POLICY AND PROCEDURE

DEPARTMENT: Quality	**DOCUMENT NAME:** Quality Operational Documents
PAGE: 1 of 48	**REPLACES DOCUMENT:** CC.MEDM.QI.01
APPROVED DATE: March 2017	**RETIRED:** QI.01.02 Quality Improvement Operation Cycle and QI.02 Program Operations
EFFECTIVE DATE: July 2017	**REVIEWED/REVISED:** 08/17; 03/18; 07/18, 12/2018, 12/2019; 4/20
PRODUCT TYPE: Medicaid, Marketplace, Medicare	**REFERENCE NUMBER:** NV.QI.01

SCOPE:
Quality and all applicable health plan departments.

PURPOSE:
To describe the Quality Program documents and the documentation cycle for continuous quality improvement.

PROCEDURE:

I. The Trilogy Documents consist of the three (3) following documents that establish a planned, systemic and comprehensive approach to measure and assess with the goal to improve health plan wide performance of care provide to the members:
   A. Quality Program Description – a written document that outlines the health plan structure and process to monitor and improve the quality and safety of clinical care and the quality of services provided to members;
   B. Quality Work Plan – an annual work plan that documents the objectives, planned activities, and provides a mechanism for tracking quality activities to identify opportunities throughout the year; and
   C. Annual Evaluation – an analysis of the overall effectiveness of the Quality Program that is completed annually to determine the level of quality member care and services delivered.

II. Document Development and Approval:
   A. Initiated and developed by the Quality Department;
   B. Reviewed and recommendations made by the Quality Committee; and
   C. Annual approval by the Quality Committee and Board of Directors.

REFERENCES:
Current NCQA Health Plan Standards and Guidelines
State and/or Federal Contract

ATTACHMENTS:
A. Quality Program Description Template
B. Quality Work Plan Template
C. Quality Program Evaluation Template

DEFINITIONS:

SilverSummit Healthplan

2020
Quality
Program Description

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INTRODUCTION

SilverSummit Healthplan is a quality-driven organization that adopts continuous quality improvement as a core business strategy for the entire health plan. SilverSummit Healthplan develops and implements a quality management strategy that is embedded within every staff role and department function, approaching quality assurance, quality management, and quality improvement as a culture, integral to all day to day operations. Each SilverSummit Healthplan operational area has defined performance metrics with accountability to the SilverSummit Healthplan Quality Improvement Committee and Board of Directors.

SilverSummit Healthplan 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. SilverSummit Healthplan provides for the delivery of quality care with the primary goal of improving the health status of members by supporting physicians/providers, who know what is best for their patients.

The SilverSummit Healthplan leadership team is committed to focusing clinical, network, and operational processes towards improving 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 SilverSummit Healthplan Quality Program applies a systematic approach to quality 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 quality improvement initiatives.

This type of methodology supports SilverSummit Healthplan to develop targeted, measurable interventions and quickly evaluate the impact of an activity on improvement goals. In many instances, SilverSummit Healthplan deploys a rapid cycling improvement activity, designed to immediately impact process improvements to improve member outcomes 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 SilverSummit Healthplan 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 Medical Management, Pharmacy, Provider Engagement/Provider Relations, Population Health Management, Network/Contracting, Member Services, Compliance, and Grievances and Appeals.

PURPOSE

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

The Quality Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of health care provided to all members. Whenever possible, SilverSummit Healthplan'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.

SilverSummit Healthplan 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.

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 SilverSummit Healthplan Quality Improvement Committee and SilverSummit Healthplan Board of Directors.

SCOPE

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

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

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

improvement information to participating providers in order to support them in their efforts to provide high quality health care, and adoption and distribution of evidence-based practice guidelines;

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

PRIORITIES AND GOALS

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

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

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

CONFIDENTIALITY

Confidential information is defined as any data or information that can directly or indirectly identify a member or provider. SilverSummit Healthplan 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 SilverSummit Healthplan 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 SilverSummit Healthplan Quality Improvement Committee and related peer review committees conduct such proceedings in accordance with SilverSummit Healthplan's bylaws and applicable federal and state statutes and regulations.

The proceedings of the SilverSummit Healthplan Quality Improvement Committee , 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 Medical Management, 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; and
- Compliance leadership.

SilverSummit Healthplan 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.

SilverSummit Healthplan 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, Medical Management, 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 Medical Management, or the Board of Directors Chairman; and
- All participating providers and employees involved in peer review activities or who participate in quality activities or committees are required to sign confidentiality agreements.

CONFLICT OF INTEREST

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

CULTURAL COMPETENCY AND HEALTH EQUITY

SilverSummit Healthplan endeavors to meet the needs of all members with sensitivity to cultural needs and the impact of cultural differences on health services and outcomes. SilverSummit Healthplan is guided by requirements set by each respective state/federal contract and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) developed by the Office of Minority Health. Specifically, the Quality Program identifies and addresses clinical areas of health disparities. SilverSummit Healthplan assures communications are culturally sensitive, appropriate, and meet federal and state requirements. Information provided to members promotes the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities and regardless of gender, sexual orientation or gender identity. Population health management initiatives are reviewed to assure cultural issues and social determinants of health are identified, considered, and addressed. Additionally, SilverSummit Healthplan is committed to improving disparities in care as an approach to improving HEDIS measures, reducing utilization costs and delivering locally tailored, culturally relevant care. As such, SilverSummit Healthplan has developed a health equity approach that identifies and hotspots disparities, prioritizes projects and collaborates across the community to reduce disparities by targeting member, provider and community interventions. Disparity analysis includes analyzing HEDIS and utilization data by eligibility category, race, ethnicity, limited English proficiency, disability, age, gender and geography to identify priority populations and interventions for targeting disparity reduction.

AUTHORITY

SilverSummit Healthplan 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 SilverSummit Healthplan Quality Improvement Committee recommendations for proposed quality studies and other quality initiatives and actions taken;
- Providing the resources, support, and systems necessary for optimum performance of quality functions;

- Designating a senior staff member as the health plan's senior quality executive;
- Designating a behavioral health professional to provide oversight of the behavioral health aspects of care to ensure appropriateness of care delivery and improve quality of service; and
- Evaluating the 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 SilverSummit Healthplan Quality Improvement Committee. SilverSummit Healthplan 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 SilverSummit Healthplan Quality Improvement Committee , which is directly accountable to the Board of Directors.

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

- Compliance with state, federal, and accreditation requirements and regulations;
- Chairing the SilverSummit Healthplan Quality Improvement Committee, as well as the Medical Management 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 SilverSummit Healthplan Quality Improvement Committee ;
- Coordinating the resolution of outstanding issues with the appropriate leadership staff, pertaining to SilverSummit Healthplan Quality Improvement Committee recommendations, subcommittee recommendations, and/or other stakeholder recommendations;
- Being actively involved in the SilverSummit Healthplan '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 on-going patient care monitoring as it relates to population health management programs, pharmacy, diagnostic-specific case reviews, and other focused studies, and directing credentialing and recredentialing activities in accordance with SilverSummit Healthplan 's policies and procedures;
- Reporting the Quality Program activities and outcomes to the Board of Directors at least annually.
- Serves as the liaision between the health plan and its providers, communicating regularly with health plans providers, including oversight of provider education, in –service training and orientation;
- Ensure members Individual Family Service Plans (IFSPs) and Individualized Education Program (IEPs) are followed; and
- Ensures coordination of out-of-network services

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:

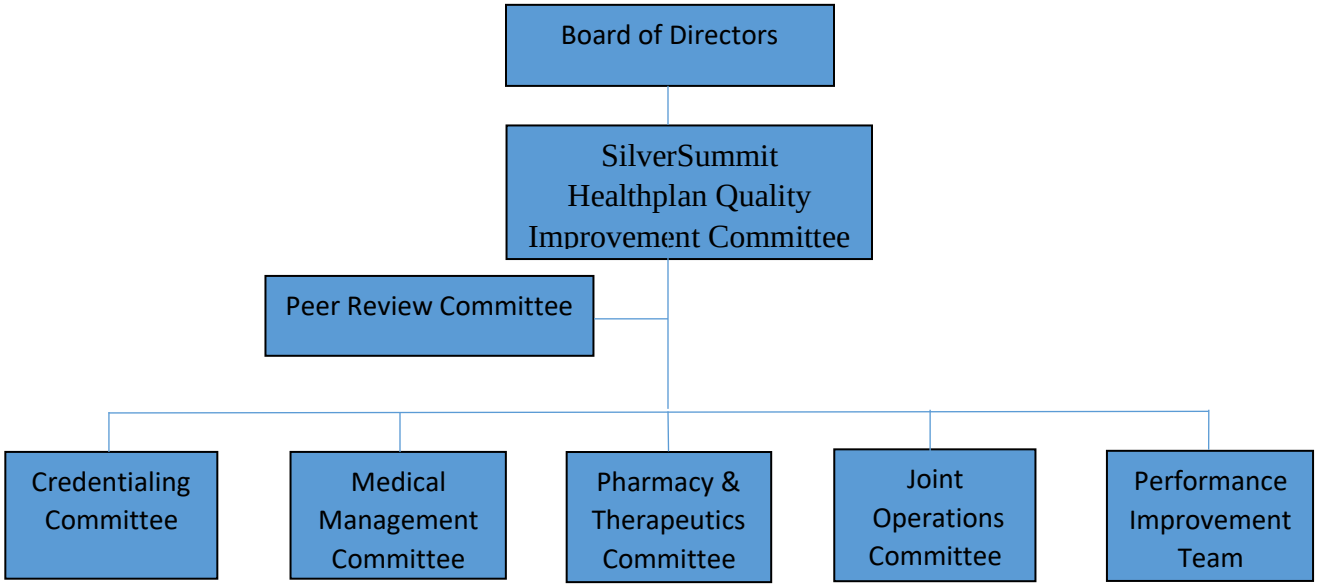
- Compliance with state, federal, and accreditation requirements and regulations related to behavioral health;
- Participating in the SilverSummit Healthplan Quality Improvement Committee and various subcommittees reporting to the SilverSummit Healthplan Quality Improvement Committee, as applicable to behavioral health;
- Monitoring and directing behavioral health quality activities among personnel and among the various subcommittees reporting to the SilverSummit Healthplan 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 is integrated throughout SilverSummit Healthplan, and represents the strong commitment to the quality of care and services for members. The Board of Directors is the governing body designated for oversight of the Quality Program and has delegated the authority and responsibility for the development and implementation of the Quality Program to the SilverSummit Healthplan Quality Improvement Committee.

The SilverSummit Healthplan 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. SilverSummit Healthplan ensures ongoing member, provider, and stakeholder input into the Quality Program through a strong [Quality Committee Name] and subcommittee structure focused on member and provider experience. The SilverSummit Healthplan 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 SilverSummit Healthplan Quality Improvement Committee serves as the umbrella committee through which all subcommittee activities are reported and approved. The SilverSummit Healthplan 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 level committees as needed based on distribution of membership. These committees assist with monitoring and supporting the Quality Program. The SilverSummit Healthplan committee structure is outlined below:

SilverSummit Healthplan Committee Structure



SilverSummit Healthplan **Core Committee Charters**

SilverSummit Healthplan Quality Improvement Committee	
Charter Statement	The SilverSummit Healthplan Quality Improvement Committee is the senior leadership committee, accountable to the Board of Directors that reviews and monitors all clinical quality and service functions of the health plan and provides oversight of all subcommittees.
Purpose	The purpose of the SilverSummit Healthplan Quality Improvement Committee is to provide oversight and direction in assessing the appropriateness of care and service delivered, and to continuously enhance and improve the quality of care and services provided to members through a comprehensive, health plan-wide system of ongoing, objective, and systematic monitoring of activities and outcomes using the quality process.

Responsibilities	• Oversight of the quality activities of the health plan to ensure compliance with contractual requirements, federal and state statutes and regulations, and requirements of accrediting bodies such as the National Committee for Quality Assurance (NCQA); • Annual development of the Quality Program Description and Work Plan incorporating applicable supporting department goals as indicated; • Development of quality and performance improvement studies and activities, and reporting of findings to the Board of Directors; • Annual review and approval or acceptance of the Credentialing, Pharmacy, Utilization Management, Care Management, and Population Health Management Program Descriptions and Work Plans as developed by the appointed subcommittees to facilitate alliance with the strategic vision and goals; • Evaluation of the effectiveness of each departments' activities to include analysis and recommendations of policy decisions based on identified trends, barrier analysis, and interventions required to improve the quality of care and/or service to members. Implements corrective actions as appropriate, and acts as a communication channel to the Board of Directors; • Prioritization of quality improvement efforts, facilitation of functional area collaboration, and assurance of appropriate resources to carry out quality activities; • Review and establishment of benchmarks and performance goals for each quality improvement initiative and service indicator; • Review and approval of due diligence information for any potential delegated entity and the annual oversight audit outcomes for delegated entities; • Adoption of preventive health and clinical practice guidelines to promote appropriate and standardized quality of care; • Monitoring of clinical quality indicators (such as HEDIS, adverse events, sentinel events, peer review outcomes, quality of care tracking, etc.) to identify deviation from standards of medical care, and supporting the formulation of corrective actions, as appropriate; and • 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.
Reports To	Board of Directors
Committee Chair	Chief Medical Director, may delegate individual meetings to an Associate Medical Director or Senior Quality Executive
Committee Composition	• Chief Executive/Operating Officer • Chief Medical Director • Behavioral Health Medical Director • VP/Director of Quality • VP/Director of Medical Management • VP/Director Network Development/Contracting • VP/Director of Member & Provider Services/Customer Service • VP/Director Compliance/Regulatory • Network practitioners, at least four (4) representing the range of practitioners within the network and across the regions in which the health plan operates, e.g. family practice, internal medicine, OB/GYN, behavioral health (i.e. physician or clinical PhD or PsyD), vision/dental care providers, and other high-volume specialists as appropriate • In addition, the committee may also have providers knowledgeable about members with disabilities; substance use, abuse of children, etc. • The provider representatives should have experience caring for the health plan membership , including a variety of ages and races/ethnicities, rural and urban populations, etc.
Frequency	Quarterly, with additional meetings scheduled per health plan need
Attendance Required	50% of scheduled meetings
Quorum	A minimum of four (4) committee members, including two health plan staff and two (2) external practitioners, must be present for a quorum. All permanent committee members are voting members; the Committee Chair is the determining vote in the case of a tie vote.

Agenda	Agenda items for the next meeting are developed by the Committee Chair in collaboration with the VP/Director of Quality. The committee receives regular reports from all subcommittees that are accountable to and/or advise the SilverSummit Healthplan Quality Improvement Committee
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable. Materials included in meeting packed are based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The SilverSummit Healthplan Quality Improvement Committee is authorized by the Board of Directors to make all decisions related to the Quality Program, with decisions made by consensus of the committee. Individuals are responsible to raise any issues at committee meetings.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information and/or situations when dissemination of information is to be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Peer Review Committee	
Charter Statement	The Peer Review Committee is an ad-hoc committee of the SilverSummit Healthplan Quality Improvement Committee and responsible for reviewing alleged inappropriate or aberrant services by a practitioner/provider, including potential quality of care incidents, adverse events, and sentinel events where initial investigation indicates a significant potential or significant, severe adverse outcome has occurred or other cases as deemed appropriate by the Medical Director.
Purpose	The purpose of the Peer Review Committee is to review clinical cases and apply clinical judgment in assessing the appropriateness of clinical care and recommending a corrective action plan to best suit the particular situation.
Responsibilities	• To make determinations regarding appropriateness of care; • To make recommendations regarding corrective actions relating to provider quality of care; • To conduct the review by a practitioner of same or similar specialty as the practitioner and/or issue under review. • To develop an approach to modifying the Corrective Action Plan if improvement does not occur • Designate the Vice President of Quality to monitor and evaluate the corrective action plan to assure required changes have been made and report back to the Peer Review Committee • Designate the Vice President of Quality to monitor for changes in the providers practice patterns and report back to the Peer Review Committee • Designate the Vice President of Quality to conduct timely follow-up on identified issues to ensure actions for improvement have been effective and report back to the Peer Review Committee.
Reports To	SilverSummit Healthplan Quality Improvement Committee
Committee Chair	Chief Medical Director
Committee Composition	• Chief Medical Director/Medical Director • VP/Director Quality • Peer practitioners; at least three (3) or more network practitioners who are peers of the practitioner being reviewed and who represent a range of specialties, including at least one practitioner with the same or similar specialty as the case under review, but whose presence does not indicate a conflict of interest • No Credentialing Committee members involved in the Peer Review Committee's recommendation will be included in the Credentialing Committee meeting when the Peer Review Committee's recommendation is discussed
Frequency	Ad hoc, date and time to be determined based on need. Network practitioners serving on the committee may or may not be the same external practitioners serving on the SilverSummit Healthplan Quality Improvement Committee or Credentialing Committee. If the same practitioners

	are used, the SilverSummit Healthplan Quality Improvement Committee or Credentialing Committee meeting is adjourned and the Peer Review meeting started as an independent meeting with an independent agenda and minutes.
Attendance Required	100% of scheduled meetings. Network provider members are not standing members of the committee and their attendance may change based on type of case being reviewed.
Quorum	At least two (2) network providers and one (1) Medical Director must be present for a quorum. All permanent committee members are voting members; the Committee Chair is the determining vote in the case of a tie vote.
Agenda	Meetings are agenda driven. The Committee Chair and/or Quality designee develop agenda items for the next meeting.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials. All names and identifying information is redacted and information is distributed in a secure manner.
Decision Authority	The SilverSummit Healthplan Quality Improvement Committee authorizes the Peer Review Committee to make decisions and recommendations regarding practitioner quality of care.
Evaluation	The committee reviews the charter annually.
Confidentiality	Peer review laws governing confidentiality of its proceedings protect each committee member. 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 committee member must agree to and sign a committee confidentiality statement on an annual basis.

Credentialing Committee	
Charter Statement	The Credentialing Committee is a standing subcommittee of the SilverSummit Healthplan Quality Improvement Committee, and oversees and has operating authority of the Credentialing Program.
Purpose	The purpose of the Credentialing Committee is to provide oversight of the development and annual review/approval of credentialing policies. The Credentialing Committee has final authority for credentialing and recredentialing licensed medical and behavioral health practitioners, other licensed healthcare professionals, and organizational providers who have an independent relationship with the health plan. The Committee oversees the credentialing process to ensure compliance with regulatory and accreditation requirements and ensure network practitioners and organizational providers are qualified, properly credentialed, and available for access by health plan members.
Responsibilities	• Provide guidance to organization staff on the overall direction of the Credentialing Program; • Review and approve credentialing and recredentialing policies and procedures; • Review and recommend credentialing and recredentialing criteria; • Final authority to approve or disapprove applications by practitioners and organization providers for network participation status and recredentialing; • Provide clinical peer input to address standards of care for a particular type of practitioner; • Review oversight audits of delegates Credentialing Program performance; • Evaluate and report to management on the effectiveness of the Credentialing Program; and • Review potential QOC events and adverse events, including any corrective action plans from peer review committee, for recredentialing decisions.
Reports To	SilverSummit Healthplan Quality Improvement Committee
Committee Chair	Chief Medical Director; as committee member leadership develops, a committee network provider may chair at the discretion of the Credentialing Committee
Committee Composition	• Chief Medical Director/Medical Director(s) • Health plan Credentialing staff designee • Centene Corporate Credentialing Manager/Supervisor • Network practitioners from a range of specialties, e.g. family practice, internal medicine, OB/GYN, behavioral health, high-volume specialists, mid-level practitioners, etc. • Other executive leadership or health plan staff as determined • The committee actively involves participating network practitioners in credentialing review activities as available and to the extent that there is not a conflict of interest.
Frequency	At least ten (10) times per year to facilitate timely review of practitioners/providers and to expedite network development; additional meetings scheduled as needed.
Attendance Required	50% of scheduled meetings
Quorum	A minimum of four (4) voting members, including the Chair, must be present for a quorum. Three (3) voting members must be appropriately licensed healthcare practitioners. Only healthcare practitioners are voting members; the Chair is the determining vote in the case of a tie vote.
Agenda	Meetings are agenda driven and follow a standard format. Agenda items for the next meeting are developed by the Corporate Credentialing Manager in collaboration with the Committee Chair.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The Medical Director may approve clean files; the SilverSummit Healthplan Quality Improvement Committee has delegated responsibility for credentialing/recredentialing practitioners, facilities, and other organizational providers not meeting clean file criteria to the committee. The decision making model is by consensus. Individuals are responsible and encouraged to raise any issues at committee meetings.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations of how dissemination of information is managed. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Medical Management Committee	
Charter Statement	The Medical Management Committee is a standing subcommittee of the SilverSummit Healthplan Quality Improvement Committee with oversight and operating authority of medical management activities.
Purpose	The purpose of the Medical Management Committee is to review and monitor the appropriateness of care provided to health plan members. The Medical Management Committee is responsible for the review and appropriate approval of medical necessity criteria and protocols, and utilization management policies and procedures, including a list of procedures requiring prior authorization.
Responsibilities	• Annually review and approve program descriptions, work plans and annual evaluations for Population Health Management, Utilization Management, and Case Management; • Review and maintain applicable policies/procedures and guidelines; • Annually review and approve the criteria for determination of medical appropriateness; • Review the utilization management process, including referrals, second opinions, prior authorization/pre-certification, concurrent and retrospective review, discharge planning, etc. • Review practitioner/facility/geographic area specific reports for trends/patterns in utilization; • Formulate recommendations for specific practitioners/providers for further study; • Examine reports of the appropriateness of care for trends or patterns of under- or over- utilization and refer for performance improvement or corrective action if indicated; • Examine results of annual surveys of members and practitioners regarding satisfaction with UM processes and medical management programs; • Create and implement a feedback mechanism for communicating findings and recommendations, as well as a plan for implementing corrective actions; and • Liaison with the SilverSummit Healthplan Quality Improvement Committee for ongoing review of indicators of clinical quality.
Reports To	SilverSummit Healthplan Quality Improvement Committee
Committee Chair	Medical Director, individual meetings may be chaired by an Associate Medical Director or network practitioner at the discretion of the Medical Director.
Committee Composition	• Executive Leadership • Chief Medical Director/Medical Director • Designated Medical Management staff • Designated Quality staff • Other operational staff as requested, e.g. Networking/Contracting, Member/Provider Services, Compliance/Regulatory, Pharmacy • Network practitioners representing the range within the network and across the service area may participate on the committee
Frequency	Quarterly, with additional meetings scheduled per health plan need
Attendance Required	50% of scheduled meetings.
Quorum	Minimum of 50% of committee members, including two (2) health plan staff and two (2) external practitioners (if included on the committee) must be present for a quorum. All permanent committee members are voting members; the Committee Chair is the determining vote in the case of a tie vote.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting are developed by the Committee Chair in collaboration with the VP/Director of Medical Management.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The Medical Management Committee is authorized by the SilverSummit Healthplan Quality Improvement Committee [Quality Committee Name] to make all decisions related to the

	Medical Management Program, with decisions made by consensus of the committee. Individuals are responsible to raise issues at committee meetings.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when information is managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Pharmacy and Therapeutics Committee	
Charter Statement	The Pharmacy & Therapeutics Committee is a standing subcommittee of the SilverSummit Healthplan Quality Improvement Committee with oversight and operating authority of the Pharmacy Program.
Purpose	The Pharmacy & Therapeutics Committee is responsible for development and annual review of the pharmacy policies and procedures, review of pharmacy utilization data, decisions regarding inclusion of drugs on the Preferred Drug List (PDL), and recommendations for formulary management activities.
Responsibilities	• Develop and annually review the pharmacy policy and procedures; • Conduct practitioner and member profiling for appropriate drug utilization (DUR) and recommendations for DUR activities such as targeted prescriber and/or member education initiatives; • Evaluate and recommend drugs for inclusion in or removal from the PDL for appropriateness as a tool for providing high quality and cost-effective care; • Evaluation of drug costs by therapeutic class for pharmaceutical containment and projection of pharmaceutical costs; • Assure compliance with all contractual, regulatory, and accreditation pharmacy requirements; • Review of complaints/grievances regarding pharmacy issues; • Recommendations for formulary management activities such as prior authorization, step therapy, age restrictions, quantity limitations, mandatory generics, and other activities that promote access and patient safety; and • Review of requests from practitioners for additions or changes to formulary.
Reports To	SilverSummit Healthplan Quality Improvement Committee
Committee Chair	Chief Medical Director, may delegate individual meetings to an Associate Medical Director or Senior Pharmacy Executive
Committee Composition	• Chief Medical Director/Medical Director • VP/Director of Pharmacy • Participating network pharmacists and internal clinical pharmacists • Other health plan executive and operational staff as requested
Frequency	Quarterly, with additional meetings scheduled per health plan need
Attendance Required	50% of scheduled meetings
Quorum	A minimum of four (4) voting members, including the Chair, must be present for a quorum. Three (3) voting members must be appropriately licensed healthcare practitioners (physicians or pharmacists). All permanent practitioner committee members are voting members; the Committee Chair is the determining vote in the case of a tie vote.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting are developed by the Committee Chair in collaboration with the VP/Director of Pharmacy.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.

Decision Authority	The committee is authorized by the SilverSummit Healthplan Quality Improvement Committee to make all decisions related to the pharmacy benefit. Decisions made by consensus. Individuals are responsible and encouraged to raise issues at committee meetings.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information will be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Joint Operations Committee	
Charter Statement	The Joint Operations Committee provides guidance to and oversight of operations affecting the scope of functions of delegated vendors, subcontractors, and Centene specialty companies that provide services to the health plan membership.
Purpose	The purpose of the Joint Operations Committee is to provide oversight and assess the appropriateness and quality of services provided on behalf of the health plan to members. The Joint Operations Committee monitors delegate/vendor compliance with the delegation service agreement and regulatory requirements, identifies issues and opportunities for improvement, and develops mitigation plans as appropriate.
Responsibilities	• Oversee operations of the delegate/vendor to ensure compliance with contractual requirements, federal and state statutes and regulations, and requirements of accrediting bodies; • Annually review the applicable delegate/vendor program descriptions, policies, & procedures; • Examine activity and performance reports to identify undesirable trends and/or patterns; • Provide a feedback mechanism for communicating findings, recommendations, and a plan for implementing corrective action (when necessary) related to the scope of delegated functions; • Monitor financial incentives to ensure quality of care/service is not compromised; • Develop utilization and quality reporting, summary analysis of data, and specialized reports designed exclusively to describe the findings of delegate/vendor activities; • Report recommended actions to address any identified opportunities for improvement to the Performance Improvement Team; • Provide a forum for discussion and collaboration for toward mutual goal attainment; • Review findings of annual delegation audits with the SilverSummit Healthplan Quality Improvement Committee and • Recommend continuation or termination of the delegation arrangement to the SilverSummit Healthplan Quality Improvement Committee
Reports To	SilverSummit Healthplan Quality Improvement Committee
Committee Chair	Delegated Department VP/Director/Manager
Committee Composition	• Chief Medical Director/Medical Director(s) • VP/Director of Compliance and Regulatory Affairs • Delegated Vendor Oversight/Compliance staff • VP/Director Quality • VP/Director of Medical Management and/or VP/Director of Pharmacy as applicable • VP/Director of Network Management and Contracting, Member Services, Provider Services • Grievance and Appeals Coordinator • Delegated vendor staff
Frequency	Quarterly, with additional meetings scheduled per health plan need
Attendance Required	50% of scheduled meetings.
Quorum	A minimum of four (4) voting members, including the Committee Chair, must be present for a quorum. All permanent committee members are voting members; the Committee Chair is the determining vote in the case of a tie vote.
Agenda	Meetings are agenda driven. Agenda items for the next meeting are developed by the Committee Chair in collaboration with the applicable department leads.
Recorder	Delegated committee designee

Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The committee is authorized by the SilverSummit Healthplan Quality Improvement Committee] to make all decisions related to delegated vendor oversight. Decisions made by consensus. Individuals are responsible and encouraged to raise issues at committee meetings.
Evaluation	The committee will review the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information will be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.
Performance Improvement Team	
Charter Statement	The Performance Improvement Team is an internal, cross-functional quality improvement team that facilitates the integration of a culture of quality improvement throughout the organization. Results from performance improvement efforts and activities planned/taken to improve outcomes compared with expected results and findings are evaluated by the Performance Improvement Team, using an industry-recognized methodology for analyzing data.
Purpose	The purpose of the Performance Improvement Team is to be responsible for gathering and analyzing performance measures, performing barrier and root cause analysis for indicators falling below desired performance, and making recommendations regarding corrective actions/interventions for improvement. The Performance Improvement Team is also responsible for overseeing the implementation of recommended corrective actions or interventions from the SilverSummit Healthplan Quality Improvement Committee and/or its supporting subcommittees, monitoring the outcomes of those improvement efforts, and reporting results to the designated committee.
Responsibilities	• Review and evaluate key clinical quality and service performance indicators; • Prompt initiation of ad hoc performance improvement initiatives (including corrective action plans) to address any negative or static trends; • Review, categorize, track, and trend grievances, administrative reviews, and requests for external reviews. Determines appropriate disposition and follow-up; • Monitor resource allocation to ensure appropriate support for the Quality Program; • Track progress of tasks in the annual Quality Work Plan, make recommendations to improve quality activities noted in the Work Plan as needed, in response to issues raised by the SilverSummit Healthplan Quality Improvement Committee; • Provide ongoing reports to the [Quality Committee Name], as appropriate, on the progress of clinical and performance improvement initiatives; and • Review operational policies and procedures at least annually and recommend modifications as necessary.
Reports To	SilverSummit Healthplan Quality Improvement Committee
Committee Chair	VP/Director of Quality
Committee Composition	• Chief Medical Officer / Medical Director • VP/Director of Quality • Designee (Director/Manager) from each applicable functional area, i.e. Medical Management, Network Development & Contracting, Provider Relations/Services, Member Services, Grievance and Appeals, Compliance & Regulatory Affairs, Pharmacy • Behavioral Health Provider/Representative • Additional staff may participate as requested by the Chair
Frequency	At a minimum ten (10) times per year
Attendance Required	50% of scheduled meetings
Quorum	50% of members. All permanent committee members are voting members; the Committee Chair is the determining vote in the case of a tie vote.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting will be developed by the Committee Chair.
Recorder	Delegated committee designee

Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The committee is authorized by the SilverSummit Healthplan Quality Improvement Committee] to make decisions and recommendations regarding performance improvement processes. Decisions made by consensus. Individuals are responsible and encouraged to raise any concerns/issues at the committee meetings.
Evaluation	The Committee will review the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if dissemination of information will be managed in a specific manner.

SilverSummit Healthplan **Additional Committee Charters**

Quality Measures Steering Committee	
Charter Statement	The Quality Measures Steering Committee is the health plan's committee responsible for monitoring and improving quality scores (e.g. HEDIS, CAHPS, Medicare STARS, Marketplace QRS measures, state critical measures, etc.)
Purpose	The purpose of the Quality Measures Steering Committee is to oversee the quality performance process at the health plan level. The committee reviews monthly rate trending, identifies data concerns, and communicates corporate initiatives to senior leadership. The Quality Measures Steering Committee directs member and provider initiatives to improve quality scores. Goals include obtaining and maintaining "Best in Class" status in the state, continued improvement in scores over time to ensure National Committee for Quality Assurance (NCQA) Accreditation, and maximize quality bonuses and/or auto-assignment, and to ensure no penalties are received.
Responsibilities	• Review monthly and final quality scores; • Analyze scores to determine areas in need of improvement; • Review, approve, and implement corporate-led initiatives; • Develop initiatives to improve selected measures and oversee the implementation, progression and outcomes monitoring of initiatives; • Recommend resources necessary to support the on-going improvement of quality scores; • Review/establish benchmarks or performance goals; and • Oversee delegated vendor roles in improving quality scores.
Reports To	Performance Improvement Team
Committee Chair	VP/Director of Quality
Committee Composition	• VP/Director of Quality • Manager of Quality • Manager/Supervisor of HEDIS • HEDIS Coordinator • Designee (Manager/Supervisor) from each applicable functional area, i.e. Medical Management, Network Development & Contracting, Provider Relations/Services, Member Services, Grievance and Appeals, Pharmacy
Frequency	Quarterly, additional meetings scheduled per health plan need
Attendance Required	50% of scheduled meetings
Quorum	A minimum of four (4) voting members, including the Chair, must be present for a quorum. All permanent committee members are voting members; the Committee Chair is the determining vote in the case of a tie vote.
Agenda	Meetings are agenda driven. Agenda items for the next meeting are developed by the Committee Chair in collaboration with the applicable department leads.
Recorder	Delegated committee designee

Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The committee is authorized by the SilverSummit Healthplan Quality Improvement Committee to make all decisions related to quality measure performance. Decisions made by consensus. Individuals are responsible and encouraged to raise any concerns/issues at the committee meetings.
Evaluation	The committee will review the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information will be managed in a specific manner.

Grievance and Appeals Committee	
Charter Statement	The Grievance and Appeals Committee is a subcommittee of the SilverSummit Healthplan Quality Improvement Committee and is responsible for maintaining compliance with contractual, federal and state, and accrediting body requirements.
Purpose	The purpose of the Grievance and Appeals Committee is to maintain compliance with contractual, federal and state, and accrediting body requirements as relating to the processing of grievance and appeals, and when appropriate, critical incidents. The scope of the Grievance and Appeals Committee includes tracking and analysis of member grievances and appeals, including type and timeliness of resolution, performing barrier and root cause analysis, and making recommendations regarding corrective actions as indicated. The committee, as required by the health plan contract, is also responsible for review, discussion, and determination of member grievances and clinical appeals and facilitating requests for administrative review filed by members (and providers who file on behalf of members regarding administrative reviews), including, as applicable, determinations by a delegated entity.
Responsibilities	• Review, categorize, track, and trend member grievances and appeals; • Perform barrier and root cause analysis and make recommendations regarding corrective action as appropriate; • Provide ongoing reports to the SilverSummit Healthplan Quality Improvement Committee and Credentialing Committee, as appropriate; and • Review operational policies and procedures at least annually and recommend modifications as necessary.
Reports To	Performance Improvement Team
Committee Chair	VP/Director of Quality or Director of Compliance & Regulatory Affairs
Committee Composition	• VP/Director of Quality Improvement • G&A Manager • G&A Coordinator • Director of Compliance & Regulatory Affairs • Additional committee members, including clinical staff and/or a community advocate, may be appointed by the Chair as appropriate, depending on the nature of the grievance/appeal or matter under review. The Grievance and Appeals Committee is composed primarily of health plan staff
Frequency	Quarterly or per health plan need
Attendance Required	50% of scheduled meetings.
Quorum	50% of members. All permanent committee members are voting members; the Committee Chair is the determining vote in the case of a tie vote.
Agenda	Meetings are agenda driven. Agenda items for the next meeting are developed by the Committee Chair in collaboration with the applicable department leads.
Recorder	Delegated committee designee

Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The SilverSummit Healthplan Quality Improvement Committee authorizes the Grievance and Appeals Committee to make decisions regarding grievance and appeal resolution, as applicable, and recommendations regarding performance improvement processes related to grievances and appeals. Decisions made by consensus. Individuals are responsible and encouraged to raise any concerns/issues at the committee meetings.
Evaluation	The committee will review the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information will be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Provider Advisory Committee	
Charter Statement	The Provider Advisory Committee is a committee utilized to communicate the health plan's programs and processes to its provider network allowing for collaboration and feedback through discussion with the providers.
Purpose	The purpose of the Provider Advisory Committee is to provide input on the health plan provider profiling and incentive programs, and other administrative practices, and supports development of the provider scorecard indicators, useful analyses of the data, and effective means of helping providers improve their performance.
Responsibilities	• To provide the health plan with feedback regarding programs and processes from a community provider-based perspective; • To allow providers to make recommendations related to the programs and processes; and • Assist the health plan to identify key issues related to programs that may affect community providers.
Reports To	Performance Improvement Team
Committee Chair	Chief Medical Director or designee
Committee Composition	• Chief Medical Director • The Chair appoints members for committee representation from the provider network (serving one year terms) • Facilities representatives • Ancillary provider representatives • Director of Contracting and Network Management • Provider Relations staff as appropriate
Frequency	Quarterly or per health plan need
Attendance Required	There is no minimum meeting attendance requirement.
Quorum	This is not a voting committee.
Agenda	Meetings are agenda driven. Agenda items for the next meeting are developed by the Committee Chair in collaboration with the applicable department leads.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The Provider Advisory Committee is a non-voting committee, intended to solicit direct feedback from the local provider network.
Evaluation	The committee will review the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information will be managed in a specific manner.

Hospital Advisory Committee	
Charter Statement	The Hospital Advisory Committee is an advisory group made up of key administrative hospital leaders and health staff to address concerns of the hospital networks with regards to prior authorization, concurrent review, discharge planning and coordination of care and payment.
Purpose	The purpose of the Hospital Advisory Committee is to make recommendations related to utilization management and care, and payment coordination based on the needs of the hospital groups, and to assist the health plan in identifying key issues related to programs that may affect specific hospital groups.
Responsibilities	• To provide the health with feedback regarding its performance from a hospital-based perspective regarding prior authorizations, concurrent review, discharge planning, and coordination of care and payment; • Make recommendations related to utilization management and care and payment coordination based on the needs of the hospital groups; and • Assist the health plan to identify key issues related to programs that may affect specific hospital groups.
Reports To	Performance Improvement Team
Committee Chair	Chief Medical Director or designee
Committee Composition	The Chair appoints members for the committee representation from hospital groups • Hospital administrative leaders • Identified health plan staff
Frequency	Determined by health plan
Attendance Required	There is no minimum meeting attendance requirement.
Quorum	This is not a voting committee.
Agenda	Meetings are agenda driven. Agenda items for the next meeting are developed by the Committee Chair in collaboration with the applicable department leads.
Recorder	Delegated committee designee.
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The Hospital Advisory Committee is a non-voting committee to solicit feedback from local hospital representatives.
Evaluation	The committee is review the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information will be managed in a specific manner.

Member Advisory Committee	
Charter Statement	The Member Advisory Committee is a group of members, parents, guardians, member advocacy groups, and health plan staff as appropriate, that reviews and reports on a variety of quality and service issues. The health plan understands that the ability to effectively engage stakeholders, including members/family members/caregivers, advocates, and community organizations in the quality program is a crucial component of our collaborative efforts to enhance a patient-centered service delivery system, to optimize clinical outcomes, and to positively affect program operations.
Purpose	The purpose of the Member Advisory Committee is to solicit member input into the approach and effectiveness of the health plan programs, policies, and services, and to promote a collaborative effort to enhance the service delivery system in local communities. The Member Advisory Committee represents the geographic, cultural and racial diversity of our membership across the state. The committee provides input for quality improvement activities, program monitoring and evaluation, and member, family, and provider education, and/or other topics as defined by the Performance Improvement Team or SilverSummit Healthplan Quality Improvement Committee.

Responsibilities	The Member Advisory Committee solicits member input into the quality programs. Based on the health plan size and distribution, the Member Advisory Committee may include regional level committees. • Members are randomly selected in accordance with the Managed Care Reform and Patient Rights Act; • Members may be informed about the committee through such materials as the member handbook, member newsletters, contacts at community events, and the health plan website; • The health plan will provide an orientation and ongoing training for Member Advisory Committee members so they have sufficient information and understanding of the managed care program to fulfill their responsibilities; • The Member Advisory Committee meets in-person to promote two-way communication where members can provide input and ask questions and the health plan can and obtain direct feedback from members; and • The Member Advisory Committee recommends program enhancements, review satisfaction survey results, and provide feedback on the health plan performance levels.
Reports To	Performance Improvement Team
Committee Chair	Director of Member Services
Committee Composition	• Director of Member Services • Members - may volunteer or be suggested by staff • Parents/foster parents/guardians of child members - may volunteer or be suggested by staff • Health plan staff as indicated • Quality Department designee • Members and families/significant others of members
Frequency	Determined by health plan; at least annually
Attendance Required	No minimum attendance required.
Quorum	This is not a voting committee.
Agenda	Meetings are agenda driven. Agenda items for the next meeting are developed by the Committee Chair in collaboration with relevant member input.
Recorder	Delegated committee designee.
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The Member Advisory Committee is a non-voting committee to solicit feedback from local hospital representatives.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information will be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Community Advisory Committee	
Charter Statement	The Community Advisory Committee is a community-wide advisory committee responsible for providing the health plan with feedback and to make recommendations regarding health plan performance from a community-based perspective.
Purpose	The purpose of the Community Advisory Committee is to assist the health plan in identifying key issues related to programs that may affect specific community groups and provide community input on potential service improvements. In addition, the Community Advisory Committee offers effective approaches from reaching or communicating with members or other issues related to the member population. Based on the health plan size and distribution, the Community Advisory Committee may include regional level committees.
Responsibilities	• To provide the health plan with feedback regarding its performance from a community-based perspective;

	• Make recommendations related to program enhancements based on the needs of the local community; • Assist health plan to identify key issues related to State programs that may directly impact specific community groups; and • Provide community input on potential health plan service improvements and offer effective approaches for reaching or communicating with members or other issues related to member population.
Reports To	Performance Improvement Team
Committee Chair	VP/Director of Operations
Committee Composition	Representation from key community stakeholders such as: • Church leaders; • Local business leaders; • Hospital representatives; • Representatives from advocacy groups; and/or • Other community based organizations.
Frequency	Determined by health plan
Attendance Required	No minimum attendance required.
Quorum	This is not a voting committee.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting are developed by the Committee Chair.
Recorder	Delegated committee designee.
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The Community Advisory Committee is a non-voting committee intended to solicit feedback from community stakeholders.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information will be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

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 include the following positions:

SilverSummit Healthplan Staffing

Chief Medical Director/Medical Director(s)	The health plan's Chief Medical Director and supporting Medical Directors (including a behavioral health Medical Director) have an active 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 Medical Management Programs, and the Grievance System.

Quality VP/Director	The VP/Director of Quality is a registered nurse or other qualified person with experience in health care, data analysis, barrier analysis, and project management as it relates to improving the clinical quality of care and quality of service provided to the members. The Quality VP/Director reports to identified executive leadership and is responsible for directing the activities of the quality staff in monitoring and auditing the health plan's

	health care delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality, and clinical quality. The Quality VP/Director assists the senior executive staff, both clinical and non-clinical, in overseeing the activities of the operations to meet the goal of providing health care services that improve the health status and health outcomes of its members. Additionally, the Quality VP/Director coordinates the SilverSummit Healthplan 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	The Quality Manager holds a bachelor's degree in nursing or a related field, or has equivalent managed care experience. The Quality Manager is responsible for management and oversight of quality and performance monitoring. The responsibilities include working with multiple departments to: establish objectives, policies and strategies; assure quality initiatives focused on improving operational and program efficiencies: focus on initiatives to improve member outcomes; develop systematic processes and structures that will assure quality and the commitment to enabling quality improvements.
Quality Coordinator/Specialist	Quality Coordinators/Specialists are highly trained clinical and non-clinical staff with significant experience in a health care setting; experience with data analysis and/or project management. At least one of the health plan's Quality Coordinators/Specialists is a registered nurse. Quality Coordinators/Specialists 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 Coordinator/Specialist may specialize in one area of the quality process or may be cross-trained across several areas. The Quality Coordinator/Specialist 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.
HEDIS Director/Manager	The HEDIS Project Director/Manager is a highly trained individual with significant experience in managed health care, data analysis, and project management. The HEDIS Project Director/Manager is responsible for maintaining departmental documentation to support state contract requirements and accreditation standards including, but not limited to, applicable policies and procedures, quality focus studies, quality improvement activities, routine control monitoring reports, meeting minutes, access and availability analysis, member experience analysis, continuity and coordination of care, delegated vendor oversight, and annual evaluation of effectiveness of the Quality Program. The HEDIS Project Director/Manager collaborates with other departments as needed to implement corrective action or improvement initiatives as identified through the health plan's quality improvement activities and quality of care reviews. Additionally, the HEDIS Project Director/Manager coordinates the documentation, collection and reporting of HEDIS measures to both National Committee for Quality Assurance (NCQA) and the State as required.
HEDIS Additional Staff	HEDIS Coordinator

Accreditation Specialist	The Accreditation Specialist reports to and supports the Accreditation Manager in the achievement of as well as the ongoing maintenance of health plan NCQA Accreditation and HEDIS reporting processes and requirements. The Accreditation Specialist supports the document prep and submission of documents for the accreditation survey. He or she supports the development of health plan performance improvement activities. In addition, the Accreditation Specialist may coordinate delegation vendor oversight.

Grievance & Appeals Manager	The Grievance & Appeals Manager is responsible for the appropriate processing of member grievances and appeals as well as requests for State Fair Hearings and external reviews. The Grievance & Appeals Manager is required to attend and represent grievances and appeals in multiple internal health plan committees as needed. This position manages grievance and appeal data and reports and the day to day responsibilities of the Grievance & Appeals Coordinator. The Grievance & Appeals Manager reports to the Quality VP/Director.
Grievance & Appeals Coordinator	The Grievance & Appeal 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 & Appeal 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 & Appeal Coordinator also tracks and resolves all administrative member grievances and provider complaints. The Grievance & Appeals Coordinator reports to the Grievance & Appeals Manager.

QUALITY PROGRAM RESOURCES: INFRASTRUCTURE AND DATA ANALYTICS

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

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

The Centelligence platform receives, integrates, and continually analyzes large amounts of transactional data, such as medical, behavioral, and pharmacy claims; lab test results; health screenings and assessments; service authorizations; member information (e.g., current and historical eligibility and eligibility group; demographics including race and ethnicity, region, and primary care provider assignment; member outreach), and provider information (e.g., participation status; specialty; demographics; languages spoken). The Centelligence analytic and reporting tools provide SilverSummit Healthplan 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, SilverSummit Healthplan develops defined data collection and reporting plans to build custom measures and reports, as applicable. SilverSummit Healthplan 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 SilverSummit Healthplan's Centelligence proprietary data integration and reporting strategy is the EDW, powered by high performance Teradata technology. The EDW systematically receives, integrates, and transmits internal and external administrative and clinical data, including medical, behavioral, and pharmacy claims data, as well as lab test results and health screening/assessment information. EDW supplies the data needed for all of Centelligence' s analytic and reporting applications while orchestrating data interfaces among core applications. Housing all information in the EDW allows SilverSummit Healthplan 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 Medical Management and Quality department staff to capture utilization, care, and population health management data, to proactively identify, stratify, and monitor high-risk enrollees, to consistently determine appropriate levels of care through integration with InterQual® medical necessity criteria and clinical policies, and capture the impact of programs and interventions. TruCare also houses an integrated appeals management module, supporting the appeals process from initial review through to resolution, and reporting on all events along the process, and a quality of care module to track and report potential quality of care incidents and adverse events.

Certified HEDIS Engine – a software system used to monitor, profile, and report on the treatment of specific episodes, care quality, and care delivery patterns. The HEDIS Engine is certified by NCQA and produces NCQA-certified HEDIS measures; its primary use is for the purpose of building and tabulating HEDIS and other state required performance measures. The Engine enables the health plan to integrate claims and member, provider, and supplemental data

into a single repository by applying a series of clinical rules and algorithms that automatically convert raw data into statistically meaningful information. Additionally, the system provides an integrated clinical and financial view of care delivery, which enables the health plan to identify cost drivers, help guide best practices, and to manage variances in its efforts to improve performance. Data is updated at least monthly by using an interface that extracts claims, member, provider, and financial information and then summarized with access for staff to view standard data summaries and drill down into the data or request ad-hoc queries.

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

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

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

Customer Relationship Management (CRM) Platform – The Customer Relationship Management (CRM) platform enables SilverSummit Healthplan to identify, engage, and serve

members, providers, and federal/state partners in a holistic and coordinated fashion across the wellness, clinical, administrative, and financial matters. The CRM platform captures, tracks, and allows SilverSummit Healthplan staff to manage complaints, grievances, and appeals for all required reporting.

SilverSummit Healthplan 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 SilverSummit Healthplan's continuous quality improvement cycle using a predetermined documentation flow such as the:

- Quality Program Description;
- Quality Work Plan; and
- Quality Program Evaluation.

Quality Program Description – The Quality Program Description is a written document that outlines SilverSummit Healthplan's structure and process to monitor and improve the quality and safety of clinical care and the quality of services provided to members. The Quality Program Description includes the following at minimum: the scope and structure of the Quality Program, including the behavioral health aspects of the program; the specific role, structure, function, and responsibilities of the SilverSummit Healthplan 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 SilverSummit Healthplan Quality Improvement Committee and Board of Directors on an annual basis. Changes or amendments are noted in the "Revision Log". SilverSummit Healthplan submits any substantial changes to its Quality Program Description to the SilverSummit Healthplan Quality Improvement Committee and appropriate state agency for review and approval as required by state contract, if applicable.

At the discretion of SilverSummit Healthplan] 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 SilverSummit Healthplan 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 the recommendations for improvements from the annual Program Evaluation. The Work Plan reflects the ongoing progress of the quality activities, including:

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

SilverSummit Healthplan 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 SilverSummit Healthplan Quality Improvement Committee Quality Committee Name] 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 progress of the Quality Program throughout the year.

At the discretion of SilverSummit Healthplan, the Quality Work Plan may include activities of all applicable departments (Member Services, Utilization Management, Care Management, Provider Services, Credentialing, 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 SilverSummit Healthplan 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, 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 SilverSummit Healthplan Quality Improvement Committee and Board of Directors for approval annually.

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

- Analysis and evaluation of the overall effectiveness of the Quality Program, including progress toward influencing network-wide 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; and
    - 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 and quality of service;
- Trending of measures collected over time to assess performance in quality of clinical care and quality of service;
- Interventions implemented to address the issues chosen for performance improvement projects and focused studies;
- Measurement of outcomes;
- Measurement of the effectiveness of interventions;
- An analysis of whether there have been demonstrated improvements in the quality of clinical care and/or quality of services;
- Identification of limitations and barriers to achieving program goals;
- Recommendations for the upcoming year's Quality Work Plan;
- An evaluation of the scope and content of the Quality Program Description to ensure it covers all types of services in all settings and reflects demographic and health characteristics of the member population; and
- 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 (calendar year, unless otherwise specified by state contract), the Quality Department facilitate/prepare 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 SilverSummit Healthplan Quality Improvement Committee should be included in the document.

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

SilverSummit Healthplan 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

SilverSummit Healthplan 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.

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

HEDIS is a collaborative process between SilverSummit Healthplan, the Centene Corporate Quality Department, and several external vendors. SilverSummit Healthplan 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, SilverSummit Healthplan supplies claims and encounter data to the appropriate EQRO and works collaboratively to assess and implement interventions for improvement.

Member Experience - SilverSummit Healthplan 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 SilverSummit Healthplan Quality Improvement Committee and appropriate subcommittees.

The Consumer Assessment of Healthcare Providers and Systems Plan Survey (CAHPS) assesses patient experience in receiving care. CAHPS results are reviewed by the SilverSummit Healthplan 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, SilverSummit Healthplan focuses on the following measures required for the NCQA Health Plan Ratings:

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

The Health Outcomes Survey (HOS) is a member-reported outcomes measure used in Medicare Star Ratings. The goal of HOS is to gather valid, reliable, and clinically meaningful health status

data from Medicare beneficiaries. HOS results are reviewed by the [Quality Committee Name] and applicable subcommittees, with specific recommendations for quality improvement activities, pay for performance, program oversight, public reporting, and to improve members' health. There are five (5) measures that are incorporated into the HOS survey:

- Improving and Maintaining Physical Health;
- Improving and Maintaining Mental Health;
- Falls Risk Management;
- Managing Urinary Incontinence; and
- Physical Activity in Older Adults.

Provider Experience - Provider satisfaction is assessed annually using valid survey methodology and a standardized comprehensive survey tool. The survey tool is designed to assess provider satisfaction with the network, claims, quality, utilization management, and other administrative services. The Provider Engagement and Network Development departments are responsible for coordinating the provider satisfaction survey, aggregating and analyzing the findings, and reporting the results to appropriate committees. Survey results are reviewed by the SilverSummit Healthplan Quality Improvement Committee, with specific recommendations for performance improvement interventions or actions. Provider experience may also assessed through monitoring of provider grievances and appeals as well as point-in-time provider surveys following call center and in-person interactions. Provider surveys, monitoring of provider grievances and appeals, and input from various quality committees and advisory workgroups provide ongoing data to the Performance Improvement Team and SilverSummit Healthplan 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. SilverSummit Healthplan 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 SilverSummit Healthplan 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 medical management staff, member services staff, provider services staff, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, state partners, Medical Directors, or the Board of Directors may inform the Quality Department of potential quality of care issues and/or critical incidents. Potential quality of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action, up to and including review by the Peer Review Committee as indicated. Potential quality of care issues and critical

incidents received in the Quality Department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

In addition, the health plan monitors for quality of care and/or adverse events through claims-based reporting mechanisms. An adverse event is an event over which health care personnel could have exercised control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred. Although occurrence of an adverse event in and of itself is not necessarily a preventable quality of care issue, SilverSummit Healthplan 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.

SilverSummit Healthplan'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 meets all accreditation requirements. Management of critical incidents safeguards the health, safety, and welfare of members by establishing protocols, procedures, and guidelines for consistent monitoring and trend analysis for all critical incidents as defined by state and federal regulations and accreditation requirements.

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

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

Medical Record Documentation Standards – SilverSummit Healthplan 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. SilverSummit Healthplan may conduct medical record reviews for purposes including, but not limited to, utilization review, quality management, medical claim review, or member complaint/appeal investigation. Providers must meet specific requirements for medical record keeping; elements scoring below a determined benchmark are considered deficient and in need of improvement.

MEMBER ACCESS TO CARE

SilverSummit Healthplan 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 SilverSummit Healthplan ensures the availability and delivery of services in a culturally and linguistically competent manner to all members, including those with limited

English proficiency and literacy and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, gender identity, etc. SilverSummit Healthplan 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. SilverSummit Healthplan also ensures members have access to accurate and easy to understand information about network providers. SilverSummit Healthplan's provider directory is available in online and in hard copy as needed and meets all regulatory and accreditation requirements. The directory is updated in a timely manner upon receipt of updated information from providers and assessment of the accuracy of the directory is completed on an ongoing basis.

The Quality Department report results to the Performance Improvement Team and/or the SilverSummit Healthplan Quality Improvement Committee for consideration of corrective action if opportunities are identified. Results are included in the annual Quality Program Evaluation. SilverSummit Healthplan 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 – SilverSummit Healthplan maintains and monitors the provider network to ensure members have adequate access to all covered services SilverSummit Healthplan 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 of health. Per applicable federal and state regulations, SilverSummit Healthplan contracts with all required and essential provider types, e.g. federally qualified health centers (FQHCs), rural health clinics (RHCs), etc. Additionally, SilverSummit Healthplan 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.

The SilverSummit Healthplan 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 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 SilverSummit Healthplan Quality Improvement Committee to address any deficiencies in the number and distribution of providers. SilverSummit Healthplan ensures compliance with contractual, regulatory, and accreditation requirements, including all reporting requirements, to maintain adequate provider availability for members.

Appointment Availability – SilverSummit Healthplan monitors practitioner appointment availability 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, SilverSummit Healthplan 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 SilverSummit Healthplan 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.

Out-of-Network Services and Second Opinions – if the provider network is unable to provide adequate and timely services as required by established standards, SilverSummit Healthplan arranges for the timely provision of services through a licensed, qualified out-of-network provider until a network provider is available. If an in-network provider is not available to offer a member a second opinion, SilverSummit Healthplan will arrange for the member to obtain a second opinion outside the network, at no cost, if requested by the member. Staff identifies a provider to meet the member's needs and execute a Single Case Agreement (SCA) to solidify payment terms, authorization parameters, and treatment plans to ensure thorough coordination of the member's care and appropriate transition to in-network services, if warranted. Once the member's immediate needs are addressed, Network/Contracting staff may attempt to recruit the provider and execute an agreement. SilverSummit Healthplan coordinates with out-of-network providers for payment of services and ensure the cost to the member is not greater than it would be if the services were furnished within the network.

SilverSummit Healthplan educates members about accessing out-of-network benefits, and obtaining second opinions in the Member Handbook, on the member website, and in interactions with Member Services staff, as applicable. If a member is obtaining services from an out-of-network provider, staff outreach to and educate the member about transitioning to a network provider as soon as appropriate for their health and safety, and assists the member with identifying network providers that meet the member's needs as well as facilitate the transfer of records.

Telemedicine – SilverSummit Healthplan is committed to transforming the health care experience for members and providing increased access to care through telemedicine services. Telemedicine services aim to enhance the member and provider experience, including member quality of life and engagement in their health care; bring quality care closer to members in urban, rural, or underserved areas while enhancing timely access to specialists such as but not limited to behavioral health and substance use providers and; facilitate and connect providers to educational resources such as webinars, trainings, and funding to provide telemedicine services. Telemedicine services provide an opportunity for member choice of multiple providers and specialists, thus can increase member choice for an alternative service delivery model for care, while complying with all state and federal laws HIPAA and record retention requirements. In situations where the SilverSummit Healthplan provider network is unable to provide adequate and timely services as required by established standards services, members have a choice

between an out-of-network provider (as described above) and telemedicine; members are not required to receive services through telemedicine.

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

- When a SilverSummit Healthplan member transitions to the health plan from either from Fee-for-Service (FFS) Medicaid or another health plan:
  - Members in an ongoing course of treatment or with an ongoing special condition where changing providers may disrupt care, the member 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 SilverSummit Healthplan 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, i.e. up to 60 days after delivery.

Continuity and Coordination of Care – SilverSummit Healthplan monitors and takes action as needed to improve continuity and coordination of care across the health care network. This includes continuity and coordination of medical 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. SilverSummit Healthplan 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. SilverSummit Healthplan 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 are measured annually and re-measurement results analyzed.

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

- General and supportive member and provider education such as articles in member and provider newsletters, face-to-face interactions, and written educational materials provided to members at health fairs, diaper distribution events, etc.;
- Targeted telephonic and/or written outreach to members/parents/guardians to remind of applicable preventive health screenings and services due or overdue and assistance with scheduling appointments and transportation to the appointments as needed; and

- 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

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

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

SilverSummit Healthplan provides care coordination, care management, and condition/disease management for members identified at risk, intervenes with specific programs of care, and measures clinical and other health-related outcomes. SilverSummit Healthplan 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. SilverSummit Healthplan's condition management and population health management programs help members understand their diagnoses, learn self-care skills, and adhere to treatment plans. All clinical management programs include the use of general awareness and targeted outreach and educational interventions, including but not limited to, newsletter articles, advertising regarding available programs, direct educational/informational mailings, and care management. Programs also include written communication to primary care providers informing of members on their panel with chronic conditions such as diabetes and/or hypertension and reminders on appropriate screening and monitoring tests as recommended by evidenced-based practice guidelines.

The Care Management Program Description further outlines SilverSummit Healthplan'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.

PROVIDER SUPPORTS

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

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, SilverSummit Healthplan provides quantitative and actionable analyses of the providers' member panel via analytic tools.

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

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

Provider Analytics – SilverSummit Healthplan 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; and/or
- Value-Based Contracting performance summaries.

Through these supporting platforms, SilverSummit Healthplan 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 practitioner 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.

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. National recognized guidelines are adopted/approved by SilverSummit Healthplan's SilverSummit Healthplan 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. 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 SilverSummit Healthplan website, and/or provider newsletters and are available to all members or potential enrollees upon request.

Practitioner adherence to SilverSummit Healthplan'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 underscore the importance of compliance; and provider incentives. SilverSummit Healthplan uses applicable HEDIS measures to monitor practitioner compliance with adopted guidelines. If performance measurement rates fall below SilverSummit Healthplan state/accreditation goals, SilverSummit Healthplan implements interventions for improvement as applicable.

PERFORMANCE IMPROVEMENT ACTIVITIES

SilverSummit Healthplan'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 also include behavioral health care issues and/or strategies.

The health plan utilizes traditional quality/risk/utilization management approaches to identify activities relevant to the health plan programs or a specific member population and that describe an observable, measurable, and manageable issue. Initiatives are identified through analysis of key indicators of care and service based on reliable data which indicate the need for improvement in a particular clinical or non-clinical area. 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 social determinants of health, age groups, disease categories, and special risk status.

The SilverSummit Healthplan Quality Improvement Committee 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 SilverSummit Healthplan Quality Improvement Committee helps to define the study question and the quantifiable indicators, criteria, and goals to ensure the project is measureable and able to show sustained improvement. Evidence-based guidelines, industry standards, and contractual requirements are used as the foundation for developing performance indicators, setting benchmarks and/or performance targets, and designing projects and programs that assist providers and members in managing the health of members. If data collection is conducted for a random sample of the population, baseline and follow-up sampling is conducted using the same methodology and statistical significance and a 90% or more confidence level is determined.

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

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

Chronic care improvement program (CCIP) – SilverSummit Healthplan conducts a CCIP, with a focus on promoting effective management of chronic disease and improving care and health outcomes for members with chronic conditions, that meets all CMS requirements for Medicare, as applicable. Effective management of chronic disease includes slowing disease progression, preventing complications and development of comorbidities, reducing preventable emergency department utilization and inpatient stays, improving quality of life, and reducing costs for both the health plan members. CCIP interventions are developed through an analysis of a SilverSummit Healthplan target population and include activities such as care coordination, promotion of preventive screening, disease and lifestyle management programs, education and outreach to members and providers, etc.

GRIEVANCE AND APPEAL SYSTEM

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

All member grievances and appeals are tracked and resolved and data is analyzed and reported to the SilverSummit Healthplan 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, who also monitors adherence to the Plan of Correction, as applicable Member grievances by associated practitioner/provider are analyzed and reported on a routine basis to the SilverSummit Healthplan Quality Improvement Committee and applicable subcommittees (including the Credentialing Committee and Peer Review Committee as appropriate) for identification of specific improvement activities or corrective action as needed.

Provider complaints and appeals are tracked and resolution is facilitated by the Provider Services Department. Data are reported to and analyzed by the SilverSummit Healthplan 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 SilverSummit Healthplan Quality Improvement Committee, along with recommendations for quality improvement activities based on results.

REGULATORY COMPLIANCE AND REPORTING

SilverSummit Healthplan 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 ACCREDITATION

SilverSummit Healthplan adheres to the belief that NCQA Health Plan Accreditation demonstrates a health plan's commitment to delivering high-quality care and service for members and thus strives for a continual state of accreditation readiness. The SilverSummit

Healthplan Chief Medical Director; VP/Director, Quality; and Manager, Accreditation facilitate the accreditation process with support from Centene Corporation's national accreditation team.

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

SilverSummit Healthplan may also include LTSS Distinction in accreditation efforts. LTSS Distinction is supplemental to NCQA Health Plan Accreditation and demonstrates the ability to effectively coordinate LTSS, in addition to physical and behavioral health services, by meeting certain requirements in areas such as conducting comprehensive assessments, managing care transitions, performing person-centered assessments, and planning and managing critical incidents.

DELEGATED SERVICES

The SilverSummit Healthplan Quality Improvement Committee may authorize participating provider entities such as independent practice associations or hospitals, or other organizations to perform activities such as utilization management, care management, credentialing, or quality on the health plan's behalf. SilverSummit Healthplan 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; and
- 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.

SilverSummit Healthplan 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 (Credentialing, Utilization Management, Care Management, Quality, etc.), routine reporting of key performance metrics, and annual or more frequent evaluation to determine whether the delegated activities are being carried out according to health plan and regulatory requirements and accreditation standards. SilverSummit Healthplan Medical Management, 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.

SilverSummit Healthplan 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 _____, _____.

_____
Vice President/ Quality and Risk Adjustment

_____
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 _____, _____.

_____
Board of Directors Chairman