2025
Quality Management
Program Description

Mississippi Coordinated Care Organization

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INTRODUCTION

Magnolia Health is a quality-driven organization that adopts continuous quality improvement as a core business strategy for the entire health plan ensuring that every member receives high-quality care that is equitable and meets the unique health, cultural and linguistic needs of a diverse population. Magnolia Health develops and implements a quality management strategy that is sensitive to cultural backgrounds, beliefs, and practices within every staff role and department function, approaching quality assurance, quality management, health equity and quality improvement as a culture, integral to all day-to-day operations. Each Magnolia Health operational area has defined performance metrics, including goals for the improvement of culturally and linguistically appropriate services (CLAS) and reduction of health care inequities, with accountability to the Quality Improvement Committee and Board of Directors.

Magnolia Health acknowledges its 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 and equitable care with the primary goal of reducing disparities and improving the health status of members by supporting physicians/providers, who know what is best for their patients. This manner accounts for diverse cultural and ethnic backgrounds, varied health beliefs and practices, limited English proficiency (LEP), disabilities, and differential abilities, regardless of race, color, national origin, sex, sexual orientation, gender identity, preferred language, or degree of health literacy.

The Magnolia Health leadership team is committed to focusing clinical, network, and operational processes towards improving CLAS and the health of members (including all demographic groups and those with special health care needs), enhancing each member's experience of care and service, lowering the per capita cost of their health care, and improving the work life of network providers and their staff, as well as their experience and satisfaction. The Magnolia Health Quality Program applies a systematic approach to quality, CLAS, and health equity using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of health care, systems, and processes. Methods such as "Plan, Do, Study, Act (PDSA)" and other validated, data driven approaches to quality improvement, are used to monitor performance and measure effectiveness of equitable, quality improvement initiatives.

This type of methodology supports Magnolia Health to develop targeted, measurable locally tailored, culturally relevant interventions and quickly evaluate the impact of an activity on improvement goals. In many instances, Magnolia Health deploys a rapid cycling improvement activity, designed to immediately impact process improvements to improve member outcomes, inequities in care and member and provider satisfaction. These systematic approaches provide a continuous cycle for improving the quality of care and service for members.

The Quality Department maintains strong inter/intradepartmental working relationships, with support integrated throughout Magnolia Health to address the priorities and goals 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. The Quality Department collaborates across the health plan with several functional areas including and not

limited to Population Health and Clinical Operations (PHCO), Pharmacy, Provider Engagement/Provider Relations, Population Health Management, Health Equity, Network/Contracting, Member Services, Compliance, and Grievances and Appeals.

PURPOSE

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

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

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 requested by the member. The plan implements processes that ensure the health care services provided have the flexibility to meet the unique needs of each member, accounting for the diverse cultural and ethnic backgrounds, varied health beliefs and practices, limited English proficiency, disabilities, and differential abilities, regardless of race, color, national origin, sex, sexual orientation, gender identity, preferred language, or degree of health literacy.

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

SCOPE

The scope of the Quality Program is comprehensive in nature and is designed to improve health outcomes and satisfaction for members. It addresses both the quality and safety of clinical care and quality of services provided to Magnolia Health members, including both physical health and behavioral health. Magnolia Health incorporates all demographic groups, care settings, and services in its quality management and improvement activities. Areas addressed by the Quality Program include, but are not limited to, the following:

- Access to care
- Acute and chronic conditions

- Behavioral Health Care Services including Substance Use Disorder
- Care Management and Care Coordination
- CLAS
- Closed Loop Referrals
- Community based organizational partnerships.
- Compliance with member confidentiality laws and regulation
- Compliance with preventive health and clinical practice guidelines
- Continuity and coordination of care both physical and behavioral health
- Delegated entity oversight
- Health Equity
- Inpatient Hospital
- Member and provider cultural competency
- Marketing practices
- Member enrollment and disenrollment
- Member Grievance and Appeal System
- Member satisfaction
- NCQA Accreditation and Health Equity Accreditation
- Patient safety
- Patient Centered Medical Home
- Practitioner after-hours telephone accessibility
- Practitioner appointment availability and accessibility
- Preventive Care
- Provider Grievance and Appeal System
- Provider network adequacy and capacity
- Provider satisfaction
- Quality of Care review
- Social Determinants of Health
- Utilization management, including over-and under-utilization.

GOALS, OBJECTIVES, AND PRIORITIES

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 in the Mississippi Division of Medicaid's Comprehensive Quality Strategy, the National CLAS Standards, Magnolia Health's mission, and other evidence-based sources. Performance measures are aligned to specific priorities and SMART goals used to drive quality improvement and operational excellence.

Objectives to accomplish the Quality Program goals include the following:

- Identification of priorities and goals aligning with the Mississippi Division of Medicaid's Comprehensive Quality Strategy, Magnolia Health's mission, 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, sexual orientation, gender identity, primary language spoken, 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.
  - 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®) survey
  - The annual ECHO® Member Satisfaction survey
  - Healthcare Effectiveness Data and Information Set (HEDIS®) results for members (HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA))
  - CMS Core Measure Sets for Adults and Children
  - Developing additional standardized performance measures that are clearly defined, objective, measurable, and allow tracking overtime.
  - Administering an annual provider satisfaction survey to determine improvement activities based on identified areas of provider need/dissatisfaction.
- Monitoring, assessing, and promoting patient safety, including efforts to prevent, detect, and remediate quality of care and critical incidents and a peer review process that addresses deviations in the provision of health care and action plans to improve services.
- Ensuring member access to care in areas such as network adequacy, availability of services, timely appointment availability, transitions of coverage, and coordination and continuity of care, etc.

- Encouraging providers to participate in quality initiatives, giving support to providers (including a provider analytics system that delivers frequent, periodic quality improvement information to participating providers 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
- Achieving/maintaining NCQA Health Plan and Health Equity accreditation and/or other applicable accreditations
- Monitoring for compliance with all regulatory and accreditation requirements
- 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.
- Ensure all quality activities and initiatives are based on claims data, member demographic information, member and provider surveys, medical record reviews, and other data as applies.
- Establish and maintain a program to address health equity and social determinants of health.

CONFIDENTIALITY

Confidential information is defined as any data or information that can directly or indirectly identify a member or provider. Magnolia Health and all network providers and subcontractors comply with the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), and all applicable federal and state privacy laws. The Quality Improvement Committee and its subcommittees have the responsibility to review quality of care and resource utilization, as well as conduct peer review activities as appropriate. The Quality Improvement Committee 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 Quality Improvement Committee, and 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 Officer/Director, Vice President of Population Health and Clinical Operations (PHCO), Vice President/Director of Quality, and designated Quality Department staff
- Peer Review Committee
- External regulatory agencies, as mandated by applicable state/federal laws.
- Health plan legal executives
- Compliance leadership

Quality Improvement Committee 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 (PHCO), Credentialing, and Pharmacy program activities are educated about maintaining the confidentiality of peer review documents.
- The Quality Vice President 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 specifically authorized in writing by the CEO, Chief Medical Director, Legal Counsel, Vice President of Population Health and Clinical Operations (PHCO), or the Board of Directors Chairman

- 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.

CLAS AND HEALTH EQUITY

Magnolia Health works to meet the needs of all members with sensitivity to cultural needs and the impact of cultural differences on health services and outcomes. The Magnolia Health Culturally and Linguistically Appropriate Services (CLAS) Program is embedded within the Quality Program and utilizes a systematic approach using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of health care provided to all members. The health plan is guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care developed by the Office of Minority Health.

Whenever possible, the health plan's Quality Program supports processes and activities designed to achieve demonstrable and sustainable improvement in the health status of its members. This systematic approach to quality improvement provides a continuous cycle for assessing the quality of care and services by addressing both medical and non-medical drivers of health and promoting health equity. The health plan ensures communications are culturally sensitive, appropriate, and meet federal and state requirements. Magnolia Health also promotes the delivery of services through a cultural humility lens to all members, including those who have limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. Population health management initiatives are reviewed to ensure cultural issues and social determinants of health (SDOH) are identified, considered, and addressed. Additionally, the health plan is committed to improving inequities in care as an approach to improving Healthcare Effectiveness Data and information Set (HEDIS) measures, reducing utilization costs, and delivering locally tailored, culturally relevant care.

As such, Magnolia Health has developed a health equity approach that identifies inequities, prioritizes projects and collaborates across the community to reduce inequities through evidence-based methodologies targeting members, providers, and community interventions. Core components of our health equity approach include:

- Enhance and sustain organizational structure for promoting health equity including training and advocacy on cultural humility, promoting diversity in recruiting and hiring, enhancing

the demographic data collection, internal and external governance structure, and incorporation of our health equity improvement model across the organization.
- Empowering members and their caregivers in their health care choices through plain language and language services innovation
- Deliberately addressing health inequities through a data-driven approach that includes analysis of inequities, identification of health equity opportunities in HEDIS, identification/mitigation of social risks, identification/addressing of social needs, obtaining stakeholder (member driven) feedback and partnership, and implementing strategies across member, provider, and community systems
- Improving health outcomes by instilling cultural humility and responsiveness into all parts of the organization, such as member services, network development, population health, utilization and care management, and quality improvement

To achieve our purpose and mission of better health outcomes at lower costs for our members and the communities we serve, SMART goals are identified, and activities and timelines are documented in an annual workplan to achieve the following:
- To ensure meaningful access and positive health outcomes through the provision of culturally and linguistically responsive services to members and providers
- To ensure that members and potential enrollees are active participants in their own health and health care through clear and effective communication.
- To advance and sustain cultural and linguistic innovations.

On an annual basis or as needed, data are reported, analyzed, and modified by the Quality Improvement Committee to identify trends, reflect changes in the population, new programs, and services, projects completed, and set SMART goals to meet the needs of the targeted population.

AUTHORITY

Magnolia Health Board of Directors has authority and oversight of the development, implementation, and evaluation of the Quality Program and is accountable for oversight of the quality of care and services provided to members. The Board of Directors supports the Quality Program by:
- Adopting the initial and annual Quality Program which requires regular reporting (at least annually) to the Board of Directors, and establishes mechanisms for monitoring and evaluating quality, utilization, and risk.
- Supporting Quality Improvement Committee recommendations for proposed health equity, CLAS, and quality studies and other quality initiatives and actions taken
- Providing the resources, support, and systems necessary for optimum performance of quality functions
- Designating a senior staff member as the health plan's senior quality executive
- Designating a behavioral health professional to provide oversight of the behavioral health aspects of care to ensure appropriateness of care delivery and improve quality of service
- 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 Quality Improvement Committee. 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 Quality Improvement Committee, which is directly accountable to the Board of Directors.

The Chief Medical Director, or a 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 Quality Improvement Committee, 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 Quality Improvement Committee
- Coordinating the resolution of outstanding issues with the appropriate leadership staff, pertaining to Quality Improvement Committee recommendations, subcommittee recommendations, and/or other stakeholder recommendations
- Being actively involved in Magnolia Health's Quality Program, including activities such as: recommending quality study methodology; formulating topics for quality studies as they relate to accreditation and regulatory requirements and state and federal law; promoting participating practitioner compliance with medical necessity criteria and clinical practice and preventive health guidelines; assisting in ongoing patient care monitoring as it relates to population health management programs, pharmacy, diagnostic-specific case reviews, and other focused studies.
- Reporting the Quality Program activities and outcomes to the Board of Directors at least annually.

The Behavioral Health Medical Director, or other appropriate behavioral health practitioner (i.e., a medical doctor or a clinical PhD or PsyD who may be a medical director, clinical director, or a participating practitioner from the organization or behavioral healthcare delegate), is the designated practitioner responsible for the behavioral health aspects of the Quality Program and is responsible for:

- Compliance with state, federal, and accreditation requirements and regulations related to behavioral health.
- Participating in the Quality Improvement Committee and various subcommittees reporting to the Quality Improvement Committee, as applicable to behavioral health
- Monitoring and directing behavioral health quality activities among personnel and among the various subcommittees reporting to the Quality Improvement Committee
- Providing oversight of the behavioral health aspects of care to ensure appropriateness of care delivery and improve quality of service.

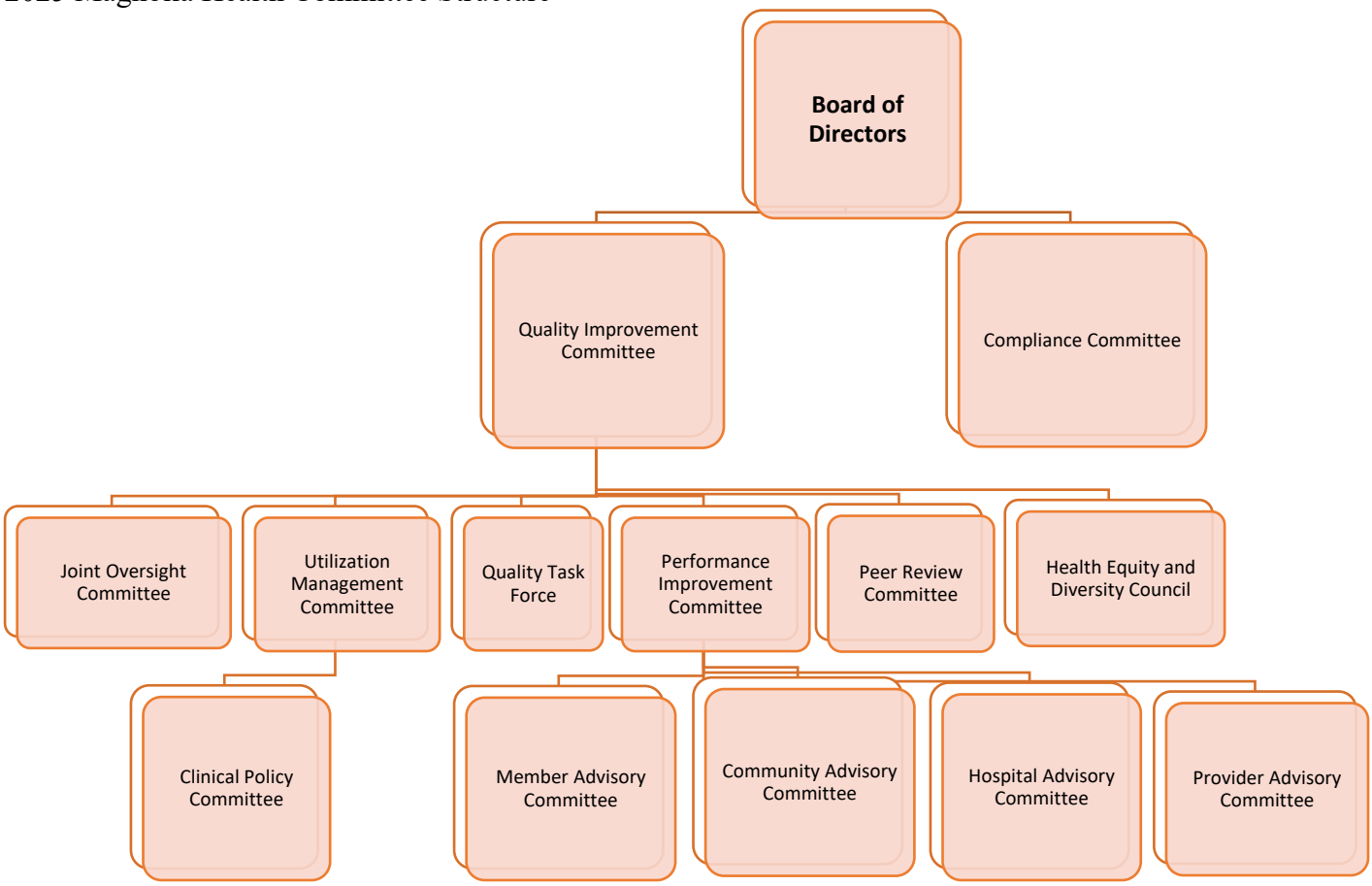
QUALITY PROGRAM STRUCTURE

Quality and equity are integrated throughout Magnolia Health and represents the strong commitment to delivering equitable, quality care and services to members. Magnolia Health has

sufficient material resources and staff with the education, experience, and training to effectively implement the written Quality Management program and related activities. 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 Quality Improvement Committee.

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

2025 Magnolia Health Committee Structure



Magnolia Health Committee Charters

Committee Name:	**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 VP 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.

Objectives of the Committee and relationship to Strategic Objectives:

1. Review clinical, physical, and behavioral health quality recommendations submitted by the Quality Sub-Committees.
2. Oversight of the quality activities of the health plan to ensure compliance with contractual requirements, federal and state statutes and regulation, and requirement of accrediting bodies such as National Committee for Quality Assurance (NCQA).
3. Collect and report data reflecting Magnolia performance on standardized measures of health outcomes.
4. Annual development of the Quality Program Description and Work Plan incorporating applicable supporting department goals and objectives, program structure as indicated.
5. Establish an effective management information system to provide the framework for monitoring quality of care or service provided.
6. Identify opportunities for improving health outcomes.
7. Recommend resources necessary to support the on-going educational needs of participating providers and Magnolia staff relative to current managed care technologies.
8. Annually evaluate the effectiveness of the Quality Improvement and Utilization Management Programs.
9. Annually review and approve the QI, UM, CM Programs
10. 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.
11. Review/establish benchmarks or performance goals for each quality improvement initiative and service indicator.
12. Facilitate the identification of system-wide trends and implement corrective action in order to improve performance.
13. Review due diligence information for any potential delegated entity and provide oversight to those entities already delegated.
14. Oversee the implementation of disease management programs, health education activities, cultural competency programs, and patient safety initiatives.
15. Prioritize quality improvement efforts and assure the appropriation of resources required to carry out QI activities.

16. Adoption of preventive health and clinical practice guidelines to promote appropriate and standardized quality of care.
17. Ongoing evaluation of the appropriateness and effectiveness of pay-for-performance and value-based contracting initiatives and support in designing and modifying the program as warranted.

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: VP, Quality Improvement, or designee

Committee Recorder: Administrative Assistant or QI designee. The Chair is responsible for approving the documented proceedings that reflect all QIC decisions.

Committee Composition:

Chief Medical Director (CHAIR)
Magnolia Network Physician two (2) at a minimum, one (1) being Behavioral Health
Nurse Practitioner one (1) minimum
Vice President, Population Health and Clinical Operations
Manager, Utilization Management
VP, Quality Improvement
Director, Provider Relations
Director, Contracting & Network Development
Member Services / G&C
Director, Pharmacy
VP, Compliance or Compliance Officer
VP, Operation or Operation Officer
Other Magnolia staff as requested.

Ad Hoc Members: Magnolia CEO/COO/CFO/Magnolia Administrator/VP, Government Relation and Communications

- ► Term limits for external participants will be 2-year appointments.
- ► 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, a replacement is needed, if participant is responsible for an agenda item, re-schedule 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: Voting members must attend 75% of scheduled meetings.

Quorum: A minimum of five (5) members including three (3) plan staff and two external physicians must be present for a quorum.

Committee Data/Document Responsibilities:

Meetings will be agenda driven. All agendas and minutes will follow Magnolia 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 copy 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, 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.

Committee Name:	**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 guarding against over and under utilization of health care services provided to our 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 VP, Population Health and Clinical Operations or designee 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:

Chief Medical Director (Chair)
VP, Population Health and Clinical Operations
Sr. Director/Director, Medical Management/PHCO
VP, Quality Improvement
VP, Compliance or Compliance Officer
VP, Network Development and Contracting
VP, Operation or Operation Officer
Director, Pharmacy
Other Magnolia operational staff as requested

Ad Hoc Members: Magnolia CEO/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, a replacement is needed; if participant is responsible for an agenda item, re-schedule 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: Voting members must attend 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 standard format.

Scheduling: Administrative Assistant or UM designee.

Facilitator: Chair, Chief Medical Director

Agenda:	The Committee Chair in collaboration with the VP of Population Health and Clinical Operations 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 UM Program Evaluation annually. The Director of Pharmacy or designee will attend the Pharmacy & Therapeutics committee meeting held by the Division of Medicaid throughout the year and report to the Committee.

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.

Committee Name:	**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 determination 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:
CMD/Medical Director as appropriate
VP, Quality Improvement
Peer Physicians of Same/Similar Specialty

Ad Hoc Members: Magnolia CEO/COO/CFO

Attendance Requirement: Voting members must attend 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 standard format.

Scheduling: Administrative Assistant.

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 its 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.

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Meeting Frequency:

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

Committee Name:	**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 evaluation of key clinical quality and service performance indicators.
2. Prompt initiation of 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. Determines 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, 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 operational policies and procedures at least annually and recommend modifications, as necessary.

Committee Structure and Operation:

The Committee will meet: Monthly, no less than ten (10) times per year.

Committee Facilitator: Magnolia Chief Medical Director or Chief Medical Director designee serves as Chair. Quality Improvement will serve as Facilitator.

Committee Recorder: Administrative Assistant or QI designee.

Committee Composition:

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: Voting members must attend 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 standard format.

Scheduling:	QI designee or Administrative Assistant.
Facilitator:	Chair, Magnolia Medical Director and Quality Improvement.
Agenda:	The PIT Chair and QI 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.

Committee Name:	**Quality Task Force (QTF)**

Charter Statement:

The QTF Committee is Magnolia's senior leadership committee responsible for monitoring and improving HEDIS scores for physical. 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 on-going 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:

CMD or Medical Director
VP, Population Health and Clinical Operations
VP, Quality Improvement
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: Voting members must attend 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 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.

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Committee Name:	**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 performance level of Magnolia' Member Hotline and to 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: Sr. Director of Marketing & Community Relations and Chair

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 standard format.

Scheduling: Community Relations Representative

Facilitator: Sr. Director of Marketing & Community Relations

Agenda: The Group 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 Magnolia membership perspective. This Committee reports to 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 **<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.

Committee Name:	**Community Advisory Committee (CAC)**
Charter Statement: The Community Advisor 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' quality improvement program and performance from community representatives and regional community advisory committee.	
Objectives of the Committee and relationship to Strategic Objectives: 1. To 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 specific 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' member population.

Based on Plan size and distribution, the Advisory Committees 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: Sr. Director of Marketing and 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 standard format.

Scheduling: Community Relations Representative

Facilitator: Chair, Sr. Director of Marketing and 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 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.

Committee Name:	**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. To 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 specific hospital groups.

Committee Structure and Operation:

The Committee will meet: Annually

Committee Facilitator: VP/Director of Contracting/Network Management and Chair

Committee Recorder: Administrative Assistant or 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 standard format.

Scheduling: Administrative Assistant.

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.

Committee Name:	**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. To provide Magnolia with feedback regarding programs and processes from a community provider-based perspective.
2. To 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: Administrative Assistant.

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 standard format.

Scheduling:	Administrative Assistant.
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 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.

Committee Name:	**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: Compliance Specialist

Committee Composition:

Magnolia Administrator/CEO
Compliance Officer
Chief Medical Director
VP, Population Health and Clinical Operations
VP, Quality Improvement

VP/Director Contracting
Director, Operations
Finance Officer / CFO
Chief Operating Officer (COO)
Human Resources Business Partner

Attendance Requirement: Voting members or their proxy must attend 75% meeting attendance.

Quorum: 50% of voting members

Committee Data/Document Responsibilities:

Meetings will be agenda driven. All agendas and minutes will follow Magnolia 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 the Magnolia 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.

Committee Name: Joint Operating Committee
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 when designated entities' 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**: Manager, Vendor Management, or designee **Committee Recorder**: Vendor Analyst **Committee Composition**: VP/Director/Manager Compliance designee VP/Director Population Health and Clinical Operations VP, Operations Manager, Vendor Management, or designee Medical Director

VP Contracting/Network Development
Director/Manager QI
Director/Manager Member Services
Director/Manager Provider Relations
Senior Accreditation Specialist

Attendance Requirement: Voting members must attend 75% of scheduled meetings.

Ad Hoc Members: Magnolia CEO/COO/CFO
Quorum: Not a voting committee

Committee Data/Document Responsibilities:

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

Scheduling: Manager, Vendor Management, or designee

Facilitator: Manager, Vendor Management, or designee

Agenda: Agenda items for the next meeting will be developed by the Manager, Vendor Management 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.

Committee Name:	**Clinical Policy Committee (CPC)**

Charter Statement:

The Clinical Policy Committee (CPC) is Magnolia Health's (Magnolia) 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: VP of Population Health and Clinical Operations or designee will serve as facilitator.

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

Committee Composition: Chief Medical Director (CHAIR)

	Magnolia Network Practitioners – two (2) at a minimum, one (1) being Behavioral Health Vice President Population Health and Clinical Operations Director of Utilization Management Compliance Officer VP of Quality Improvement VP/ Director Pharmacy Medical Director(s) Other Magnolia operation staff as requested
Ad Hoc Members:	Magnolia CEO/COO/CFO
	► If a participant cannot attend, no replacement is needed; if participant is responsible for an agenda item, re-schedule 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:	Voting members must attend 75% of scheduled meetings.
Quorum:	A minimum of five (5) members including three plan staff and two 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:	Administrative Assistant or UM designee
Facilitator:	Chair, Chief Medical Director
Agenda:	The Committee Chair in collaboration with the VP of Population Health and Clinical Operation 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 copy 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' 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.

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.

Committee Name: Health Equity and Diversity Council (HEDC)

Charter Statement:

The Health Equity and Diversity Council is a leadership committee that provides guidance and leadership to improve health outcomes and reduce costs associated with health inequities.

Purpose:

The purpose of the Health Equity and Diversity Council is to improve Magnolia Health member health outcomes by supporting regulatory oversight and assessing culturally and linguistically appropriate services (CLAS); health equity initiatives; drivers of health; and diversity, equity, and inclusion. The Health Equity and Diversity Council Committee (HEDC) provides oversight and direction of all Magnolia activities associated with health inequities and to assess the appropriateness of care and service delivered and to continuously enhance and improve the quality of services provided to members in an effort to enhance health equity. The HEDC will review and direct clinical, physical, behavioral health, and service operational activities to identify health disparities, identify root cause(s), and address by tailoring services to remove barriers. 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 health disparities and social determinants of health. This is a multi-disciplinary committee of Magnolia Health (MH) leadership staff. HEDC activities

include, but are not limited to review of clinical, physical, behavioral health, and non-clinical issues/activities affecting the health equity of members, coordination of actions and making decisions regarding health equity functions.

Objectives of the Committee and Relationship to Strategic Objectives:

1. Evaluate data from internal and external sources to identify disparities in Mississippi and within Magnolia Health's membership.
2. Establish appropriate goals, policies, and leadership accountability throughout the health plan's planning and operations as it relates to health equity, culturally and linguistically appropriate services, and ensuring a diverse, equitable and inclusive workforce and workplace.
3. Ensure diverse viewpoints are represented.
4. Ensure there are opportunities or members of culturally representative communities to help identify and prioritize opportunities for improvement.
5. Integrate strategies for identifying and addressing Drivers of Health into healthcare planning and member care.
6. Regularly review and communicate progress towards established goals.
7. Integrate member and community-based organizational perspectives to ensure the health plan is responsive to diverse beliefs and practices and other member needs.
8. Regularly review and communicate progress towards established goals. Seek out and integrate perspectives of both Magnolia Health members and representatives of community-based organizations with lived experience as part of historically marginalized and under-resourced communities.

Committee Responsibilities:

1. Act as an ally for groups experiencing health inequities in Mississippi
2. Support community-based organizations that work with populations experiencing health inequities
3. Utilize evidence-based quality and performance improvement practices
4. Identify and prioritize gaps and opportunities for CLAS and health equity efforts and establish enterprise priorities for health equity
5. Review, approve, and support implementation of Magnolia Health's Health Equity Workplan and CLAS elements of QI Workplan
6. Assist with and support quality improvement workgroups to implement the health equity lens within their work.
7. Evaluate and develop recommendations for Magnolia Health health equity and CLAS training needs
8. Identify need for or support of enhancements to culturally relevant and Drivers of Health-related programs
   Include and empower those who have historically been excluded from decision-making and influential processes to co-develop, with the health plan, solutions for eliminating health inequities.

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: VP, Population Health and Clinical Operations or designee
Committee Recorder: Administrative Assistant or PHCO designee. The Chair(s) is responsible for approving the documented proceedings that reflect all HEDC decisions.

Committee Composition:

Chief Medical Director
VP, Population Health and Clinical Operations
VP, Quality Improvement (Chair)
VP, Government Relations and Communications
Director, PHCO/MM
Manager, Utilization Management
Sr. Manager, Clinical Operations
Director, Quality Improvement
VP, Network Development and Contracting
Director, Pharmacy
VP, Compliance
VP, Finance
Human Resource Business Partner
Director, Communications and Marketing
Director, Provider Relations
Member and Provider Services
Medical Director Behavioral Health
Accreditation Manager/Senior Accreditation Specialist

- 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.
- Each participant is responsible to work with his/her peers to understand meeting events and implement actions in their department.

Attendance Requirement: Voting members must attend 75% of scheduled meetings.

Quorum: A minimum of seven (7) or 50% of voting members must be present for a quorum.

Committee Data/Document Responsibilities:

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

Scheduling: PHCO designee

Agenda: The HEDC Chairs will develop agenda items for the next meeting in collaboration with committee members.

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(s) at the next regularly scheduled meeting. Minutes will be maintained in a secure area.

Handouts/Meeting Packets: Documents will be securely distributed to committee members prior to the meeting date with sufficient time to provider review of meeting materials, as applicable.

Decision Authority:

The HEDC is authorized by the Quality Improvement Committee to make all decisions to promote health equity.

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

Evaluation:

Evaluation criteria, including health disparity metrics will be established by the committee and will be analyzed annually and reported to the QIC.

Other:
Confidentiality:

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

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 includes the following positions:

Magnolia Health Staffing

Chief Medical Director/Medical	The health plan's Chief Medical Director and any supporting Medical Directors (including a behavioral health Medical Director) have an active

Director(s)	unencumbered license in accordance with the health plan's state laws and regulations to serve as Medical Director to oversee and be responsible for the proper provision of core benefits and services to members, the Quality Program, the Population Health and Clinical Operations Program, 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 health plan's health care delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality, clinical quality, equitable hiring and recruitment practices, and related policies, promotion of diversity, equity, and inclusion at all levels that reflect the composition of the community served. The Quality VP/Director, or designee, collaborates with the heads of all functional units to ensure that culturally and linguistically appropriate services are included and properly executed to support a diverse membership. Leadership promotes this through policy, practices, and the allocation of human and financial resources to ensure integration and alignment of CLAS opportunities across the health plan and functional areas (e.g., medical management, customer service, provider services, quality, Information Technology, etc.). 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 Manager/Senior Manager	The Quality Managers/Senior Managers are registered nurses. The Quality Managers are responsible for management and oversight of quality and performance monitoring. The responsibilities include working with multiple departments to establish objectives, policies, and strategies; assuring quality initiatives focused on improving operational and program efficiencies; focusing on initiatives to improve member outcomes; developing systematic processes and structures that will assure quality; and ensuring Magnolia Health's commitment to enabling quality improvement activities and quality of care reviews.
Quality Improvement	Quality Improvement Coordinators are highly trained clinical staff with significant experience in a health care setting; experience with data analysis

Coordinator	and/or project management. At least one of the health plan's QICs is a registered nurse. The Quality Improvement Coordinators' scope of work may include medical record audits; data collection for various quality improvement studies and activities; data analysis and implementation of improvement activities; review, investigation, and resolution of quality-of-care issues; and complaint response with follow up review of risk management and sentinel/adverse event issues. A Quality Improvement Coordinator may specialize in one area of the quality process or may be cross trained across several areas. The Quality Improvement Coordinator collaborates with other departments as needed to implement corrective action or improvement initiatives as identified through health plan's quality improvement activities and quality of care reviews.
Quality Practice Advisor	Quality Practice Advisors 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 QPAs is a registered nurse. The Quality Practice Advisors' 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 Operations Director/Senior Manager/Manager	The HEDIS Operations Director/Senior Manager/Manager is a highly trained individual with significant experience in managed health care, data analysis, and project management. The HEDIS Operations Director/Senior Manager/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 Operations Director/Senior Manager/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 Operations Director/Senior Manager/Manager coordinates the documentation, collection, and reporting of HEDIS measures to both National Committee for Quality Assurance (NCQA) and the State as required.
Accreditation Specialist	The responsibilities of the Accreditation Manager/Senior Accreditation Specialist 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/Senior Accreditation Specialist serves as the Subject Matter Expert for accreditation for the health plan.
Grievance and Appeals Coordinator	The Grievance and Appeals Coordinator logs member grievances and appeals and refers those pertaining to potential quality of care issues to a Quality Coordinator (or Medical Director as appropriate) for investigation and resolution. The Grievance and Appeals Coordinator evaluates complaints and grievances by type, location, and region to identify trends indicating potential areas in need of further analysis and intervention. The Grievance and Appeals Coordinator also tracks and resolves all administrative member and provider grievances and complaints. The Grievance and Appeals Coordinator reports to the Grievance and Appeals Supervisor.
Grievance and Appeals Supervisor	The Grievance and Appeals Supervisor is a highly trained clinical staff member with significant experience with grievance and appeals policy, processes, and procedures. The Grievance and Appeals Supervisor is responsible for management and oversight of the appropriate processing of member grievances and appeals as well as State Fair Hearing and external reviews. The Grievance and Appeals Supervisor is responsible for performance monitoring, process improvement, and policy management related to the Grievance and Appeals program. The Grievance and Appeals Supervisor is the grievance and appeals representative in multiple health plan committees. This position manages grievance and appeals data, reports day-to-day responsibilities of the Grievance and Appeals Coordinators, and completes monthly Division of Medicaid required reports/logs. The Grievance and Appeals Supervisor reports to the Quality Manager/Senior Manager.
Quality Improvement Specialist	The Quality Improvement Specialist assists with the development and coordination of health services, reports, audits, policy and procedures, and activities for various committees and meetings.

QUALITY PROGRAM RESOURCES: INFRASTRUCTURE AND DATA ANALYTICS

Magnolia Health has the technology infrastructure and data analytics capabilities to support goals for health outcomes, cultural competency and linguistic assistance services, quality management and value. Magnolia Health's health information systems collect, analyze, integrate, and report encounter data and other types of data to support quality analysis, demographic analysis, disparity outcomes and analysis, utilization (including but not limited to language services), complaints/grievances and appeals, care management/coordination, and all quality activities. The IT infrastructure makes data, including race, ethnicity, language, sexual orientation, and gender identity, available for effective monitoring, analysis, and evaluation toward improving 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 quality, cultural competency and linguistic assistance services, 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, retrieve, and analyze data from internal, subcontractor, and external sources and for effective use through a suite of data informatics and reporting solutions.

Demographic data is requested from members, including race, ethnicity, language, sex, sexual orientation, gender identity and preferred pronouns. Sexual orientation, gender identity and pronoun data for minors (those younger than 13 years of age) are not collected in compliance with Children's Online Privacy Protection Act (COPPA). Direct methods of data collection include methods for which a member, or a parent, guardian, or caregiver on behalf of a member, self-reports race, ethnicity, preferred language, sex, and alternate format through survey or enrollment data. In an effort to not stigmatize individuals, and recognizing the complexity, sensitivity, and fluidity of contemporary terminology related to sexual orientation and gender identity, members may self-identify and report their personal pronouns, sexual orientation, and gender identity through a secure member portal at any time.

Direct member demographic data is initially collected from third-party sources for Medicaid, Medicare and Marketplace lines of business (e.g., state or local agencies, CMS enrollment data, health information exchange (HIE), electronic health records (EHR) data) to capture race, ethnicity, sex and preferred language and is maintained in the IT infrastructure. Post enrollment, the health plan employs additional direct collection methods to enhance members volunteering demographic data at various points of interaction. When a member engages with Member Services, staff use a script and are trained to review contact information, as well as race, ethnicity, and language at each point of contact. In order to standardize race and ethnicity data the information is mapped and aggregated according to U.S. Office of Management and Budget (OMB) guidelines. Adult members can self-report gender identity, sexual orientation and preferred pronouns to Member Services and staff will notate their file, so it is housed in the IT infrastructure, therefore, this information will not be directly solicited; however, the IT platform allows collection, should a member self-disclose. Once the data is in the IT infrastructure it is accessible to all member-facing staff. If the member has opted out of providing information during enrollment or the member has declined to answer, the member record is coded as “Declined to State” in the relevant fields and they will no longer be asked for this information.

Since providing race and ethnicity is voluntary, indirect estimations and data sources aid in creating a demographic profile when member reported data is not sufficient. Magnolia Health utilizes analytics and artificial intelligence services to predict a person’s race/ethnicity based on first name, surname, and nine-digit zip code. The analysis is applied to all members and results are available in membership tables in Centelligence databases. Indirect data are also mapped according to U.S. Office of Management and Budget (OMB) guidelines.

In addition, the health plan evaluates state-level census data to determine what languages are spoken in its service area and to determine threshold languages. The evaluation identifies languages spoken by 1 percent of the population or 200 individuals, whichever is less, and threshold languages, up to a maximum of 15 languages.

Annually, the member demographic data above is collected and assessed to identify healthcare disparities and to improve CLAS.

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 Health 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, ethnicity, language, sexual orientation and gender identity, region, and primary care provider assignment; member outreach), and provider information (e.g., participation status; specialty; demographics that are provided on a voluntary basis, such as race, ethnicity, languages spoken).

The Centelligence analytic and reporting tools provide Magnolia Health 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 Health develops defined data collection and reporting plans to build custom measures and reports, as applicable. Magnolia Health 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 Health'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 Centelligence' s analytic and reporting applications while orchestrating data interfaces among core applications. Housing all information in the EDW allows Magnolia Health to generate standard and ad hoc quality reports from a single data repository.

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

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

RSA Archer- RSA Archer is an enterprise system that supports Centene's core Governance, Risk, and Compliance (GRC) functions. It houses the Policy and Procedure Portal which simplifies the policy review process and improves security around policies and work processes.

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 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 summarizes, 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 the Medicaid NCQA Health Plan Rating System. In addition, scorecards are produced for Quality-related 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 and certified CAHPS vendor. Additional data points provided are

source-of-truth rates from prior year final rates, prior year current month, and 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. Month-over-month and year-over-year graphs are provided to show trending performance across the 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 Health'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 and 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.

Centene Clinical Action- is a clinical analytics solution that computes NCQA HEDIS measure at the individual member level for Medicaid, Commercial, Marketplace and Medicare populations. Interpreta is a physical-led platform and a subsidiary of Centene.

OMNI – Is a call center application in which all member and provider calls are documented. CSR's will use workbaskets within OMNI to communicate with operational areas of plans and central departments. OMNI creates business driven processes that more easily integrate with other systems. It also has features that allow the business to have a greater flexibility to make changes and easily adapt to a changing environment.

Portico- MAGNOLIA HEALTH's Portico data management system is a central repository used to manage and maintain all network provider demographic, credentialing, and financial data elements. Portico has a daily feed that migrates provider data elements to populate MAGNOLIA HEALTH's claims processing system and web portal directory. Reporting requirements for reports are generated from Portico that requires any provider demographic data elements.

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

DOCUMENTATION CYCLE

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

- Quality Program Description

- Quality Work Plan
- Quality Program Evaluation

The continuous quality improvement (CQI) model of choice is based upon the Deming Cycle or Plan-Do-Study-Act (PDSA) developed by W. Edwards Deming and Walter A. Shewhart. The PDSA quality improvement methodology is a systematic approach employed across all departments to ensure continuous quality improvement in the Plan's clinical and service performance and operational functions. The following are the steps applied to all QI initiatives undertaken by MAGNOLIA HEALTH:

Plan:

Magnolia Health monitors a variety of performance measures covering clinical care and service delivery to identify opportunities for improvement. HEDIS results, member and provider satisfaction survey results, utilization data, patient safety, accessibility and availability data and other sources of data are used to guide and inform the quality improvement process. Causal analysis is conducted in collaboration with performance improvement work groups to better understand trends identified in the data, to isolate opportunities for improvement and to design interventions which will reduce or eliminate barriers.

Do:

The QI team leaders in collaboration with departmental leaders carry out the interventions designed based on the Plan step.

Study:

The departmental leaders analyze the effectiveness of the interventions and the results to goal for each activity including the identification of barriers and the interventions for overcoming the identified barriers. The data is collected, analyzed and the results are reported based on the targets established for each activity using the PDSA methodology including the identification of barriers and the interventions for overcoming the identified barriers.

Act:

The QI team leaders, in collaboration with their improvement work groups modify the interventions as necessary, identify if specific interventions should be continued, modified, or discontinued and new interventions may be applied. Successful interventions are monitored for sustainability.

To ensure that quality improvement is continuous, and the identified goals and/or objectives are being met, each quality improvement activity is reviewed and discussed regularly. Modifications to the initiatives are implemented as necessary and incorporation.

Quality Program Description – The Quality Program Description is a written document that outlines Magnolia Health's structure and process to monitor and improve the quality and safety of clinical care, quality of services provided to members, culturally and linguistically appropriate services for the reduction of disparities and better health outcomes. The Quality Program Description includes the following at minimum: the scope and structure of the Quality Program,

including the behavioral health aspects, measurable goals and a plan for monitoring trends; the specific role, structure, function, and responsibilities of the Quality Improvement Committee and subcommittees/work groups, including meeting frequency and accountability to the governing body; a description of dedicated Quality Program staff and resources, including involvement of a designated physician and behavioral health care practitioner; the behavioral health aspects of the program, and how the health plan serves a diverse membership. No less than annually, ideally during the first quarter of each calendar year, the designated Quality Department staff prepares, reviews, and revises, as needed, the Quality Program Description. The Quality Program Description is reviewed and approved by the Quality Improvement Committee 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 Quality Improvement Committee 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 departments may maintain their own program description. In either case, all program descriptions are formally approved or accepted by the Quality Improvement Committee 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 includes 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, including measurable goals, for improving quality of clinical care, safety of clinical care, quality of services, including CLAS, member experience, and the network's cultural responsiveness.
- Individual(s) accountable for each task
- Target dates for start dates.
- Target dates for completion of all phases of all QM activities
- Updates on at least a quarterly basis
- Annual submission, which must include prospective QM initiatives for the year.
- Data collection methods and analysis target dates
- Evaluation and reporting of findings to the Mississippi Division of Medicaid
- Implementation of improvement actions where applicable

QI leadership, or designee, is responsible for review of data collected and/or reports used to monitor progress against goals, for all measures, throughout the year. Magnolia Health annually reviews the existing Work Plan and confirms compliance with the health plan's current needs, accreditation requirements, and current state and/or federal requirements and deliverables related

to the Quality Program, as applicable. Work Plan status reports are reviewed by the Quality Improvement Committee on a regular basis (e.g., quarterly, or semiannually). The Work Plan is a fluid document; designated Quality Department staff make frequent updates to document the 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, Provider Services, etc.) within the health plan, or each department may maintain their own work plan independently. In either case, all work plans are formally approved or accepted by the Quality Improvement Committee 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 and network responsiveness, language, and member services, utilization management, care management, complex case management, condition management, and safety of clinical care. Program Evaluation findings are incorporated in the development of the annual Quality 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 Quality Improvement Committee and Board of Directors for approval annually.

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

- Analysis and evaluation of the overall effectiveness of the Quality Program, including progress toward influencing network-wide culturally competent care, safe clinical practices, and an evaluation of the adequacy of resources (e.g., staffing, analytic tools, etc.) and training related to the Quality Program
- The effectiveness of the Quality Committee structure, including subcommittees and workgroups
- Effectiveness of health plan leadership and external practitioner involvement in the Quality Program
- Conclusions regarding the need to restructure the Quality Program for the following year.
- A description of completed and ongoing quality activities that address quality and safety of clinical care, quality of service, including culturally and linguistically appropriate services
- Trending of measures collected over time to assess performance in quality of clinical care, quality of service, improvement in CLAS and reduction of healthcare disparities.
- Interventions implemented to address the issues chosen for performance improvement projects and focused studies.
    - Rationales and methodologies for activities and studies undertaken.
    - Results of the activities and measurement of the effectiveness of activities

    - Subsequent improvement actions
    - An analysis of claims data, member demographic information, member and provider surveys, and other data, as it applies, and whether there have been demonstrated improvements in the quality of clinical care and/or quality of services.
- 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
- Systematic analysis and re-measurement of barriers to care and the quality of care provided to members.
- 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.
- The communication of necessary information to other committees when problems or opportunities to improve member care involved more than one committee's intervention.

At the end of the Quality Program cycle each year the Quality Department facilitates and 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 Quality Improvement Committee should be included in the document.

In addition to providing information to the Quality Improvement Committee, the annual Program Evaluation, or an executive summary as appropriate, can be used for review and evaluation of the results by community representatives and to provide information to a larger audience such as, accrediting agencies, regulators, stockholders, new employees, and the Board of Directors.

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

PERFORMANCE MEASUREMENT

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

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

The Mississippi Division of Medicaid has assigned the entire suite of the Centers for Medicare and Medicaid Services (CMS) Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) to Magnolia. These measures are for both physical and behavioral health. Per the technical specifications, these measures are guided by either NCQA, CMS, The Joint Commission (TJC), Agency for Healthcare Research and Quality (AHRQ), Health Resources and Services Administration (HRSA), or the Pharmacy Quality Alliance (PQA).

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

Member Experience - Magnolia Health supports continuous ongoing measurement of member experience by monitoring member inquiries, complaints/grievances, and appeals; member satisfaction surveys; member call center performance; and direct feedback from member focus groups and other applicable committees. The Quality Department analyzes findings related to member experience and presents results to the Quality Improvement Committee and appropriate subcommittees.

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

- Getting Care Quickly
- Getting Needed Care
- Coordination of Care
- Customer Service

- Rating of Health Plan
- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

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

PROMOTING MEMBER SAFETY AND QUALITY OF CARE

The Quality Program is a multidisciplinary program that utilizes an integrated approach to monitor, assess, and promote patient safety and quality of care. 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 the Magnolia Health 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 Relations staff, Grievance and Appeals 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 requires 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 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.

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

Magnolia Health also performs ongoing monitoring of the provider network.

Medical Record Documentation Standards – Magnolia Health promotes maintenance of medical records in a current, detailed, and organized manner which permits effective and confidential patient care and quality review. The minimum standards for practitioner medical record keeping practices, which include medical record content, medical record organization, ease of retrieving medical records, and maintaining confidentiality of member information, are outlined in the Provider Manual. Magnolia Health may conduct medical record reviews for purposes including, but not limited to, utilization review, quality management, medical claim review, or a member complaint/appeal investigation. Providers must meet specific requirements for medical record keeping; elements scoring below a determined benchmark are considered deficient and in need of improvement.

WORKFORCE AND ORGANIZATIONAL READINESS

Recruiting and Hiring Practices to Build a Diverse Staff

To ensure organizational governance, leadership, and workforce are responsive and representative of our member population, health plan hiring and recruitment practices, and related policies, promote diversity, equity, and inclusion, at all levels and positions, and reflect the composition of the community served. Our Talent Attraction (TA) team, in partnership with hiring leaders and human resources, nurtures a talent pipeline that connects us to a diverse workforce. All our talent advisors receive training to become Certified Diversity Recruiters. And the team works to activate stakeholder partnerships such as those with nonprofits and academic institutions, including Historically Black Colleges and Universities (HBCUs), to enhance our ability to recruit and develop diverse talent, to reflect the diversity of Health plan membership. Recruitment and hiring practices that support diversity include:

- developing and posting online job descriptions emphasizing organizational values on diversity and inclusion,
- targeted job fairs to engage diverse candidates and underrepresented groups,

- engagement with local community leaders, community-based organizations (CBO), universities, community colleges, and faith-based organizations to promote opportunities within the organization,
- provide guides and resources for hiring leaders, such as, the Partnership Guide and Interview Structure Best Practices: Selecting a Diverse Interview Panel to promote diverse hiring,

Promoting and Monitoring Diversity, Equity, and Inclusion in the Workplace
Our commitment to diversity, equity, and inclusion starts at the top of the organization with our board of directors and permeates every layer and level. To help our employees maintain their level of excellence in support of our members, we provide programs, resources, and support tools to ensure employee development and growth. Every individual is a leader, and as such, all staff set goals around and are measured against our Leadership Model. This process enables staff from all backgrounds and cultures to collaborate, contribute, and provides opportunities for development and advancement.

The Diversity, Equity & Inclusion (DEI) efforts of the health plan and the Centene Corporate enterprise include workforce metrics and tracking capabilities to ensure we value diversity, create equity, and embrace inclusion. Centene believes that a diverse workforce and an inclusive workplace fuel improved service, innovation, and performance. We strengthen our workforce by hiring a range of candidates with varying life experiences and professional backgrounds, and we thoughtfully engage them throughout their employee life cycles with dedicated support and leadership development opportunities (Corporate Policy CC.HUMR.12). This includes reporting mechanisms that ensure we have the capability to develop and monitor strategic initiatives that address areas of opportunity for DEI advancement. A new DEI dashboard for our DEI Councils, HR Business Partners, and Business Unit Leadership provides a way to track ongoing progress of programs and initiatives.

Another monitoring activity involves the deployment of the Shaping Centene enterprise-wide surveys to obtain employee feedback on what is most important to them while measuring employee engagement and sentiment on current DEI initiatives, People Leader Effectives, and Company Culture. The surveys create opportunities for employees to feel valued and heard throughout the year, and the insights gathered serve as an important catalyst in how we further improve our employee experience, and the organization's commitment to DEI. Additional support of a diverse workforce includes the opportunity to participate in Inclusion Groups. These groups are the Veterans and Military Families Employee Inclusion Group; the Multicultural Employee Inclusion Group; I.N.S.P.I.R.E., the Women's Employee Inclusion Group; ABILITY, the People with Disabilities & Caregivers Employee Inclusion Group; and cPRIDE, the company's LGBTQ+ Employee Inclusion Group. Furthermore, the company maintains an Executive Diversity and Inclusion Council comprised of senior leaders who guide their respective business units in implementing and sustaining successful diversity and inclusion practices across the enterprise.

Magnolia Health annually identifies and evaluates opportunities to improve diversity, equity, inclusion or cultural humility for staff, leadership, committees, and governance bodies.

Training and Development
To ensure organizational governance, leadership, workforce and those external to the organization, but serve on committees, are prepared to meet the needs of our diverse population, we provide a range of learning opportunities in variety of modalities to engage staff and leadership throughout the organization. Understanding and developing a process-oriented approach to cultural humility, though complex, positions our organization to better achieve our mission and reduce health disparities.

To ensure education and development opportunities are relevant to member needs and barriers to care, the health plan reviews membership demographic profiles and ensures that training topics and consulting services integrate concepts reflective of the diverse membership. Magnolia Health provides all employees, regardless of position within the organization, with training and educational opportunities at least annually on culturally and linguistically appropriate practices, reducing bias or promoting inclusion, and reports and evaluates completion rates.

MEMBER ACCESS TO CARE

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

The Quality Department report results to the Performance Improvement Team and/or the Quality Improvement Committee for consideration of corrective action if opportunities are identified. Results are included in the annual Quality Program Evaluation. Magnolia Health ensures compliance with contractual, regulatory, and accreditation requirements, including all reporting requirements, to maintain timely and appropriate access to care for all members.

Network Adequacy – Magnolia Health maintains and monitors the provider network to ensure members have adequate access to all covered services. Magnolia Health recognizes the necessity

to have providers who are best able to meet the complete needs of members and eliminate barriers to access. Numerous factors beyond network adequacy analyses are considered, such as patterns of care, cultural and linguistic needs, and social determinants and drivers of health. Per applicable federal and state regulations, Magnolia Health contracts with all required and essential provider types, such as federally qualified health centers (FQHCs) and rural health clinics (RHCs), etc. Additionally, Magnolia Health ensures adequate numbers and geographic distribution of primary care, specialists, behavioral health practitioners, and other healthcare practitioners and providers while taking into consideration the special and cultural needs of members.

Magnolia Health used a regionally focused data-driven approach to identify network adequacy issues and ensure implementation of locally driven mitigation strategies. Network adequacy is assessed on an ongoing basis to ensure adequacy standards are met and to determine if modifications to the network need to occur. Standards are set for the number and geographic distribution (i.e., time and distance standards), with consideration of clinical safety and appropriate standards for the applicable service area for designated practitioner/provider types. Results are reviewed and recommendations are made to the Performance Improvement Team and/or the Quality Improvement Committee to address any deficiencies in the number and distribution of providers. Magnolia Health ensures compliance with contractual, regulatory, and accreditation requirements, including all reporting requirements, to maintain adequate provider availability for members.

Appointment Availability – Magnolia Health monitors practitioner appointment availability using targets set by the Division of Medicaid contract on an ongoing basis. At least annually, the health plan uses a statistically valid sampling methodology to conduct appointment availability audits of PCPs, high-volume specialists including OB/GYNs, behavioral health, and high-impact specialists. CAHPS results are also analyzed to identify primary care, behavioral health, and specialty appointment availability issues. In addition, Magnolia Health analyzes appointment access complaints/grievances/appeals and may solicit feedback from the Member, Provider and/or Community Advisory Committees related to appointment access trends.

After Hours Access – Magnolia Health annually conducts after hours call surveys to assess compliance with non-business hours telephone coverage standards. Member complaints/grievances to identify potential issues are also analyzed, and PCP offices surveyed after hours to verify availability of a live respondent or appropriate messaging about how to reach the covering doctor.

Transitions of Coverage – Magnolia Health ensures compliance with all federal, state, and accreditation transition of care policy requirements, for example:

- When a Magnolia Health member transitions to the health plan from either Fee-for-Service (FFS) Medicaid or another health plan:
    - A member in an ongoing course of treatment, or with an ongoing special condition where changing providers may disrupt care, may continue seeing his/her provider (even if they are out-of-network) for up to 90 days and/or

    - New members who are pregnant and, in their 2nd or 3rd trimester, may continue seeing their provider(s) through their pregnancy and up to 60 days after delivery.
- When a practitioner in good standing leaves the Magnolia Health network
    - Members may continue seeing that provider for up to 90 days and/or
    - Pregnant members in their 2nd or 3rd trimester may continue seeing the provider through pregnancy and the postpartum period, for up to 60 days after delivery.

Continuity and Coordination of Care – Magnolia Health monitors and acts as needed to improve continuity and coordination of care across the health care network. This includes continuity and coordination of medical care through collection of data on member movement between practitioners and data on member movement across settings. Continuity and coordination between medical care and behavioral healthcare is also monitored with data collected in several areas to identify opportunities for collaboration. Magnolia Health collaborates with behavioral healthcare practitioners to complete analysis of the data collected in the areas noted above and identify opportunities for improvement.

Continuity and coordination of medical care, and between medical care and behavioral healthcare, may be assessed via several different measures or activities. These include, but are not limited to, HEDIS measures, CAHPS or other member experience survey results, provider satisfaction surveys, etc. Magnolia Health collects data related to continuity and coordination of care, analyzes the data to identify opportunities for improvement, selects opportunities for improvement, and implements actions for improvement. The effectiveness of improvement actions is measured annually, and re-measurement results analyzed.

Cultural Responsiveness – Recognizing that a strong relationship between the individual or caregiver, physician, and care team enhances care coordination and is the key to improving the health and care experience for our members, we evaluate our practitioner network annually against the cultural needs and preferences of our member population.

To support this effort, demographic data is collected from practitioners and practices. Provider demographic information such as race and ethnicity, and the practice's language fluency and language services offered, are obtained through the credentialing and enrollment process as outlined in the CC.PRVR.47 policy. Self-reported, practitioner demographic information is available upon request for member access preferences. Through data, we can expose and analyze deficiencies in our practitioner network and adjust the network as appropriate. The annual report describes our assessment, methodology, monitoring, results, and analysis for each data source, and actions initiated to improve the network adequacy. The health plan is committed to ensuring that its policies and infrastructure are attuned to the diverse needs of all members, thereby taking active steps to reduce known healthcare disparities that stem from cultural and linguistic issues.

Language Access and Availability – The CLAS Program and CC.QI.CLAS.29 policy addresses the provision of language access services with guidance to departments that interact with members and providers to ensure a continuum of language services to members and/or

caregivers who have limited English proficiency (LEP); are deaf, deaf-blind, or hard of hearing; and/or those who request language services. Language Services include:

- Over-the-phone (OPI): interpretation that occurs over the telephone.
- On-site Interpretation, otherwise known as in-person or face-to-face interpreting, when a language interpreter is scheduled to meet a member at a defined location.
- Video Remote Interpretation (VRI): available to mitigate communication barriers to individuals who are deaf, deaf-blind, and hard of hearing. All attempts will be made to secure an on-site sign language; however, it is recommended that the VRI device be introduced into the communication process as soon as possible in the case that on-site interpreter cannot be secured.
- TTY/TDD (toll-free number) capability. TTY is presently the preferred term for this technology.
- Written Translation: transposition of a text from one language to another.
- Alternate Format: materials as an alternative to traditional print: audio, Braille, large print, and machine-readable electronic formats.

Member-facing staff are trained to receive and effectively access language services requested or required by members at the point of contact with the health plan. OPI services are available on-demand in more than 150 languages and accessed by the health plan at the point-of-contact to ensure that members with LEP have access to plan benefit information. Additionally, Member facing staff are trained on the use of the 711 relay to communicate with members who are deaf and hard of hearing. Members who are deaf and/or hard of hearing will be able to contact the call center using 711 relay operations. Member communications from Magnolia Health must clearly identify the toll-free number for members who are deaf and/or hard of hearing to provide to the 711-relay operator to reach the call center.

Language Access Services are available at no cost, at all points of contact where a covered benefit or service is accessed. The Language Access Service modality (i.e., OPI, VRI, etc.) requested and/or required for practitioner interactions is evaluated at the point-of-contact with the health plan staff and scheduled on the members behalf through the network of nationally known interpretation vendors (i.e., Voiance, Language Service Associates, etc.) and/or local resources. Additionally, the health plan supplements cultural and linguistic services by contracting with community organizations including tribal organizations to meet the full range of cultural and linguistic needs of members. Contractors, major subcontractors, and subcontractors are responsible for implementing language services and cultural humility programs as aligned with regulations. The health plan incorporates this requirement through contracting and/or the submission of reports demonstrating compliance.

Spoken and Sign Language Services are also part of the Language Access Services offered by Magnolia Health, which has established quality standards for interpreters, translations and alternate formats that are based on the definitions provided in 45 CFR 92 (Section 1557 of the ACA). The health plan ensures the use of competent spoken language and sign language interpreters to facilitate communication accurately and effectively with people who are LEP, deaf, deaf-blind, hard of hearing and hearing impaired. Quality standards for contracted

interpreter services are documented in detail in contracts with individual language services vendors.

Bilingual workforce at the health plan may be used for interpreting if the staff member has been assessed for language proficiency and completed the requisite education and training programs in effective communication techniques. Bilingual workforce at the health plan engaging in direct communication with LEP individuals are assessed for language proficiency through bilingual assessments in target languages and can perform their responsibilities either in English or in another language. Evaluation and documentation are maintained in the employee profile with the organization's Human Resource system.

Practitioners and offices who provide bilingual services attest to proficiency during the credentialing process. This information is included in the provider directory. Providers are advised of the quality standards and both providers and members are encouraged and educated on the use of language services that are available from the health plan, in compliance with the federal CLAS standards and Company policy.

Access and Availability: Written Translation Services (Standard 8)
The health plan provides easy-to-read, culturally sensitive materials in English and threshold languages. Materials are written in plain language at, or below maximum reading grade level defined by Mississippi, and take into consideration language proficiencies, type of disabilities, literacy levels, cultural variation, age-specific targeted learning skills and ability to access and use technology. Plain language is assessed through resources such as the Flesch Reading Ease and Flesch-Kincaid grade level scales, in addition to tools such as Readability Studio and Health Literacy Advisor available through Centene. Training materials on how to write and communicate using plain language are available to all departments that produce member materials. Translation vendors are also required to maintain the reading level of the English version in their translations.

The health plan provides required translated materials in threshold/prevalent languages in accordance with state and federal requirements for mailed materials and materials available electronically. At a minimum, these materials are provided upon request by the member. Written translations are available as required by contract or regulation and ensures that all non-English translations and alternate formats meet the standards of quality required by law, regulatory agency, contract, or oversight agency. The organization uses contracted vendors for all non-English translations and braille. Translation vendors provide an attestation of quality for all materials and adhere to agreed-upon standards for timeliness in producing translations, as documented in contracts.

If available, certified bilingual staff may be utilized for sight translations. Requests for written translation and for sight translation (oral translation) of print materials are managed in accordance with (HEALTH PLAN: Insert name of health plan policy outlining this process here; if not applicable, delete paragraph).

Notification of Language Access Services (Standard 6)

Member Notification: Communication and dissemination of the health plan's availability of language assistance services is critical to ensure members with limited English proficiency, are deaf, and/or hard of hearing can meaningfully access program services. The health plan works to ensure that members are informed on how to access language services at all points of contact (member services, claims, utilization management, disease management, care management, and/or grievances and appeals).

The organization disseminates notice of Language Access Services using Taglines on printed and electronic materials. Taglines are designed to inform individuals with limited English proficiency about the availability of language assistance services. For example, a tagline written in Spanish might say: "If you speak Spanish, language assistance services are available free of charge. Call XXX-XXX-XXXX for assistance." Members also receive written materials informing them of the availability of language services in threshold languages. Threshold languages are all languages other than English spoken by 5 percent of the population or by 1,000 individuals, whichever is less. Threshold languages are evaluated at least every three years using census or community-level data.

The notification of language assistance must be provided annually to all individuals as per Section 1557 of the Patient Protection and Affordable Care Act or under state law, whichever provides more robust guidelines for notification. If the percentage of community individuals speaking any non-English languages reach a 1 percent threshold, or other threshold outlined in federal law, state law, or contractual obligations of Magnolia Health, certain materials may be required to be provided in a threshold language to individuals with a documented preference for the threshold language.

Written communications (i.e., Member Handbook, Newsletters, etc.,) provide notice of Language Access Services available and written in plain language. A language insert is also sent with new member materials advising members how to request a translation, alternate format or arrange for interpreter support. The language notice and nondiscrimination notice are included with all significant communications and posted in public spaces. To ensure members have unlimited access to information on language services and the plan's nondiscrimination efforts, the health plan's website also contains these materials on both its public and secure member portals. Provider and practice language capabilities are published in provider directory (see policy CC.PRVR.19).

Practitioner Notification: Communication and dissemination of the health plan's availability of language assistance services to practitioners is critical to ensure members with limited English proficiency, are deaf, and/or hard of hearing can meaningfully access program services. To facilitate language access services, information about the language patterns of the community or service area are provided and individual member level data is available through the Provider Portal to prepare the practitioner for interaction and educates contracted practitioners on how members can get access to no-cost interpreter services and oral translation services.

The organization disseminates information and resources on Language Access Services to Practitioners to assist in the provision of services. Practitioners receive information on the

availability of language assistance services contracted through the health plan, language composition of the service area and/or state, and how to access services. Information is disseminated through the Provider Manual, Provider Portal, and online provider newsletter. Additionally, materials and resources are available for practitioners to deploy at their locations to educate members about language services. Resources and materials include:

- "'I Speak' Cards": these cards are cards to help identify what language an individual speaks, and to identify what language an interpreter will need to speak to communicate effectively with that individual. "I speak" cards are also called language identification cards and contain the text "I speak" in a variety of languages. They are intended to help an individual point to a language they understand.
- Practitioners are offered training on the provision of language services.
- Practitioners are offered cultural humility training demonstrating the impact that culture and language have on health care outcomes and patient decisions.

Monitoring Utilization Patterns
To ensure appropriate care and service to members, Magnolia Health's UMC performs routine assessment of utilization data to identify potential over- and under-utilization issues or practices. Data analysis is conducted using various data sources such as medical service encounter data and pharmacy reporting to identify patterns of potential or actual inappropriate utilization of services. The Medical Management department works closely with the Medical Directors to identify problem areas and provide improvement recommendations to the UMC for approval. The PHCO Department implements approved actions to improve appropriate utilization of services.

Preventive Health Reminder Programs – These population-based initiatives 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, digital, and/or written outreach to members/parents/guardians to remind of applicable preventive health screenings and services due or overdue and assistance with scheduling appointments and transportation to the appointments as needed.
- Targeted written and/or face-to-face education and communication to providers identifying assigned members due or overdue for preventive health screenings such as annual well visits, immunizations, lead testing, cervical cancer screening, breast cancer screening, etc.

POPULATION HEALTH MANAGEMENT

Magnolia's Population Health Management (PHM) strategy is guided by the Magnolia Health Population Strategy Description and includes a comprehensive plan for managing the health of its enrolled population, reducing disparities, improving health outcomes, and controlling health care costs and is coordinated with activities addressed in this program description. The PHM Strategy is closely aligned with the Quality Program priorities and goals, with PHM goals and objectives focused on four key areas of member health needs: keeping members healthy, managing members with emerging health risk, patient safety/outcomes across settings, and managing multiple chronic illnesses. Magnolia Health's PHM framework has three pillars: whole health, focus on individuals, and active local involvement.

The PHM Strategy aims to reduce inequities and prevent health risk and manage existing conditions including outlining how member health needs are identified and stratified and segmented 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, resources, and outcomes are reported to the Quality Improvement Committee for review, recommendations, and approval.

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

Magnolia Health 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 Health 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 Health's condition management and population health management programs help members understand their diagnoses, learn self-care skills, and adhere to treatment plans. Eligibility for PHM programs and services varies by the members' conditions and needs but is not limited to risk stratification, population segmentation, provider referral, self-referral, and care giver referral.

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. Members that are eligible for participation in PHM programs are informed about how they

became eligible to participate in the specific program, how to use program services and how to opt-in or opt-out of the program.

The Care Management team will complete a health risk screening and or care management assessment as needed and explain their role, function, and benefits of the program. Programs also include written communication to primary care providers informing 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 evidence-based practice guidelines.

The Care Management Program Description further outlines Magnolia Health'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.

BEHAVIORAL HEALTH SERVICES

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

Special populations such as serious mental illness (SMI) or serious emotional disturbance (SED) adults may require additional services and attention, which may lead to the development of special arrangements and procedures with our provider network to arrange for and provide certain services to include:

- Coordination of services for members after discharge from state and private facilities to integrate them back into the community; this includes coordination to implement or access services with network behavioral health providers or Community Mental Health Centers (CMHCs)
- Targeted case management by community mental health providers for adults in the community with a severe and persistent mental illness

The goals of the Behavioral Health Program mirror that of the Utilization and Care Management Programs. The program is intended to decrease fragmentation of healthcare service delivery; facilitate appropriate utilization of available resources; and optimize member outcomes through education, care coordination, and advocacy services for the served. It is a collaborative process that utilizes a multi-disciplinary, member-centered model to foster the integration of services and delivery of care across the care continuum. It supports the Institute for Healthcare Improvement's Triple Aim objectives, which include:

- Improving the patient experience of care (including quality and satisfaction).
- Improving the health of populations.
- Reducing the per capita cost of healthcare.

COMMUNITY ENGAGEMENT

Magnolia Health establishes a Community Advisory Committee (CAC) and Member Advisory Committee (MAC) to ensure members of culturally diverse communities are included in processes to assist in identifying and prioritizing opportunities for improvement. The MAC assists with identifying cultural competency and/or language service-related issues, provides feedback on service needs of the community, and promotes health equity services to community members.

The CAC and MAC are comprised of a diverse and demographically representative group of participants that reflect the community. As defined by the charter, the CAC and MAC consists of community members, health plan members, representatives of community-based organizations (CBOs), providers, and other invested stakeholders, representing ≥ 5% of the geographic, cultural, racial/ethnic, and linguistic diversity of the membership. The CAC and MAC meets on an as needed basis to share issues and opportunities with the health plan. Meeting minutes and information are shared with plan leadership and incorporated into quality improvement projects to close gaps as appropriate.

PROVIDER SUPPORTS

Magnolia Health collaborates with network providers to build useful, understandable, and relevant analyses, and reporting tools to improve the network's cultural responsiveness to member preference, 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 and CLAS improvement activities that yield performance improvements and reduces outcome disparities.

Included is 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 linguistically appropriate, 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:

- Member demographics, including race, ethnicity, language, sexual orientation, and gender identity.
- Disease registries
- Care gap reporting at member and population levels.
- Claims-based patient histories
- Exportable patient data to support member outreach.

Provider Analytics – Magnolia Health offers a quality cost and utilization tool designed to support providers who participate in a value-based program in order to identify provider performance opportunities and assist with population health management initiatives. Provider analytics prioritizes measures based on providers' performance to help identify where to focus clinical efforts in order to optimize pay-for-performance (P4P) payouts, which may include:

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

Through these supporting platforms, Magnolia Health works to keep providers engaged in the delivery of value-based care by promoting wellness and incentivizing the prudent maintenance of chronic conditions. This engagement helps providers identify performance insights as well as identify opportunities for improvement.

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

Practitioner Profiling

As part of its motivational incentive strategies, Magnolia Health may systematically profile the quality of care delivered by high-volume PCPs to improve Provider compliance with clinical and/or preventive practice guidelines and clinical performance indicators. The profiling system is developed with Magnolia Health network physicians and providers to ensure the process has value to physicians, providers, members, and Magnolia Health.

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

Practitioner adherence to Magnolia Health's adopted preventive and clinical practice guidelines may be encouraged in the following ways: new provider orientations include reference to practice guidelines with discussion of health plan expectations; measures of compliance are shared in provider newsletter articles available on the provider web site; targeted mail outs that include guidelines relevant to specific provider types and underscore the importance of compliance; and provider incentives. Magnolia Health uses applicable HEDIS measures to monitor reduction of healthcare disparities and practitioner compliance with adopted guidelines. If performance measurement rates fall below Magnolia Health /state/accreditation goals, Magnolia Health implements interventions for improvement as applicable.

Network Cultural Responsiveness - Recognizing that a strong relationship between the individual/caregiver, physician, and care team enhances care coordination and is the key to improving the health and care experience for our members, we evaluate our practitioner network annually against the cultural, ethnic, racial, and linguistic needs and/or preferences of our member population.

To support this effort, demographic data is collected from practitioners and practices. Race, ethnicity, and language proficiency is obtained through the credentialing and/or enrollment process as outlined in the CC.PRVR.47 policy. Self-reported, practitioner demographic information is available upon request for member access preferences. Through data, we can expose and analyze deficiencies in our practitioner network and make adjustments as appropriate. The health plan is committed to ensuring that its policies and infrastructure are attuned to the diverse needs of all members, thereby taking active steps to obtain practitioner data to reduce known healthcare disparities that stem from cultural and linguistic issues.

Education and Development – Magnolia Health supports contracted practitioners in their efforts to provide culturally responsive and linguistically appropriate care and covered services to members. Contracted providers are advised on how to access language services in the provider operations manual, through routine provider updates, and via online newsletter articles. The services offered to contracted providers are intended to:

- Promote cultural responsiveness and awareness.
- Support access to and coordination of language services (i.e., interpretation and translation)
- Offer tips for effective communication using interpreters.

Providers may request cultural humility and responsiveness training tailored to the needs of their practice. Customized training may include specific strategies to address the cultural barriers to health care prevalent in the service area. The health plan may provide the training in person, as a webinar, or in computer-based training modules. Providers are also encouraged to take the online cultural competency trainings offered by the Office of Minority Health on its website. These training modules encourage providers to focus on local population cultural needs and includes:

- Information on the cultural expectations for health care.
- Information on traditional or alternative health care.
- Tips and suggestions on how to address cultural issues.

- Patient-centered care and effective communication techniques.

Additional training courses offer specialized information for nurses, psychiatrists, psychologists, behavioral health professionals, maternal health providers, oral health professionals, and more. Providers are reminded annually of their responsibility to take cultural competency training through an annual provider newsletter or an annual provider update and in the provider manual. Providers may also call the health plan's toll-free Provider Relations number with any questions they may have about cultural or linguistic issues.

PERFORMANCE IMPROVEMENT ACTIVITIES

Magnolia Health's Quality Improvement Committee 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 to identify and reduce inequities also include behavioral health care issues and/or strategies.

The health plan utilizes traditional quality/risk/population health and 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. Baseline data may come from: performance profiling of contracted providers, mid-level providers, ancillary providers, and organizational providers; provider office site evaluations; focus studies; utilization information (over- and under-utilization performance indicators); sentinel event monitoring; trends in member complaints, grievances, and/or appeals; issues identified during care coordination; and/or referrals from any source indicating potential problems, including those identified by affiliated hospitals and contracted providers. 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 cultural preferences, disparity reduction, social determinants and drivers of health, age groups, disease categories, and special risk status.

The Performance Improvement Team 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 Performance Improvement Team helps to define the study question and the quantifiable indicators, criteria, and goals to ensure the project is measurable 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 Performance Improvement Team 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 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)
- The improvement is reasonably attributable to interventions undertaken by the health plan.

PERFORMANCE IMPROVEMENT PROJECTS

Magnolia Health develops Performance Improvement Projects (PIP) designed to achieve significant improvement, sustained over time, in health outcomes and in member satisfaction. PIPs include measuring the impact of the interventions or activities toward improving the quality of care, health equity, and service delivery. PIPs are aligned with the priorities in the MS DOM Quality Strategy. PIPs have SMART (Specific, Measurable, Actionable, Realistic, and Timebound) goals and utilize quality management tools to drive improvement, monitor and evaluate. Magnolia Health will collaborate with the DOM and other CCOs on PIPs as required for both MSCAN and CHIP.

GRIEVANCE AND APPEALS SYSTEM

Magnolia Health ensures members can address their concerns quickly and with minimal burden. Magnolia Health investigates and resolves member complaints/grievances, appeals, and quality of care concerns in a timely manner. All complaints/grievances are aggregated by type and category to identify the underlying reason, including perceptions of ethnic, racial, cultural, or linguistic bias in access and deficiencies in organizational processes were interpreted to identify barriers to improvement and/or impacting our ability to achieve our member experience goals. To facilitate aggregation of data, perceptions of ethnic, racial, cultural, or linguistic bias are grouped into two primary CLAS sub-categories of cultural needs and discrimination.

Members may file a complaint/grievance to express dissatisfaction with any issue that is not related to an adverse benefit determination (e.g., concerns regarding quality of care or behavior of a provider or Magnolia Health employee) or file a formal appeal of an adverse benefit determination. Upon exhaustion of the internal appeal process, members may request additional levels of appeal as applicable. Magnolia Health reports on grievance and appeals processes and outcomes as required.

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

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

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, the federal government, etc. The Quality Department maintains a schedule of relevant quality reporting requirements for all applicable state and federal regulations and accreditation requirements and submits reports in accordance with these requirements. Additionally, the Quality Program and all health plan departments fully support every aspect of the federal privacy and security standards; Business Ethics and Code of Conduct; Compliance Plan, and Waste, Fraud and Abuse Plan.

NCQA HEALTH PLAN & HEALTH EQUITY ACCREDITATION

Magnolia Health adheres to the belief that NCQA Health Plan and Health Equity Accreditation demonstrates a health plan's commitment to delivering high-quality, equitable care and service for members and thus strives for a continual state of accreditation readiness. The Magnolia Health Chief Medical Director; VP/Director, Quality; and Senior Accreditation Specialist facilitate the accreditation process with support from Centene Corporation's national accreditation team.

Magnolia Health also believes NCQA Health Equity Accreditation better aligns with NCQA's values to reflect the continuous quality improvement necessary to advance health equity and symbolizes the importance for all organizations. Health Equity Accreditation focuses on race, ethnicity, and language as avenues for improving culturally and linguistically appropriate care and reducing health care disparities. The Magnolia Health Chief Medical Director; VP/Director, Population Health and Clinical Outcomes; and Senior Accreditation Specialist facilitate the accreditation process with support from Centene Corporation's national accreditation team.

Magnolia Health works to meet all NCQA Health Plan and Health Equity standards. Magnolia Health will provide the MS Division of Medicaid with the accreditation certificates after each

survey and/or any updated certificates of accreditation status. The certificates will show proof of meeting all NCQA standards. The accreditation certificate will indicate the type of accreditation, accreditation status, and level of accreditation as applies, and the expiration date. Magnolia Health will notify the MS Division of Medicaid of any NCQA recommended actions or improvements, corrective action plans, and summaries of findings during or at the end of a survey. Accreditation status will be posted on the Magnolia Health website at the bottom of the landing page.

DELEGATED SERVICES

The Quality Improvement Committee may authorize participating provider entities, such as independent practice associations, hospitals, or other organizations, 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, and as such monitors the performance of the delegated entity through annual approval of the delegate's programs (Dental, Vision, Transportation, 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 Population Health and Clinical Operations (PHCO), 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.

Magnolia Health Quality Improvement Committee 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 _____, <<Year>>_____.

_____
Vice President Quality

_____
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 _____, <<Year>>____.

_____
Board of Directors Chairman