/or Credentialing Committee of a health plan-affiliated entity or that of a contracted medical group/independent physician association.

Magnolia Health has adopted the following confidentiality standards to ensure quality proceedings remain privileged:

- All peer review and quality related correspondence documents are appropriately labeled "Privileged and Confidential, Peer Review" and maintained in locked files/secure electronic files;
- Confidentiality policies and procedures comply with applicable state statutes that address protection of peer review documents and information;
- Committee members and employees responsible for Quality, Population Health and Clinical Operations, Behavioral Health, Credentialing, and Pharmacy program activities are educated about maintaining the confidentiality of peer review documents;
- The Vice President of Quality designates Quality Department staff responsible for taking minutes and maintaining confidentiality;
- For quality studies coordinated with or provided to outside peer review committees, references to members are coded by identification number rather than a protected health information (PHI) identifier such as medical record number or ID number, with references to individual providers by provider code number;
- Records of review findings are maintained in secured files, which are made available only as required by law or when specifically authorized in writing by the CEO, Chief Medical Director, Legal Counsel, VPMM, or the Board of Directors Chairman; and
- All participating providers and employees involved in peer review activities or who participate in quality activities or committees are required to sign confidentiality agreements.

CONFLICT OF INTEREST

Magnolia Health 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. Peer reviewers may not participate in decisions on cases where the reviewer is the consulting practitioner or where the reviewer's partner, associate, or relative is involved in the care of the member, or cases in which the practitioner or other consultant has previously reviewed the case. When a practitioner 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 COMPETENCY

Magnolia Health endeavors to meet the needs of all members with sensitivity to cultural needs and the impact of cultural differences on health services and outcomes. Magnolia Health 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. Magnolia Health assures communications are culturally sensitive, appropriate, and meet federal and state requirements. Population health management initiatives are reviewed to assure cultural issues and social determinants of health are identified, considered, and addressed. Additionally,

Magnolia Health is committed to improving disparities in care as an approach to improving HEDIS measures, reducing utilization costs, and delivering locally tailored, culturally relevant care. As such, Magnolia Health 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. As part of the annual program evaluation, Magnolia Health also reviews member needs from a cultural competency standpoint; analyzes data for cultural, ethnic, race, and linguistic issues; and addresses identified barriers.

AUTHORITY

Magnolia Health's Board of Directors has authority, responsibility, 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 QIC 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, defining the role of a physician in the Quality Program, and defining the role of a behavioral health practitioner in the Quality Program; and
- Evaluating the Quality Program Description and Quality Work Plan annually to assess whether program objectives were met and recommending adjustments when necessary.

The Board of Directors delegates the operating authority of the Quality Program to the QIC. Magnolia Health 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 QIC, which is directly accountable to the Board of Directors.

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

- Compliance with state, federal, and accreditation requirements and regulations;
- Chairing the QIC, 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 QIC;
- Coordinating the resolution of outstanding issues with the appropriate leadership staff, pertaining to QIC recommendations, subcommittee recommendations, and/or other stakeholder recommendations;

- Being actively involved in Magnolia Health's Quality Program including: 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 guidelines; assisting in ongoing patient care monitoring as it relates to preventive health/sponsored wellness programs, pharmacy, diagnostic-specific case reviews, and other focused studies; and directing credentialing and re-credentialing activities in accordance with Magnolia Health's policies and procedures;
- Reporting the Quality Program activities and outcomes to the Board of Directors at least annually.

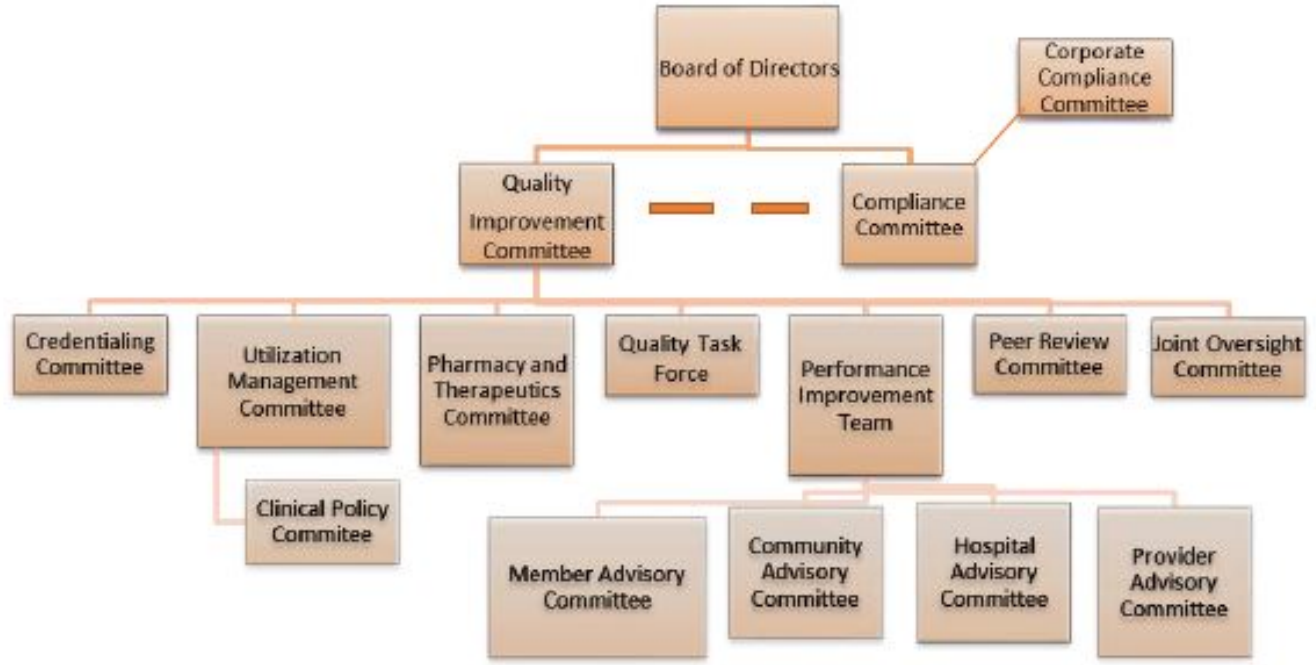
Behavioral Health Medical Director supports the core benefits and services for members with behavioral health issues and/or diagnosis, the Quality Improvement program, the Population Health Management and Clinical Outcomes, and grievance systems.

QUALITY PROGRAM STRUCTURE

Quality is integrated throughout Magnolia Health and represents a 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 QIC.

The QIC is the senior management-led committee reporting to the Board of Directors. Magnolia Health has established subcommittees and work groups based on Magnolia Health's needs as well as regulatory and accreditation requirements. 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 Magnolia Health committee structure is outlined below.

Magnolia Health Committee Structure for 2021



Magnolia Health Core Committee Charters

Quality Improvement Committee (QIC)
Charter Statement: The Quality Improvement Committee (QIC) is Magnolia Health Plan's (Magnolia) senior leadership committee, accountable to the Board of Directors (BOD) that reviews and monitors all clinical, physical, and behavioral health quality and service functions of Magnolia and provides oversight of all sub-committees, except for the Compliance Committee which reports directly to the BOD. The Magnolia Senior Director for Quality Improvement, as designated by the CEO, or as designated by the BOD in the absence of a CEO, is responsible for the implementation of the QI Program.

Purpose:

The purpose of the Quality Improvement Committee (QIC) is 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. The QIC will review and direct clinical, physical, behavioral health, and service operational activities provided to Magnolia members. This will be accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring, identification, evaluation, and resolution of process problems; identification of opportunities to improve member outcomes; and the education of members, providers, and staff regarding the Quality Improvement (QI), Utilization Management (UM), Credentialing, and Pharmacy programs. This is a multi-disciplinary committee of Magnolia senior leadership staff 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 Committee acts as an oversight committee and receives regular reports from all Magnolia sub-committees that are accountable to and/or advise the Committee. QIC activities include, but are not limited to, review of clinical, physical, behavioral health, and non-clinical issues affecting Magnolia; coordination of actions of other sub-committees; and making decisions regarding quality improvement functions.

Objectives of the Committee and Relationship to Strategic Objectives:

- Review clinical, physical, and behavioral health quality recommendations submitted by the Quality sub-committees.
- Collect and report data reflecting Magnolia's performance on standardized measures of health outcomes.
- Establish an effective management information system to provide the framework for monitoring quality of care or service provided.
- Identify opportunities for improving health outcomes.
- Recommend resources necessary to support the ongoing educational needs of participating providers and Magnolia staff relative to current managed care technologies.
- Annually evaluate the effectiveness of the Quality Improvement, Utilization Management, Credentialing, and Pharmacy programs.
- Annually review and approve the QI, UM, CM, Credentialing, and Pharmacy programs.
- Make recommendations to the Magnolia sub-committees regarding monitoring, follow-up, barrier analysis, and interventions required in order to improve the quality of care or service to Magnolia members.
- Review/establish benchmarks or performance goals for each quality improvement initiative and service indicator.
- Facilitate the identification of system-wide trends and implement corrective action in order to improve performance.
- Review due diligence information for any potential delegated entity and provide oversight to those entities already delegated.
- Oversee the implementation of disease management programs, health education activities, cultural competency programs, and patient safety initiatives.
- Prioritize quality improvement efforts and assure the appropriation of resources required to carry out QI activities.

Committee Structure and Operation:

The Committee will meet:	Quarterly – date and time to be determined based on availability of committee members and may be combined with the Utilization Management and Compliance Committee. Additional meetings may be scheduled as needed.
Committee Facilitator:	Vice President (VP) of Quality Improvement or designee
Committee Recorder:	QI designee. The Chair is responsible for approving the documented proceedings that reflect all QIC decisions.
Committee Composition:	Magnolia Administrator/CEO VP, Medical Affairs Chief Medical Director (chair) Medical Directors (including Behavioral Health) Magnolia Network Physicians (minimum of 2, with at least1 Behavioral Health) Nurse Practitioner (minimum of 1) VP, Medical Management (VPMM) Director, MM (Ambetter/Allwell) Sr. Director, MM Director of Utilization Management VP, Quality Improvement (QI) Manager, Provider Relations VP, Network Development & Contracting VP, Operations VP, Compliance VP, Pharmacy QI Director and Managers Director, Marketing & Communications Sr. Manager, Operations Pharmacy Director Finance Officer/CFO Chief Operating Officer (COO) ► If a participant will be absent, she/he is responsible to discuss and provide input/proxy to the Facilitator on topics to be presented whenever possible. ► If a participant cannot attend, no replacement is needed; if a participant is responsible for an agenda item, reschedule the item to the next meeting and/or use another avenue to update the group ► Each participant is responsible to work with his/her peers to understand meeting events and assignments.
Attendance Requirement:	75% of scheduled meetings
Quorum:	A minimum of 5 members, including 3 plan staff and 2 external physicians, must be present for a quorum.

Committee Data/Document Responsibilities:

Meetings will be agenda driven. All agendas and minutes will follow Magnolia's standard format.

Scheduling: QI designee

Agenda: The QIC chairs and/or QI designee will develop agenda items for the next meeting.

Minutes: Minutes will be drafted and distributed within thirty (30) business days of the meeting. The minutes will be approved and signed by the Chair at the next regularly scheduled meeting. Minutes will be maintained in a secure area.

Handouts/Meeting Packets: Documents will be emailed (or hard copies will be mailed) to Network Physician committee members approximately 1-2 weeks before the scheduled meeting date.

Decision Authority:

The Magnolia Board of Directors authorizes the Quality Improvement Committee to make all decisions related to the Quality Improvement Program, quality activities, and processes.

- ► Decisions are made by consensus.
- ► Individuals are responsible to raise any concerns/issues at the committee meetings.

Evaluation:

The Committee will review the charter annually in conjunction with the annual QI Program Description, QI Work Plan, QI Program Evaluation, Credentialing Program Description, and UM Program Description.

Other:

Confidentiality:

- ► Each Committee Member is accountable to identify confidential information or situations when/if the dissemination of the information needs to be managed in a specific manner.
- ► Each External Committee Member must agree to and sign a committee confidentiality statement.

Credentialing Committee (CC)

Charter Statement:

The Credentialing Committee (CC) has the responsibility for credentialing and re-credentialing physicians, non-physician practitioners, facilities, long-term care providers, and other practitioners (physical and behavioral health) in the Magnolia network and to oversee the credentialing process to ensure its compliance with regulatory and accreditation requirements.

Purpose:

The Credentialing Committee shall ensure network providers, facilities, and practitioners are qualified, properly credentialed, and available for access by Magnolia members.

Objectives of the Committee and Relationship to Strategic Objectives:

1. Provide guidance to organization staff on the overall direction of the Credentialing Program.
2. Review and approve credentialing and recredentialing policies and procedures.
3. Review and recommend credentialing and recredentialing criteria.
4. Possess final authority to approve or disapprove applications by providers for network participation status and recredentialing.
5. Provide access to clinical peer input when discussing standards of care for a particular type of provider.
6. Review the oversight audits of delegated networks' Credentialing Program performance.
7. Evaluate and report to Magnolia's management on the effectiveness of the Credentialing Program.

Committee Structure and Operation:

The Committee will meet: Monthly, but no less than ten times per year to facilitate timely review of providers and to expedite network development. Additional meetings can be scheduled as needed.

Committee Facilitator: Magnolia's Chief Medical Director serves as Chair. Corporate Credentialing Liaison will serve as Facilitator.

Committee Recorder: Administrative Assistant or Credentialing designee. The Magnolia Medical Director is responsible for approving the documented proceedings that reflect Credentialing decisions.

Committee Composition:

VP of Medical Affairs
Magnolia Medical Director
Centene Credentialing designee
Magnolia Network Physicians from the following Specialties:

- Family Practice/Internal Medicine
- OB/GYN (high volume specialists)
- Behavioral Health
- Nurse Practitioner

Magnolia Medical Director may designate other members as needed to participate in the committee.
Ad Hoc Members: Magnolia CEO/COO/CFO

Attendance Requirement: 75% of scheduled meetings

Quorum: 50% of voting members

Committee Data/Document Responsibilities:
Meetings will be agenda driven. All agendas and minutes will follow Magnolia's standard format.

Scheduling: Credentialing designee

Agenda:	The CC Chair and Credentialing designee will develop agenda items for the next meeting.
Minutes:	Minutes will be drafted and distributed within thirty (30) business days of the meeting. The minutes will be approved and signed by the Chair at the next regularly scheduled meeting. Minutes will be maintained in a secure area.
Handouts/Meeting Packets:	Copies will be provided by email to the meeting attendees.

Decision Authority:
The Quality Improvement Committee has delegated to the Credentialing Committee (CC) the responsibility for credentialing and re-credentialing physicians, facilities, and other providers.

- ► Decisions are made by consensus.
- ► Individuals are responsible to raise any concerns/issues at the committee meetings.

Evaluation:

The Committee will review the charter annually.

Pharmacy & Therapeutics Committee (P&T)

Charter Statement:

The Magnolia Health Pharmacy & Therapeutics (P&T) Committee is a multidisciplinary team of Magnolia network providers that coordinates its efforts with Magnolia's pharmacy operations, ensuring a high quality pharmacy program. Magnolia's P&T Committee addresses quality and utilization issues related to pharmaceuticals. This team also functions as the link between the state Drug Utilization Review Board and Magnolia, and it ensures Magnolia's compliance with state pharmaceutical mandates.

Purpose:

The purpose of the Magnolia P&T Committee is to review health plan pharmaceutical management, preferred drug lists, and other activities that may affect access and patient safety and to make recommendations regarding drug utilization review activities such as targeted prescriber and/or member education initiatives, as needed.

Objectives of the Committee:

1. Discuss issues and make determinations related to Pharmacy & Therapeutics on an as needed basis.
2. Review policies and procedures related to the pharmaceutical management.
3. Review the list of pharmaceuticals and updates as appropriate.
4. Review of Magnolia contractual and regulatory requirements to ensure compliance with all mandates.
5. Support implementation of the Quality Improvement Program (QIP).
6. The minutes will be provided to the Division of Medicaid, Office of Pharmacy.

Committee Structure and Operation:
The Committee will meet: Annually – date and time to be determined based on availability of committee members.

Committee Chair: Chief Medical Director

Committee Facilitator:	Director of Pharmacy
Committee Recorder:	The Chief Medical Director or designee is responsible for approving documented proceedings that reflect P&T Committee decisions.
Committee Composition:	VP, Medical Affairs Chief Medical Director Magnolia Associate Medical Directors VP, Pharmacy Magnolia Director of Pharmacy Magnolia Network Physicians and Pharmacist(s) – noted below In addition, Magnolia Executive Leadership and staff may also participate actively in the proceedings of the P&T; however, they will be non-voting members. ► Additional members may be added to the P & T by the health plan at any time, as the need arises. ► If a participant will be absent, she/he is responsible to discuss and provide input/proxy to the facilitator on topics to be presented whenever possible. ► If a participant cannot attend, no replacement is needed; if a participant is responsible for an agenda item, reschedule the item to the next meeting and/or use another avenue to update the group. ► Each participant is responsible to work with his/her peers to understand meeting events and assignments.
Attendance Requirement:	75% of scheduled meetings
Quorum:	50% of voting members

Committee Data/Document Responsibilities:

Meetings will be agenda driven. All agendas and minutes will follow Magnolia's standard format.

Scheduling:	Pharmacy designee or Administrative Assistant
Facilitator:	Director of Pharmacy
Agenda:	The P&T Chair will develop the agenda items for the meeting.
Minutes:	Minutes will be drafted and distributed within thirty (30) business days of the meeting for approval. The minutes will be approved and signed by the Chair. Minutes will be maintained in a secure area.

Handouts/Meeting Packets: Copies will be emailed to committee members approximately 2 weeks before the scheduled meeting date.

Decision Authority:
The Committee is authorized by the Quality Improvement Committee (QIC) to review Magnolia's Pharmacy operations.

- ► Decisions are made by consensus.
- ► Individuals are responsible to raise any concerns/issues at the committee meetings.

Evaluation:
The Committee will review the charter annually.

Other:
Confidentiality:

- ► Each Committee Member is accountable to identify confidential information or situations when/if the dissemination of the information needs to be managed in a specific manner.
- ► Each External Committee Member must agree to and sign a confidentiality statement.

Utilization Management Committee (UMC)

Charter Statement:
The Utilization Management Committee (UMC) is accountable to the QIC. The primary function is to monitor the appropriateness of care and guard against over- and under-utilization of health care services provided to members. The UMC reports to the BOD through the QIC, unless extenuating circumstances require immediate direct reporting by the UMC to the BOD.

Purpose:
The purpose of this committee is to review and monitor the appropriateness of care (physical and behavioral health) and guard against over- and under-utilization of services provided to Magnolia members.

Objectives of the Committee and Relationship to Strategic Objectives:

Oversee the Utilization Management activities of Magnolia to ensure compliance with State and accrediting body regulations

1. Annually review and approve the UM program description, guidelines, and procedures.
2. Annually review and approve the criteria for determination of medical appropriateness to be used for nurse review.
3. Adapt criteria for determination of medical appropriateness to work within the delivery system.
4. Review provider specific reports for trends or patterns in utilization.
5. Review and analyze information related to provider contracts.
6. Review reports specific to facility or geographic areas for trends or patterns.
7. Formulate recommendations for specific providers for further study.
8. Monitor the adequacy of the network to meet the needs of the patient population.
9. Examine reports of the appropriateness of care for trends or patterns of under- or over-utilization and refer them to the proper provider group for performance improvement or corrective action.
10. Examine results of annual surveys of members and providers regarding satisfaction with the UM program.
11. Include a feedback mechanism for communicating findings and recommendations, and contain a plan for implementing corrective actions.
12. Report findings to the QIC.

13. Liaison with the QIC for ongoing review of indicators of clinical quality.

Committee Structure and Operation:

The Committee will meet:	Quarterly – date and time to be determined based on availability of committee members. Additional meetings may be scheduled as needed.
Committee Facilitator:	Chair, Chief Medical Director. The VPMM will serve as Facilitator.
Committee Recorder:	Administrative Assistant or UM designee. The Chief Medical Director is responsible for approving the documented proceedings that reflect all UMC decisions.
Committee Composition:	VP, Medical Affairs Chief Medical Director (chair) Behavioral Health Medical Director VP, Medical Management Director of Utilization Management Sr. Director of Medical Management VP, Quality Improvement QI Manager (Accreditation) VP, Compliance VP, Network Development and Contracting VP, Pharmacy VP, Operations Other Magnolia operational staff as requested Ad Hoc Members: Magnolia CEO/COO/CFO ► If a participant will be absent, she/he is responsible to discuss and provide input/proxy to the facilitator on topics to be presented whenever possible. ► If a participant cannot attend, no replacement is needed; if a participant is responsible for an agenda item, reschedule the item to the next meeting and/or use another avenue to update the group. ► Each participant is responsible to work with his/her peers to understand meeting events and assignments.
Attendance Requirement:	75% of scheduled meetings
Quorum:	50% of voting members

Committee Data/Document Responsibilities:

Meetings will be agenda driven. All agendas and minutes will follow Magnolia's standard format.

Scheduling:	Administrative Assistant or UM designee
Facilitator:	Chair, Chief Medical Director

Agenda:	The Committee Chair in collaboration with the VP/Director of MM will develop agenda items for the next meeting.
Minutes:	Minutes will be drafted and distributed within thirty (30) days of the meeting. The minutes will be approved and signed by the Chair at the next regularly scheduled meeting. Minutes will be maintained in a secure area.
Handouts/Meeting Packets:	Documents will be provided in the meeting invite via email.

Decision Authority:

The Committee is authorized by the Quality Improvement Committee to make all decisions regarding the utilization of clinical care and services provided on behalf of Magnolia to Magnolia members.

- ► Decisions are made by consensus.
- ► Individuals are responsible to raise any concerns/issues at the committee meetings.

Evaluation:
The Committee will review the UM Program Description and Charter annually. The Committee will also review the annual Pharmacy & Therapeutics Program Description and Pharmacy & Therapeutics Program Evaluation.

Other:

Confidentiality:	► Each Committee Member is accountable to identify confidential information or situations when/if the dissemination of the information needs to be managed in a specific manner. ► Each External Committee Member must agree to and sign a committee confidentiality statement.

Peer Review Committee (PRC)
Charter Statement: The PRC is an ad hoc committee that includes peer level representation coordinated for reviewing alleged inappropriate or aberrant service by a provider, including quality of care concerns, adverse events, and sentinel events where initial investigation indicates a significant potential or significant, severe adverse outcome has occurred
Purpose: To review clinical physical and behavioral health cases and apply clinical judgment in assessing the appropriateness of clinical and behavioral health care and recommending a corrective action plan that will best suit the particular provider's situation.
Objectives of the Committee and Relationship to Strategic Objectives: 1. To make determinations regarding appropriateness of care. 2. To make recommendations regarding corrective actions relating to provider quality of care.
Committee Structure and Operation: The Committee will meet: As needed – date and time to be determined based on availability of committee members. Additional meetings may be scheduled as needed.

Committee Facilitator:	Chair, Magnolia Chief Medical Director/Medical Director as appropriate
Committee Recorder:	QI designee
Committee Composition:	Chief Medical Director/Medical Director as appropriate VP, Quality Improvement Peer Physicians of same/similar specialty VP, Medical Affairs Ad Hoc Members: Magnolia CEO/COO/CFO
Attendance Requirement:	75% of scheduled meetings
Quorum:	50% of voting members

Committee Data/Document Responsibilities:
Meetings will be agenda driven. All agendas and minutes will follow Magnolia's standard format.

Scheduling:	Peer Review Chair Designee
Facilitator:	Chair, Magnolia CMD/Medical Director
Agenda:	The QI designee will develop agenda items for the next meeting.
Minutes:	Minutes will be drafted and distributed within thirty (30) days of the meeting. The minutes will be approved and signed by the Chair at the next regularly scheduled meeting. Minutes will be maintained in a secure area.

Handouts/Meeting Packets: Blinded copies will be mailed to the designated Lead Network Physician for each case approximately 2 weeks before the scheduled meeting date. All others will receive copies at the meeting.

Decision Authority:
The PRC is authorized by the Quality Improvement Committee to make decisions and recommendations regarding provider quality of care. The PRC reports and is accountable to the Quality Improvement Committee.

Evaluation:
The Committee charter is reviewed annually.

Other:

Confidentiality:

- ► Each Committee Member is protected by peer review laws governing confidentiality of Committee proceedings.
- ► Each Committee Member is accountable to identify confidential information or situations when/if the dissemination of the information needs to be managed in a specific manner.
- ► Each External Committee Member must agree to and sign a committee confidentiality statement.

Meeting Frequency:
As needed – date and time to be determined based on availability of committee members. Additional meetings may be scheduled as needed.

Performance Improvement Team (PIT)
Charter Statement: The PIT is an internal, management level, cross-functional quality improvement team. The PIT is responsible for gathering and analyzing data, identifying barriers to quality improvement, resolving problems, and/or making recommendations for performance improvements.
Purpose: To gather, analyze, and identify barriers to the quality improvement process for physical and behavioral health.
Objectives of the Committee and Relationship to Strategic Objectives: 1. Review and evaluate key clinical quality and service performance indicators. 2. Promptly initiate ad hoc performance improvement initiatives (including corrective action plans) to address any negative trends. 3. Review, categorize, track, and trend grievances, administrative reviews, and requests for external reviews. Determine appropriate disposition and follow-up. 4. Monitor resource allocation to ensure appropriate support for the Quality Improvement Program. 5. Track progress of tasks in the annual QI Work Plan and make recommendations to improve quality activities noted in the Work Plan as needed, in response to issues raised by the QIC. 6. Provide ongoing reports to the QIC, as appropriate, on the progress of clinical and performance improvement initiatives. 7. Review Magnolia's operational policies and procedures at least annually and recommend modifications as necessary.
Committee Structure and Operation: The Committee will meet: Monthly but no less than ten (10) times per year. Committee Facilitator: Magnolia CMD or CMD designee serves as Chair. Committee Recorder: QI Designee Committee Composition: VP, Medical Affairs Medical Director(s) Management Staff from functional areas: Population Health and Clinical Operations Quality Improvement Grievance & Appeals Pharmacy Director Operations Provider Relations/Contracting Member/Provider Services Additional staff may participate as requested by the Chair. Ad Hoc Members: Magnolia CEO/COO/CFO Attendance Requirement: 75% of scheduled meetings Quorum: 50% of voting members
Committee Data/Document Responsibilities: Meetings will be agenda driven. All agendas and minutes will follow Magnolia's standard format.

Scheduling:	QI Designee
Facilitator:	Chair, Magnolia Medical Director, Quality Improvement
Agenda:	The PIT Chair will develop agenda items for the next meeting.
Minutes:	Minutes will be drafted and distributed within thirty (30) days of the meeting. The minutes will be approved and signed by the Chair at the next regularly scheduled meeting. Minutes will be maintained in a secure area.
Handouts/Meeting Packets:	Documents will be provided in the meeting invite via email.
Decision Authority: The PIT Committee is authorized by the Quality Improvement Committee to make decisions and recommendations regarding performance improvement processes. The Performance Improvement Team reports to the Quality Improvement Committee.	
Evaluation: The Committee charter is reviewed annually.	
Other: **Confidentiality:**	► Each Committee Member is accountable to identify confidential information or situations when/if the dissemination of the information needs to be managed in a specific manner. ► Each External Committee Member must agree to and sign a committee confidentiality statement.
Meeting Frequency: The PIT meets monthly, no less than 10 times per year, and reports to QIC on a quarterly basis.	

Quality Task Force (QTF)
Charter Statement: The QTF Committee is Magnolia's senior leadership committee responsible for monitoring and improving HEDIS scores for physical and behavioral health. The QTF reports directly to the QIC.
Purpose: The purpose of the QTF Committee is to oversee the HEDIS process at the plan level. The QTF will review monthly rate trending, identify data concerns, and communicate Corporate initiatives to Magnolia senior leadership. The QTF will direct member and provider initiatives, both clinical and non-clinical, to improve HEDIS scores.
Objectives of the Committee and Relationship to Strategic Objectives: 1. Review monthly and final HEDIS scores. 2. Analyze HEDIS scores to determine areas in need of improvement. 3. Review, approve, and implement Corporate-led initiatives. 4. Develop initiatives to improve selected HEDIS measures. 5. Oversee the implementation, progression, and outcomes monitoring of initiatives specific to HEDIS. 6. Recommend resources necessary to support the ongoing improvement of HEDIS scores. 7. Review/establish benchmarks or performance goals for HEDIS. 8. Oversee delegated vendor roles in improving HEDIS scores.

Committee Structure and Operation:

The Committee will meet: Monthly, no less than 10 times per year

Committee Facilitator: Quality Improvement

Committee Chair: Chief Medical Director or CMD designee

Committee Recorder: Administrative Assistant or QI designee

Committee Composition:
VP, Operations
VP, Medical Affairs
CMD or Medical Director
VP, Medical Management
VP, Quality Improvement/Manager QI
VP, Contracting/Network Management
Member/Provider Services Management
VP/Director/Manager Pharmacy
VP/Director/Manager Provider Relations
Other members as deemed necessary
Ad Hoc Members: Magnolia CEO/COO/CFO

Attendance Requirement: 75% of scheduled meetings

Quorum: 50% of voting members

Committee Data/Document Responsibilities:
Meetings will be agenda driven. All agendas and minutes will follow Magnolia's standard format.

Scheduling: QI designee

Facilitator: Quality Improvement

Agenda: The Committee Chair and/or QI designee will develop agenda items for the next meeting.

Minutes: Minutes will be drafted and distributed within thirty (30) days of the meeting. The minutes will be approved and signed by the Chair at the next regularly scheduled meeting. Minutes will be maintained in a secure area.

Handouts/Meeting Packets: Documents will be provided in the meeting invite via email.

Decision Authority:
The QTF is authorized by the Quality Improvement Committee (QIC) to make decisions and recommendations regarding corrective actions. The QTF reports to the QIC.

Evaluation:
The Committee charter is reviewed annually.

Other:

Confidentiality:	► Each Committee Member is accountable to identify confidential information or situations when/if the dissemination of the information needs to be managed in a specific manner. .

Member Advisory Committee (MAC)

Charter Statement:
The MAC is a group of members, parents, guardians, and Magnolia staff as appropriate, that reviews and reports on a variety of quality improvement issues**.**

Purpose:
The primary purpose is to review member satisfaction survey results, evaluate the performance level of Magnolia's Member Hotline, and provide feedback on member related service issues**.**

Objectives of the Committee and Relationship to Strategic Objectives:
The MAC solicits member and provider input into the quality improvement program. Based on plan size and distribution, the MAC may include regional level committees that will report up to the central office MAC.

Committee Structure and Operation:

The Committee will meet:	No less than semi-annually.
Committee Facilitator:	Director of Marketing & Communications
Committee Recorder:	Community Relations Representative
Committee Composition:	Magnolia Member Services representatives Magnolia Members/Guardians of MHP Members Magnolia Staff as appropriate
Attendance Requirement:	Magnolia Health Plan Members may not be standing members of the Committee. Therefore, there is no minimum meeting attendance requirement.
Quorum:	This is not a voting committee

Committee Data/Document Responsibilities:
Meetings will be agenda driven. All agendas and minutes will follow Magnolia's standard format.

Scheduling:	Community Relations Representative
Facilitator:	Director, Marketing & Communications
Agenda:	The Committee Chair will develop agenda items for the next meeting.
Minutes:	Minutes will be drafted within thirty (30) days of the meeting. The minutes will be approved and signed by the Chair at the next regularly scheduled meeting. Minutes will be maintained in a secure area.

Handouts/Meeting Packets: Copies will be provided at the meeting.

Decision Authority:

The MAC is a non-voting committee to solicit feedback from the perspective of Magnolia's membership. This Committee reports to the Performance Improvement Team, which reports to the QIC.

Evaluation:

The Committee charter is reviewed annually.

Meeting Frequency:

The MAC meets no less than semi-annually.

Other Confidentiality:

- ► Each Committee Member is accountable to identify confidential information or situations when/if the dissemination of the information needs to be managed in a specific manner.
- ► Each External Committee Member must agree to and sign a committee confidentiality statement.

Community Advisory Committee (CAC)

Charter Statement:

The Community Advisory Committee is a statewide advisory committee that is responsible to provide Magnolia with feedback and to make recommendations regarding health plan performance from a community and provider-based perspective.

Purpose:

To obtain feedback on Magnolia's quality improvement program and performance from community representatives and regional community advisory committee.

Objectives of the Committee and Relationship to Strategic Objectives:

1. Provide Magnolia with feedback regarding its performance from a community-based perspective.
2. Make recommendations related to program enhancements based on the needs of the local community.
3. Assist Magnolia to identify key issues related to programs that may specifically affect certain community groups.
4. Provide community input on potential health plan service improvements.
5. Offer effective approaches for reaching or communicating with members or other issues related to Magnolia's member population.

Based on plan size and distribution, the Community Advisory Committee may include regional level committees that will report up to the central office committee.

Committee Structure and Operation:

The Committee will meet: On an ad hoc basis.

Committee Facilitator: Director, Marketing & Communications

Committee Recorder: Community Relations Representative

Committee Composition: The Chair appoints members of the Committee.
Representation from key community stakeholders such as:

- Church leaders
- Local business leaders
- Representatives from advocacy groups
- Other community based organizations.

Community representatives to serve one year terms.

Attendance Requirement: There is no minimum meeting attendance requirement.

Quorum: This is not a voting committee

Committee Data/Document Responsibilities:

Meetings will be agenda driven. All agendas and minutes will follow Magnolia's standard format.

Scheduling: Administrative Assistant

Facilitator: Chair, Magnolia Director of Marketing & Communications

Agenda: The CAC Chair will develop agenda items for the next meeting.

Minutes: Minutes will be drafted and distributed within fifteen (15) business days of the meeting. The minutes will be approved and signed by the Chair at the next regularly scheduled meeting. Minutes will be maintained in a secure area.

Handouts/Meeting Packets: Copies will be provided at the meeting.

Decision Authority:

The Community Advisory Committee is a non-voting committee to solicit feedback from local community stakeholders. This Committee reports to the Performance Improvement Team, which reports to the QIC.

Evaluation:

The Committee charter is reviewed annually.

Meeting Frequency:

This committee meets on an ad hoc basis.

Other

Confidentiality:

► Each Committee Member is accountable to identify confidential information or situations when/if the dissemination of the information needs to be managed in a specific manner.

► Each External Committee Member must agree to and sign a committee confidentiality statement.

Hospital Advisory Committee (HAC)

Charter Statement:

The Hospital Advisory Committee is an advisory group made up of key administrative hospital leaders and Magnolia plan staff to address concerns of the hospital networks concerning prior authorization, concurrent review, discharge planning, and coordination of care and payment for physical and behavioral health.

Purpose:

To address concerns of the hospital networks concerning prior authorization, concurrent review, discharge planning, and coordination of care and payment.

Objectives of the Committee and Relationship to Strategic Objectives:

1. Provide Magnolia with feedback regarding its performance from a hospital-based perspective regarding prior authorizations, concurrent review, discharge planning, and coordination of care and payment.
2. Make recommendations related to utilization management and care and payment coordination based on the needs of the hospital groups.
3. Assist Magnolia to identify key issues related to programs that may specifically affect certain hospital groups.

Committee Structure and Operation:

The Committee will meet: Annually

Committee Facilitator: VP/Director of Contracting/Network Management (Chair)

Committee Recorder: Contracting/Network Management Designee

Committee Composition: The Chair appoints members of the Committee.

Representation from hospital groups (serving one year terms)

Attendance Requirement: There is no minimum meeting attendance requirement.

Quorum: This is not a voting committee

Committee Data/Document Responsibilities:

Meetings will be agenda driven. All agendas and minutes will follow Magnolia's standard format.

Scheduling: Contracting/Network Designee

Facilitator: Chair, VP/Director of Contracting/Network Management

Agenda: The HAC Chair will develop agenda items for the next meeting.

Minutes: Minutes will be drafted within thirty (30) days of the meeting. The minutes will be approved and signed by the Chair at the next regularly scheduled meeting. Minutes will be maintained in a secure area.

Handouts/Meeting Packets: Copies will be provided at the meeting.

Decision Authority:

The Hospital Advisory Committee is a non-voting committee to solicit feedback from local hospital representatives. This Committee reports to the QIC.

Evaluation:

The Committee charter is reviewed annually.

Meeting Frequency:

This committee meets on an annual basis.

Other Confidentiality:

►Each Committee Member is accountable to identify confidential information or situations when/if the dissemination of the information needs to be managed in a specific manner.

►Each External Committee Member must agree to and sign a committee confidentiality statement.

Provider Advisory Committee (PAC)
Charter Statement: The Provider Advisory Committee, or "Physician Summits", will be held to communicate Magnolia's programs and processes to its provider network, allowing for immediate and face-to-face reaction and discussion with the providers.
Purpose: To communicate Magnolia's programs and processes to its provider network, allowing for immediate and face-to-face reaction and discussion with the providers
Objectives of the Committee and Relationship to Strategic Objectives: 1. Provide Magnolia with feedback regarding programs and processes from a community provider-based perspective. 2. Allow providers to make recommendations related to Magnolia's programs and processes. 3. Assist Magnolia to identify key issues related to programs that may affect community providers.
Committee Structure and Operation: The Committee will meet: Annually Committee Facilitator: VP/Director of Contracting/Network Management and Chair Committee Recorder: Contracting/Network Designee Committee Composition: The Chair appoints members of the Committee. Representation from the provider network (serving one year terms) Attendance Requirement: There is no minimum meeting attendance requirement. Quorum: This is not a voting committee.
Committee Data/Document Responsibilities: Meetings will be agenda driven. All agendas and minutes will follow Magnolia's standard format.

Scheduling:	VP/Director of Contracting/Network Management
Facilitator:	Chair, VP/Director of Contracting/Network Management
Agenda:	The PAC Chair will develop agenda items for the next meeting.
Minutes:	Minutes will be drafted and distributed within thirty (30) days of the meeting. The minutes will be approved and signed by the Chair at the next regularly scheduled meeting. Minutes will be maintained in a secure area.
Handouts/Meeting Packets:	Copies will be provided at the meeting.
Decision Authority: The Provider Advisory Committee is a non-voting committee to solicit feedback from local provider representatives. This Committee reports to the QIC.	
Evaluation: The Committee charter is reviewed annually.	
Meeting Frequency: This committee meets on an annual basis.	
Other	
Confidentiality:	► Each Committee Member is accountable to identify confidential information or situations when/if the dissemination of the information needs to be managed in a specific manner. ► Each External Committee Member must agree to and sign a committee confidentiality statement.

The Compliance Committee is a Magnolia core committee that reports directly to the Magnolia BOD and Centene Corporate Compliance Committee. The Quality Department's role with the Compliance Committee is to ensure all quarterly meetings are held and minutes are provided as defined in the committee charter.

Compliance Committee
Charter Statement: The Compliance Committee consists of a cross-functional team that is responsible to provide Magnolia with feedback and to make recommendations regarding health plan compliance issues. This Committee reports directly to the BOD.
Purpose: To assist in the maintenance of the compliance program for both physical and behavioral health.
Objectives of the Committee and Relationship to Strategic Objectives: 1. Analyze the organization's environment, the legal requirements with which it must comply, and specific risk areas. 2. Assess existing policies and procedures that address these areas for possible incorporation into the compliance program. 3. Work with appropriate departments to develop standards of conduct and policies and procedures to promote compliance with the company's program.

4. Recommend and monitor, in conjunction with relevant departments, the development of internal systems and controls to carry out the organization's standards, policies, and procedures as part of its daily operations.
5. Assist the Compliance Officer in monitoring, reviewing, and assessing the effectiveness of the Compliance Program and timeliness of reporting.
6. Determine the appropriate strategy/approach to promote compliance with the program and detect potential violations, such as through the Ethics and Compliance or BEAF Hotlines and other fraud and abuse reporting mechanisms.
7. Maintain a system to solicit, evaluate, and respond to complaints and problems, including being involved in reports made to Centene's Ethics & Compliance and BEAF hotlines to provide Magnolia with feedback regarding its performance from a community-based perspective.

Committee Structure and Operation:

The Committee will meet: Quarterly – date and time to be determined based on availability of committee members. Additional meetings may be scheduled as needed.

Committee Facilitator: Compliance Officer will serve as Chair.

Committee Recorder: Administrative Assistant

Committee Composition: Magnolia Administrator/CEO
Compliance Officer
VP, Medical Affairs
Chief Medical Director
VP, Medical Management
VP, Quality Improvement
VP/Director of Contracting
VP/Director of Member/Provider Services
Finance Officer/CFO
Director of Human Resources
Chief Operating Officer

Attendance Requirement: 75% meeting attendance

Quorum: 50% of voting members

Committee Data/Document Responsibilities:
Meetings will be agenda driven. All agendas and minutes will follow Magnolia's standard format.

Scheduling: Administrative Assistant

Facilitator: Chair, Magnolia Compliance Officer

Agenda: Agenda items for the next meeting will be developed by the Compliance Committee Chair.

Minutes:	Minutes will be drafted and distributed within thirty (30) days of the meeting. The minutes will be approved and signed by the Chair at the next regularly scheduled meeting. Minutes will be maintained in a secure area.
Handouts/Meeting Packets: Copies will be provided at the meeting.	
Decision Authority: The Compliance Committee has been given the authority to provide feedback and make recommendations regarding compliance issues. The Committee reports directly to Magnolia's Board of Directors, as well as to Centene's Corporate Compliance Committee also on a quarterly basis.	
Evaluation: The Committee charter is reviewed annually.	
Meeting Frequency: Quarterly – date and time to be determined based on availability of committee members. Additional meetings may be scheduled as needed.	
Other **<u>Confidentiality:</u>**	► Each Committee Member is accountable to identify confidential information or situations when/if the dissemination of the information needs to be managed in a specific manner. ► Each External Committee Member must agree to and sign a committee confidentiality statement.
Joint Oversight Committee (JOC)	
Charter Statement: The JOC provides oversight of all delegated entities utilized by Magnolia to provide services to members for both physical and behavioral health.	
Purpose: To provide oversight of delegated entities' activities to ensure the delegated activities are being carried out according to State, NCQA, and/or Magnolia standards.	
Objectives of the Committee and Relationship to Strategic Objectives: 1. Review all quality improvement activities of delegated entities and provide feedback regarding opportunities for action. 2. Ensure all delegated entities remain in compliance with State, NCQA, and/or Magnolia standards. 3. Recommend the placement of a Corrective Action Plan (CAP) when a designated entity's activities are found to be deficient. 4. Monitor any Corrective Action Plans in place and determine when those CAPs may be removed.	
Committee Structure and Operation: The Committee will meet:	Quarterly, but no less than twice annually. These meetings may take place in the form of teleconferences.
Committee Facilitator:	VP, Operations or designee
Committee Recorder:	Vendor management designee

Committee Composition: VP, Operations or designee
Vendor Manager
VP/Director of Medical Management
VP, Medical Affairs
Medical Director
VP, Contracting/Network Development
VP, Quality Improvement/Manager QI
Director/Manager of Member Services
Director/Manager of Provider Relations

Attendance Requirement: 75% of scheduled meetings

Quorum: This is not a voting committee.

Committee Data/Document Responsibilities:

Meetings will be agenda driven. All agendas and minutes will follow Magnolia's standard format.

Scheduling: VP Operations or designee

Facilitator: VP Operations or designee

Agenda: Agenda items for the next meeting will be developed by the VP of Compliance or designee.

Minutes: Minutes will be drafted and distributed within thirty (30) days of the meeting. The minutes will be approved and signed by the Chair at the next regularly scheduled meeting. Minutes will be maintained in a secure area.

Handouts/Meeting Packets: Copies will be provided at the meeting or distributed via email.

Decision Authority:

The JOC has been given the authority to provide feedback and make recommendations regarding delegated entities. The Committee reports to the Quality Improvement Committee.

Evaluation:

The Committee charter is reviewed annually.

Meeting Frequency:

Quarterly, but no less than twice annually. These meetings may take place in the form of teleconferences.

Clinical Policy Committee (CPC)

Charter Statement:

The Clinical Policy Committee (CPC) ensures that clinical policies provide a guide to medical necessity, are reviewed and approved by appropriately qualified Mississippi licensed physicians, and are available to all physicians and providers servicing our members.

Purpose:

The purpose of the Clinical Policy Committee (CPC) is to provide a guide to medical necessity. Benefit determinations should be based, in all cases, on the applicable contract provisions governing plan benefits ("Benefit Plan Contract") and applicable state and federal requirements, as well as applicable plan-level administrative policies and procedures. To the extent there are any conflicts between these policies and the Benefit Plan Contract provisions, the Benefit Plan Contract provisions will control.

Clinical policies are intended to be reflective of current scientific research and evidence-based clinical standards. Clinical policies are not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment given to members. All clinical policies are available to providers in compliance with all federal, statutory, and regulatory requirements and upon request.

Objectives of the Committee and Relationship to Strategic Objectives:

Coordinating development of new local clinical policies and review of both proposed new and/or changes to existing corporate clinical policies.

Committee Structure and Operation:

The Committee will meet: Quarterly – date and time to be determined based on availability of committee members. Additional meetings may be scheduled as needed.

Committee Facilitator: Director of Utilization Management

Committee Recorder: UM designee. The Chair is responsible for approving the documented proceedings that reflect all CPC decisions.

Committee Composition:
VP, Medical Affairs
Chief Medical Director (chair)
Magnolia Network Physicians (minimum of 2, with at least 1 BH)
VP, Medical Management
Director of Utilization Management
VP, Quality Improvement
Pharmacy Director
Medical Directors

► If a participant cannot attend, no replacement is needed; if a participant is responsible for an agenda item, reschedule the item to the next meeting and/or use another avenue to update the group.
► Each participant is responsible to work with his/her peers to understand meeting events and assignments.

Attendance Requirement: 75% of scheduled meetings

Quorum: A minimum of 5 members, including 3 plan staff and 2 external physicians, must be present for a quorum.
Committee Data/Document Responsibilities: Meetings will be agenda driven. All agendas and minutes will follow Magnolia's standard format. Scheduling: UM designee or CMD Agenda: The CPC Chair and/or UM designee will develop agenda items for the next meeting. Minutes: Minutes will be drafted and distributed within thirty (30) business days of the meeting. The minutes will be approved and signed by the Chair at the next regularly scheduled meeting. Minutes will be maintained in a secure area. Handouts/Meeting Packets: Documents will be emailed (or hard copies will be mailed) to Network Physician committee members approximately 1-2 weeks before the scheduled meeting date.
Decision Authority: The CPC is a subcommittee of the Utilization Management committee who is authorized by the Quality Improvement Committee (QIC) to make all decisions related to Magnolia's clinical policies. The QIC reports to the Board of Directors, who have the ultimate authority, responsibility, and accountability for health plan operations. ► Decisions are made by consensus. ► Individuals are responsible to raise any concerns/issues at the committee meetings.
Evaluation: The Committee will review the charter annually in conjunction with the annual QI Program Description and UM Program Description.
Other: **<u>Confidentiality</u>:** ► Each Committee Member is accountable to identify confidential information or situations when/if the dissemination of the information needs to be managed in a specific manner. ► Each External Committee Member must agree to and sign a committee confidentiality statement.

QUALITY DEPARTMENT STAFFING

The Quality Department staffing model is outlined below. Department staffing is determined by membership, products offered, and (when applicable) state and/or federal contract requirements and should include, at a minimum, the following positions.

Magnolia Health Staffing

Chief Medical Director/Medical Director(s)	The health plan's Chief Medical Director and any supporting Medical Directors (including a behavioral health Medical Director) must have an active, unencumbered license in accordance with the health plan's state laws and

	regulations. The CMD will oversee and be responsible for the proper provision of core benefits and services to members, the Quality Program, the Population Health and Clinical Operations Programs, and the Grievance System.

Quality VP/Director	The VP/Director of Quality is a registered nurse, or other qualified person, with experience in health care, data analysis, barrier analysis, and project management as it relates to improving the clinical quality of care and quality of service provided to the members. The Quality VP/Director reports to identified executive leadership and is responsible for directing the activities of the quality staff in monitoring and auditing the plan's health care delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality, and clinical quality. The Quality VP/Director assists the senior executive staff, both clinical and non-clinical, in overseeing the activities of the operations to meet the goal of providing health care services that improve the health status and health outcomes of its members. Additionally, the Quality VP/Director coordinates the Quality Improvement Committee proceedings in conjunction with the Chief Medical Director; supports corporate initiatives through participation on committees and projects as requested; reviews statistical analysis of clinical, service, and utilization data; and recommends performance improvement initiatives while incorporating best practices as applicable.
Quality Managers	The Quality Managers are registered nurses. Quality Managers are responsible for management and oversight of quality and performance monitoring. Their responsibilities include working with multiple departments to establish objectives, policies, and strategies; assure quality initiatives focused on improving operational and program efficiencies; focus on initiatives to improve member outcomes; develop systematic processes and structures that will assure quality; and ensure Magnolia's commitment to enabling quality improvements.
Quality Improvement Coordinator	Quality Improvement Coordinators (QICs) are highly trained clinical staff with significant experience in a health care setting and experience with data analysis and/or project management. At least one of the health plan's QICs is a registered nurse. The QIC's scope of work includes data collection for various quality improvement studies and activities; development and implementation of initiatives to improve HEDIS rates; conducting year round targeted medical record retrieval, data entry, and abstraction in the HEDIS User Interface (HUI) system; and performing duties as assigned during the annual HEDIS hybrid project. A QIC may specialize in one area of the quality process or may be cross-trained in several areas. The QICs collaborate with other departments as needed to implement improvement initiatives as identified through the health plan's quality improvement activities.
Provider Partnership Associate	Provider Partnership Associates (PPAs) are highly trained clinical staff with significant experience in a health care setting and experience with data analysis and/or project management. At least one of the health plan's PPAs is a registered nurse. The PPA's scope of work includes conducting onsite provider visits for HEDIS education, acting as a liaison between the provider and health plan to ensure a coordinated effort in improving financial and quality performance, data analysis and implementation of improvement activities, supplying status updates

	for providers regarding incentive agreements, and conducting annual medical record review audits.

HEDIS Director/Manager	The HEDIS Project Director/Manager is a highly trained individual with significant experience in managed health care, data analysis, and project management. The HEDIS Project Director/Manager is responsible for maintaining departmental documentation to support state contract requirements and accreditation standards including, but not limited to, applicable policies and procedures, quality focus studies, quality improvement activities, routine control monitoring reports, meeting minutes, access and availability analysis, member experience analysis, continuity and coordination of care, delegated vendor oversight, and annual evaluation of the effectiveness of the Quality Program. The HEDIS Project Director/Manager collaborates with other departments as needed to implement corrective action or improvement initiatives as identified through the health plan's quality improvement activities and quality of care reviews. Additionally, the HEDIS Project Director/Manager coordinates the documentation, collection, and reporting of HEDIS measures to both NCQA and the State as required.

Accreditation Manager	The responsibilities of the Accreditation Manager include ensuring compliance with NCQA accreditation requirements, conducting routine readiness assessments, evaluating policies and procedures, and reviewing processes and records. He or she develops, implements, and leads a process for ensuring that the health plan achieves and maintains NCQA accreditation. The incumbent establishes and implements objectives, policies, and strategies to maintain a continual state of accreditation readiness and to achieve successful accreditation status for the health plan. The Accreditation Manager serves as the Subject Matter Expert for accreditation for the health plan.

INTER/INTRADEPARTMENTAL QUALITY PROGRAM RESOURCES

The Quality Department maintains strong inter/intradepartmental working relationships, with support integrated throughout the health plan to address the goals and objectives of the Quality Program and assess effectiveness of the program. Collaborative activities include development of department objectives and plans, coordination of activities to achieve department goals, and participation on quality committees as needed to support the Quality Program. Partnerships include, but are not limited to, the health plan departments/functional areas identified below:

- Population Health and Clinical Operations
- Pharmacy
- Provider Engagement/Provider Relations
- Network/Contracting
- Member Services
- Compliance
- Grievances & Appeals

QUALITY PROGRAM /ADDITIONAL PROGRAM RESOURCES

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

Magnolia Health has the technology infrastructure and data analytics capabilities to support goals for quality management and value. Magnolia Health's 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. Magnolia Health 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 Magnolia 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 Magnolia 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, Magnolia develops defined data collection and reporting plans to build custom measures and reports, as applicable. Magnolia 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 Magnolia's 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 Magnolia 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 coordination and care, behavioral health, condition, and utilization management. Integrated with Centelligence for access to supporting clinical data, TruCare allows Population Health and Clinical Operations 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 criteria and clinical policies; and to capture the impact of programs and interventions. TruCare also houses an integrated appeals management module that supports the appeals process from initial review through resolution and reports on all events along the process, as well as 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 –** Magnolia's 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.

Magnolia Health obtains data and analytical support through the Information and Management Systems Department, Corporate Quality, Health Economics, and other support resources as deemed 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 Magnolia Health's continuous quality improvement cycle using a predetermined documentation flow such as the following:

- Quality Program Description
- Quality Work Plan
- Quality Program Evaluation

Quality Program Description: The Quality Program Description is a written document that outlines Magnolia Health's structures and processes to monitor and improve the quality and safety of clinical care and the quality of services. The Quality Program Description includes at least the following: specific roles, structure, and function of the QIC and subcommittees/work groups, including meeting frequency and accountability to the governing body; a description of dedicated Quality Program staff and resources; and behavioral health care involvement. No less than annually, ideally during the first quarter of each calendar year, the designated quality staff prepares, reviews, and revises, as needed, the Quality Program Description. The Quality Program Description is reviewed and approved by the QIC and Board of Directors on an annual basis. Changes or amendments are noted in the "Revision Log". Magnolia Health submits any substantial changes to its Quality Program Description to the QIC and appropriate state agency for review and approval as required by state contract, if applicable.

At the discretion of Magnolia Health, the Quality Program Description may include structure and process outlines for applicable functional areas within the health plan, or each department may maintain its own program description. In either case, all program descriptions are formally approved or accepted by the QIC at least annually.

Quality Work Plan: To implement the comprehensive scope of the Quality Program, 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.

The Work Plan is developed annually after completing the Quality Program Evaluation for the previous year, and it includes all 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;
- Staff members responsible for each activity;
- Monitoring of previously identified issues; and
- Evaluation of the Quality Program.

Magnolia Health utilizes the existing Work Plan and confirms compliance with the health plan's current needs and the most recent updates from NCQA and assures the Work Plan reflects all current state and/or federal requirements. Work Plan status reports are reviewed by the QIC on a regular basis (e.g. quarterly or semiannually). The Work Plan is a fluid document; designated Quality staff make frequent updates to document progress of the Quality Program throughout the year.

At the discretion of Magnolia Health, the Quality Work Plan may include activities of all applicable departments (Member Services, Utilization Management, Care Management (physical & BH), Provider Services, Credentialing, etc.) within the health plan, or each department may maintain its own work plan independently. In either case, all work plans are formally approved or accepted by the QIC at least annually.

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 (physical & BH), complex case management, condition management, and safety of clinical care. Program Evaluation findings are incorporated in the development of the annual Quality Program Description and Quality Work Plan for the subsequent year. The senior quality executive and Quality VP/Director are responsible for coordinating the evaluation process and a written description of the Evaluation and Work Plan is provided to the QIC and Board of Directors for approval annually.

The annual Quality Program Evaluation identifies outcomes and includes, but is not limited to, evaluation of the following:

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

At the end of the Quality Program cycle each year (calendar year, unless otherwise specified by state contract), the Quality Department facilitates/prepares the Quality Program Evaluation. The evaluation assesses both progress in implementing the quality improvement strategy and the

extent to which the strategy is in fact promoting the development of an effective Quality Program. Recommended changes in program strategy or administration and commitment of resources that have been forwarded and considered by the QIC should be included in the document.

In addition to providing information to the QIC, the annual Program Evaluation, or an executive summary as appropriate, can be used to provide information to a larger audience such as accrediting agencies, regulators, stockholders, new employees, and the Board of Directors.

CLINICAL PERFORMANCE MEASURES

As reported by NCQA, HEDIS is one of the most widely used sets of health care performance measures in the United States. HEDIS includes measures across 5 domains of care including: Effectiveness of Care, Access and Availability, Satisfaction with the Experience of Care, Use of Services, Cost of Care, Health Plan Descriptive Information, Health Plan Stability, and Informed Health Care Choices.
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HEDIS rates and state performance metrics are used by Magnolia Health as one of the primary sources to monitor, assess, and promote patient safety and quality of care. HEDIS is a collaborative process between the health plan, Corporate Quality, and several external vendors. Ultimate ownership and accountability of the HEDIS project, HEDIS and CAHPS survey metrics, as well as state and CMS performance metrics are the responsibility of the health plan. Magnolia Health reports and monitors population-appropriate metrics as defined by NCQA and/or state and federal contracts.

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

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. Magnolia Health 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 Magnolia Health's 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 and Clinical Operations 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, Magnolia Health 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.

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

Access and Availability - Magnolia Health's QIC provides oversight to the provider network in order to ensure adequate numbers and geographic distribution of primary care, specialty, and behavioral health practitioners, while taking into consideration the special and cultural needs of members.

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

The Quality Department analyzes practitioner appointment accessibility (primary, specialty, and behavioral health care practitioners) and Member Services telephone accessibility at least annually. Results are reviewed by the QIC and included in the annual Quality Program Evaluation to ensure compliance with contractual, regulatory, and accreditation requirements and to maintain appropriate appointment access and availability.

Member and Provider Experience - Magnolia Health supports continuous ongoing measurement of clinical and non-clinical effectiveness and member and provider experience by monitoring member and provider complaints and appeals, member and provider satisfaction surveys, and member and provider call center performance. The health plan collects and analyzes data at least annually to measure its performance against established benchmarks or standards and identifies and prioritizes improvement opportunities. Specific interventions are developed and implemented to improve performance and the effectiveness of each intervention is measured at specific intervals, applicable to the intervention.

Magnolia Health solicits feedback from members, medical consenters, and caregivers to assess satisfaction using a range of approaches, such as the CAHPS member satisfaction survey, BH member satisfaction survey, monitoring member complaints/grievances, and direct feedback from member focus groups and/or the Member Advisory Committee. The Quality Department is responsible for coordinating the CAHPS surveys, aggregating and analyzing the findings, and reporting the results. Survey results are reviewed by the QIC, with specific recommendations for performance improvement interventions or actions. The Member Advisory Committee or other member focus group may also review survey results.

Provider satisfaction is assessed annually using valid survey methodology and a standardized comprehensive survey tool. The survey tool is designed to assess provider satisfaction with the network, claims, quality, utilization management, and other administrative services. The Provider Communications/Network Development departments are responsible for coordinating the provider satisfaction survey, aggregating and analyzing the findings, and reporting the results to appropriate committees. Survey results are reviewed by the QIC, with specific recommendations for performance improvement interventions or actions.

Member Grievances and Provider Complaints - The Quality Department investigates and resolves member quality of care concerns/grievances. Member grievances related to quality of care and service are tracked, classified according to severity, reviewed by the Medical Directors, categorized by the Quality Department, and analyzed and reported on a routine basis to the QIC. The QIC recommends specific practitioner/provider improvement activities as needed.

The Operations Department investigates and resolves member grievances. All member grievances are tracked and resolution is facilitated by the Grievance & Appeals Coordinator. Data are analyzed and reported to the QIC on a regular basis to identify trends and to recommend performance improvement activities as appropriate. Grievance reports are submitted to the QIC, along with recommendations for quality improvement activities based on results.

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

Practice Guidelines - Preventive health and clinical practice guidelines assist practitioners, providers, members, medical consenters, and caregivers in making decisions regarding health care in specific clinical situations. Guidelines are adopted in consultation with network

practitioners/providers (including behavioral health as indicated) and based on the health needs and opportunities for improvement identified as part of the Quality Program, valid and reliable clinical evidence or a consensus of health care professionals in the particular field, and needs of the members. Magnolia Health adopts clinical practice guidelines for at least two (2) non-preventive acute or chronic medical conditions and at least two (2) behavioral health conditions (preventive or non-preventive) relevant to the target population. At least two (2) of the adopted clinical practice guidelines directly correspond with disease management programs offered by the health plan. Magnolia Health also adopts preventive health guidelines for perinatal care, care for children, and care for adults. Clinical and preventive health guidelines are updated upon significant new scientific evidence or change in national standards or at least every two (2) years. Guidelines are distributed to providers via the Provider Manual, website, and/or provider newsletters.

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

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

Continuity and Coordination of Medical and Behavioral Health Care – The health plan monitors and takes action as needed to improve continuity and coordination of care across the health care network. This includes continuity and coordination of medical and behavioral health care through collection of data on member movement between practitioners *and* data on member movement across settings. Annually, this data is collected and analyzed to identify opportunities for improvement. Opportunities for improvement are selected, and actions to improve coordination of medical care are implemented. The effectiveness of improvement actions are measured annually, and results are re-measured with an analysis performed each year to assess the progress of improvement.

Medical Record Documentation Standards - As required by state and federal regulations, Magnolia Health monitors network practitioners for maintenance of medical records in a current, detailed, and organized manner which permits effective and confidential patient care and quality review. The minimum standards for practitioner medical record keeping practices, which include medical record content, medical record organization, ease of retrieving medical records, and maintaining confidentiality of member information, are outlined in the Provider Manual. Additionally, the health plan may conduct medical record reviews for purposes including, but not limited to, utilization review, quality management, medical claims review, or member complaint/appeal investigations. Providers must meet specific requirements for medical record keeping; elements scoring below a determined benchmark are considered deficient and in need of improvement. The health plan works with providers who score below benchmark to develop an action plan for improvement. Medical record review results are filed in the Quality

Department and shared with the Credentialing Department as needed for consideration at the time of re-credentialing.

- **Monitoring Utilization Patterns** - To ensure appropriate care and service to members, the Utilization Management Committee performs at least 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, pharmacy, dental, and vision encounter data reporting to identify patterns of potential or actual inappropriate utilization of services. The Population Health and Clinical Operations Department works closely with the Quality Department, Chief Medical Director, VP of Medical Management, and Medical Directors to identify problem areas and provide improvement recommendations to the QIC for approval. Once approved, the Quality and Population Health and Clinical Operations departments implement approved actions to improve appropriate utilization of services.

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

- General and supportive member and provider education such as articles in member and provider newsletters, face-to-face interactions, and written educational materials provided to members at health fairs, diaper distribution events, etc.
- Targeted telephonic and/or written outreach to members/parents/guardians to remind them of applicable preventive health screenings and services due or overdue and offer 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 annual well visits, immunizations, lead testing, cervical cancer screening, breast cancer screening, etc.

POPULATION HEALTH MANAGEMENT

Magnolia's Population Health Management (PHM) Strategy includes a comprehensive plan for managing the health of its enrolled population, improving health outcomes, and controlling health care costs, and it 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. Magnolia's PHM Strategy outlines how member health needs are identified and stratified for intervention; details the PHM programs and services offered to address those needs for all stages of health and across health care settings; explains how members are informed of the programs and services and their eligibility to utilize them; and describes proven prevention interventions and tactics used to promote the transition to value-based care in the health plan's network. PHM programs, activities, and outcomes are reported to the Quality Improvement Committee for review, recommendations, and approval.

Care Management and Coordination of Services – Magnolia 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, Magnolia coordinates with the applicable payer source to ensure continuity and non-duplication of services.

Magnolia provides care coordination, care management, and condition/disease management for members identified as at risk, intervenes with specific programs of care, and measures clinical and other health-related outcomes. Magnolia 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. Magnolia's 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.

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

Chronic Care and Complex Care Management – This program provides care and condition management for members identified as at risk, intervenes with specific programs of care, and measures clinical and other health-related outcomes. Decision support encourages informed health care decisions by providing members with education about their conditions and treatment options, and by supporting members to make informed treatment decisions in collaboration with their providers. Magnolia Health's condition management and population health management programs help members understand their diagnoses, learn self-care skills, and adhere to treatment plans. All clinical and BH 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 them of members on their panels with chronic conditions such as diabetes and/or hypertension and reminders on appropriate screening and monitoring tests as recommended by evidenced-based practice guidelines. Clinical care management programs include asthma, behavioral health, diabetes, lead poisoning, and high-risk OB management. The Care Management Program Description further outlines the health plan's approach to addressing the needs of members with complex health issues, which may include physical disabilities, developmental disabilities, chronic conditions, and severe and persistent mental illness.

Practitioner/Provider Profiling – As a as part of its network performance strategy, the health plan systematically profiles the quality of care delivered by high-volume PCPs or other network practitioners to improve provider compliance with preventive health and clinical practice guidelines and clinical performance indicators. By providing quantitative feedback on clinical measures, the health plan promotes the success of providers and the health of members. The profiling system is developed with input from Magnolia Health network providers to ensure the process has value to practitioners, providers, and members and may include a financial component, as noted below.

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

Profiles include a multidimensional assessment of a PCP or other practitioner's performance using clinical and administrative indicators of care that are accurate, measurable, and relevant to the target population. To support providers in their delivery of robust preventive and interventive care, Magnolia Health provides quantitative and actionable analyses of the providers' member panel via analytic tools.

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
- Exportable patient data to support member outreach

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

Through these supporting platforms, the health plan works to keep providers engaged in the delivery of value-based care by promoting wellness and the prudent maintenance of chronic conditions. This engagement helps providers identify performance insights as well as identify opportunities for improvement. Practitioners who meet or exceed established performance goals and who demonstrate continued excellence or significant improvement over time may be recognized by Magnolia Health in publications such as newsletters, bulletins, press releases, and recognition in the provider directories.

Interventions are discussed with the practitioner whose performance is out of range (outliers) from his/her peers. 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. For providers identified as significantly outside the norm, re-measurement at six (6) month intervals may be required.

PERFORMANCE IMPROVEMENT ACTIVITIES

Magnolia Health's QIC 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.

The health plan utilizes traditional quality/risk/utilization management approaches to identify activities relevant to the health plan programs or a specific member population and that describe an observable, measurable, and manageable issue. Initiatives are identified through analysis of key indicators of care and service based on reliable data, which indicate the need for improvement in a particular clinical or non-clinical area. Other initiatives may be selected to test an innovative strategy or as required by state or federal contract. Projects and focus studies reflect the population served with consideration of social determinants of health, age groups, disease categories, and special risk status.

The QIC assists in prioritizing initiatives focusing on those with the greatest need or expected impact on health outcomes and member experience. Performance improvement projects, focused studies, and other quality 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 QIC helps to define the study question and the quantifiable indicators, criteria, and goals to ensure the project is measureable and able to show sustained improvement. Evidence-based guidelines, industry standards, and contractual requirements are used as the foundation for developing performance indicators, setting benchmarks and/or performance targets, and designing projects and programs that assist providers and members in managing the health of members. If data collection is conducted for a random sample of the population, baseline and follow-up sampling is conducted using the same methodology and statistical significance and a 90% or more confidence level is determined.

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

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

COMMUNICATING TO MEMBERS AND PROVIDERS

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

REGULATORY COMPLIANCE AND REPORTING

Magnolia Health departments perform required quality of service, clinical performance, and utilization studies throughout the year based on contractual requirements, requirements of other state and regulatory agencies, and those of applicable accrediting bodies such as NCQA. All functional areas utilize standards/guidelines from these sources and those promulgated by national and state medical societies or associations, the Centers for Disease Control, and the federal government. 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. This includes any federal/state requirements that apply to joint contracts (e.g., dual eligible Special Needs Plans, Financial Alignment Demonstrations, etc.). Additionally, the Quality Program and all health plan departments fully support every aspect of the federal privacy and security standards; Business Ethics and Integrity Program; Compliance Plan; and Waste, Fraud, and Abuse Plan.

DELEGATED SERVICES

The QIC may authorize participating provider entities, such as independent practice associations or hospitals, or organizations such as disease management companies, to perform activities (such as utilization management, care management, credentialing, or quality) on the health plan's behalf. Magnolia Health evaluates each delegated entity's capacity to perform the proposed delegated activities prior to the execution of a delegation agreement. A mutually agreed upon delegation agreement, signed by both parties, includes, but is not limited to, the following elements:

- Responsibilities of the health plan and the delegate
- Specific activities being delegated
- Frequency and type of reporting (i.e. minimum of semiannual reporting)
- The process by which the health plan evaluates the delegate's performance

- Explicit statement of consequences and corrective action process if the delegate fails to meet the terms of the agreement, up to and including revocation of the delegation agreement
- The process for providing member experience and clinical performance data to the delegate when requested

If the delegation arrangement includes the use of protected health information (PHI), the delegation agreement also includes PHI provisions, typically accomplished in the form of a Business Associate Agreement signed by the delegated entity.

Magnolia Health retains accountability for all functions and services delegated. Performance of the delegated entity is monitored through annual approval of the delegate's programs (Credentialing, Utilization Management, Care Management, Quality, 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 health plan and regulatory requirements and accreditation standards.

- Magnolia Health Population Health and Clinical Operations, Quality and/or Compliance designees, in conjunction with Centene Corporate Compliance designees, conduct an annual evaluation and documentation review that includes the delegate's program, applicable policies and procedures, applicable file reviews, and review of meetings minutes for compliance with health plan, state, and federal requirements and accreditation standards. The health plan retains the right to reclaim the responsibility for performance of delegated functions, at any time, if the delegate is not performing adequately.

Delegated services may include dental care, vision services, pharmacy management services, transportation, nurse hotline, and disease management services. See individual delegation agreements for specifics on delegated activities.

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

ENDORSEMENT OF THE Quality Program Description
The Quality Program Description has been reviewed and endorsed by the quality senior leadership effective this day of _____, month of _____, 2021.

Carrie Mitchell RN
Vice President of Quality Improvement

Dr. Jeremy Erwin, MD
Chief Medical Director

ENDORSEMENT OF THE Quality Program Description
The Quality Program Description has been reviewed and endorsed by the Board of Directors effective this day of __ _____, month of ___ _____, 2021.

Aaron Sisk, CEO/Plan President
Board of Directors Chairman

This QI activity was reported to the following QI committees:

Committee Name	Meeting Date	Committee Actions or Recommendations	Person Responsible for Report
QIC	2/23/2021	Approved	Jeff Martin