POLICY AND PROCEDURE

DEPARTMENT: Quality	**DOCUMENT NAME:** Quality Operational Documents
PAGE: 1 of 64	**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; 3/21; 1/22
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

2022
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.

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

SCOPE OF THE QUALITY PROGRAM

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 (inpatient, ambulatory, private practice offices and home care, LTSS), behavioral health, preventive, primary, specialty care and ancillary, 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; including providing effective, equitable, understandable and respectful quality of care and services that are responsive to the diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs of our Members;
- 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, ensuring data accuracy;
- 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; including participation in efforts by the State to prevent, detect, and remediate critical incidents (consistent with ensuring Member health and welfare that are based, at a minimum, of the requirements on the State for home and community based waiver programs;
- 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 that are objective, measureable, and based on current knowledge and clinical experience 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), including specification of clinical or health service delivery to be monitored, reflect the population served in terms of age groups, disease categories and special risk groups, including CSHCN;
- 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, including

assessment of care between care settings and comparison of services and support received according to treatment plan/services home and community
- 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.

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. SilverSummit Healthplan participates in State and federal efforts to promote the delivery of services in a culturally competent manner to all Members including those with limited English proficiency and diverse cultural and ethnic backgrounds. SilverSummit recognizes that the State has identified Spanish, as the prevalent non-English language. 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 Upon receipt of regular written reports delineating actions taken and improvements made, will take action when appropriate and direct that the operational IQAP be modified on an ongoing basis to accommodate review findings and issues of concern and document in minutes of the Governing Board Meetings in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to the quality assurance

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 liaison 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.

OBJECTIVES (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.

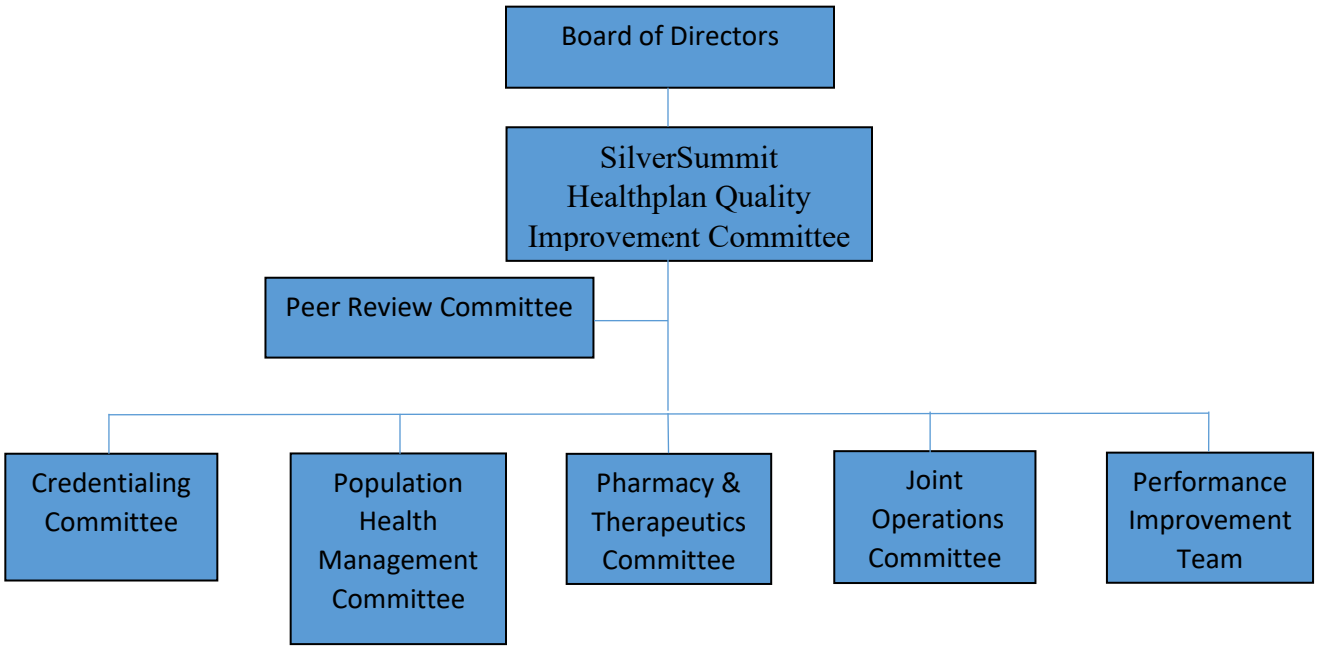
QUALITY PROGRAM STRUCTURE

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 Improvement Committee 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

Purpose: The purpose of this document is to outline the Internal Quality Assurance Program (IQAP) Committee Charters that are required for Plan implementation.

Note: The Committee Charters are based on the Request for Proposal (RFP) or Contract, The National Council of Quality Assurance (NCQA), Federal/State Regulations and standard operating procedures for similar lines of business Committee members are identified for each committee as required by the Plan. An example of tracking the members for each committee is below:

Committee Name: Quality Improvement Committee (QIC)
Charter Statement: The Quality Improvement Committee (QIC) is SilverSummit's senior leadership committee, accountable to the Board of Directors (BOD) that reviews and monitors all clinical quality service functions of SilverSummit and provides oversight of all committees. SilverSummit's Chief Medical Director is the Senior Executive for Quality Improvement (SEQI) responsible for the implementation of the Internal Quality Assurance Program (IQAP).
Purpose: The purpose of the QIC is to provide oversight and direction in assessing the appropriateness of care and service delivered, to continuously enhance and improve the quality of care and services provided to members. This is accomplished through a comprehensive, health plan-wide system of ongoing, objective, and systematic monitoring of activities and outcomes. This may include the identification, evaluation, and resolution of process problems,

the identification of opportunities to improve member outcomes, the education of members, providers and staff regarding the Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Credentialing, and Pharmacy programs.

Objectives of the Committee and Relationship to Strategic Objectives:

- Oversight of the QI activities of SilverSummit to ensure compliance with contractual requirements, federal and state statutes and regulations, and requirements of accrediting bodies such as National Committee for Quality Assurance (NCQA);
- Annual development and approval of the SilverSummit IQAP Description, Work Plan and Program Evaluation, incorporating applicable supporting department goals as indicated;
- Development of quality improvement studies, activities, and reporting of findings to the BOD;
- Annual review and approval or acceptance of SilverSummit Credentialing, Pharmacy, Population Health Management, and Case Management Program Descriptions and Work Plans as developed by the appointed subcommittees to facilitate alliance with strategic vision and goals;
- Evaluation of the effectiveness of each departments' activities to include analysis and recommendations regarding identified trends, follow-up, barrier analysis, and interventions required in order to improve the quality of care and/or service to members and implement corrective actions as appropriate, and act as a communication channel to the BOD;
- Prioritization of quality improvement efforts, facilitation of functional area collaboration and assurance of appropriate resources to carry out QI activities;
- Review and establishment of benchmarks or performance goals for each quality improvement initiative and service indicator;
- Review and approval of due diligence information for any potential delegated entity and the annual oversight audit outcomes for those entities already delegated;
- 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 management; and supporting the formulation of corrective actions, as appropriate;
- Evaluation of the appropriateness and effectiveness of practitioner profiling and pay for performance initiatives and support in designing and modifying the program as warranted;
- Ensure alignment with SilverSummit Cultural Competency Plan.

Committee Structure and Operation:

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

Committee Chair: Chief Medical Director, or as designated by the BOD.

Committee Recorder: QI designee

Reports To: Board of Directors

Committee Composition:

- Chief Executive Officer

- Chief Medical Director
- Behavioral Health Medical Director
- VP/Director of Quality Improvement
- VP/Director of Population Health Management
- VP/Director Network Management
- VP/Director of Member and Provider Services
- VP/Director Compliance
- Other SilverSummit staff as determined by Plan
- At least four (4) network providers representing various practitioners within the network and across the regions in which it operates:
    - Family Practice
    - Internal Medicine
    - OB/GYN
    - Pediatrics
    - Behavioral Health
    - Vision/Dental care providers, and
    - other high-volume specialists as appropriate
- In addition, the committee will have providers knowledgeable about disability, mental health and substance use/abuse of children, adolescents, and adults in Nevada.
- The provider representatives should have experience caring for the SilverSummit population, including a variety of ages and races/ethnicities, and rural and urban populations.

Scheduling: completed by the QIC Designee, as directed by the QIC Chair.

Agenda: Agenda items for the meetings will be developed by the QIC Chair in collaboration with the QI VP/Director. The committee receives regular reports from all Plan committees and subcommittees that are accountable to and/or advise the QIC.

Meeting Packets: Meeting packets distributed by secure means to committee members approximately 1-2 weeks prior to the scheduled meeting date. Decisions made prior to each meeting as to what materials are included in the meeting packets based on need for prior review and privacy/sensitivity of materials.

Minutes: Minutes taken during the meeting and reflect attendance and participant discussion. Each item for discussion includes the person responsible and a timeline for completion. The QI Designee is responsible for maintaining detailed records and minutes of all QIC meetings, activities, program statistics and recommendations made by the QIC. The Chair is responsible for approving the documented proceedings that reflect all QIC decisions. Draft minutes completed within 30 days of the meeting, reviewed by the Chair, and amended/corrected as needed by at least 10 days prior to the next meeting, or as needed for other regulatory reporting. Minutes are stored in a secure electronic file. The QIC submits meeting minutes as well as a written summary regarding the outcomes and effectiveness of the IQAP to the BOD at least quarterly.

Attendance Requirement: 75% of scheduled meetings.

Quorum: A minimum of four (4) committee members, including two SilverSummit staff and two (2) external providers, must be present for a quorum. All permanent committee members are voting members; the Chief Medical Director is the determining vote in the case of a tie vote.

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

Decision Authority: The QIC is authorized by the SilverSummit BOD to make all decisions related to the IQAP, quality activities and processes. Decisions will be by consensus of the committee. Individuals are responsible to raise any concerns/issues at the committee meetings.

Evaluation: The Committee will review the charter annually in conjunction with the annual IQAP Description, IQAP Work Plan, and IQAP Evaluation.

Confidentiality: Each committee member is accountable to identify confidential information or situations when dissemination of information is managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Committee Name: Adverse Credentialing Committee

Charter Statement: The Adverse Credentialing Committee is a subcommittee of the Quality Improvement Committee (QIC), oversees and has operating authority of the Credentialing Program. The CC communicates its activities to the Board of Directors (BOD) through the QIC.

Purpose: The Adverse Credentialing Committee is responsible for development, annual review and approval of the Credentialing Program Description and its associated policies and procedures. The Adverse Credentialing Committee has final authority for credentialing and re-credentialing licensed providers (including Behavioral Health (BH)), other licensed healthcare professionals and certain facilities who have an independent relationship with SilverSummit. The Adverse Credentialing Committee oversees the credentialing process to ensure its compliance with regulatory and accreditation requirements.

Objectives of the Committee and Relationship to Strategic Objectives:

- Provide guidance to organization staff on the overall direction of the Credentialing Program;
- Review and approve credentialing and re-credentialing policies and procedures;
- Review and recommend credentialing and re-credentialing criteria;
- Final authority to approve or disapprove applications by providers, other licensed healthcare professionals and certain facilities for network participation status and re-credentialing to the extent that there is not a conflict of interest;
- Ensure network providers; facilities and practitioners are qualified, properly credentialed and available for access by SilverSummit members;
- Provide access to clinical peer input when discussing standards of care for a particular type of provider;
- Review the oversight audits of delegated networks' Credentialing Program performance;
- Evaluate and report to SilverSummit management on the effectiveness of the Credentialing Program;
- Review potential Quality of Care (QOC) events and adverse events, including corrective action plans from peer review committee, for re-credentialing criteria.

Committee Structure and Operation:

Frequency: At least ten (10) times per year to facilitate timely review of providers and to expedite network development. Additional meetings scheduled as needed.

Committee Chair: SilverSummit Chief Medical Director

Committee Recorder: Adverse Credentialing Committee designee or Director of Credentialing. SilverSummit Medical Director is responsible for approving the documented proceedings that reflect Credentialing decisions.

Reports To: QIC

Committee Composition:

- Chief Medical Director / Medical Director(s)
- SilverSummit Credentialing designee
- Corporate Credentialing Manager
- SilverSummit network providers from the following specialties to include statewide regional representation:
  - Family Practice/Internal Medicine
  - OB/GYN
  - Behavioral Health Providers
  - High-Volume Specialists (defined according to geographic benchmarks for each particular specialty)
  - Mid-Level Practitioners- referencing Advanced Nurse Practitioners, Physician Assistants, Advanced Practice Nurses etc.
- Other executive leadership or staff as determined.

Scheduling: to be completed by Credentialing designee.

Agenda: the Corporate Credentialing Director in collaboration with the Adverse Credentialing Committee Chair develops Agenda items for the next meeting.

Meeting Packets: Meeting packets distributed at the meeting.

Minutes: Minutes will be taken during the meeting and reflect attendance and participant discussion. Each item for discussion includes the person responsible and a timeline for completion. Draft minutes completed within 30 days of the meeting. Minutes reviewed by the Chair and Director of Credentialing, and amended/corrected as needed by at least 10 days prior to the next meeting, or as needed for other regulatory reporting. Minutes are stored in a secure electronic file. The Adverse Credentialing Committee routinely submits meeting minutes as well as written reports regarding analysis of the above tracking and monitoring processes and status of corrective action plans (as applicable) to the QIC.

Attendance Requirement: 75% of schedule meetings.

Quorum: A minimum of four (4) voting members, including the Chair, must be present for a quorum. Three (3) voting members must be practitioners.

Committee Data/Document Responsibilities: Meetings will be agenda driven.

Decision Authority: The Medical Director may approve files if providers SilverSummit's criteria and have been practicing within SilverSummit's guidelines without any potential Quality of Care (QOC) incidents. If providers do not meet the SilverSummit's criteria or have any potential QOC events, the QIC has delegated to the Adverse Credentialing Committee the responsibility for credentialing and re-credentialing practitioners, facilities and other providers.

The decision making model is democratic or by consensus. Individuals are responsible and encouraged to raise any concerns/issues at the committee meetings.

Evaluation: The Committee will review the Adverse Credentialing Committee charter annually in conjunction with the annual Credentialing Program Description and review the delegation of specific credentialing activities.

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.

Committee Name: Peer Review Committee (PRC)

Charter Statement: The Peer Review Committee (PRC) is an ad-hoc committee of the Quality Improvement Committee (QIC) that is responsible for reviewing allegations of substandard care and recommending corrective action. Those services include potential quality of care incidents and adverse events where initial investigation indicates a significant potential or significant, severe adverse outcome has occurred or other cases as deemed appropriate by the Chief Medical Director.

Purpose: The purpose of the PRC is to review clinical cases and apply clinical judgment in assessing the appropriateness of clinical care and recommending a corrective action plan that will best suit the particular provider's situation. The PRC communicates its activities to the Board of Directors (BOD) through the QIC.

Objectives of the Committee and Relationship to Strategic Objectives:

- To review providers that are potentially out of compliance with standards of care
- 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 provider of same or similar specialty as the provider and/or issue under review.

Committee Structure and Operation:

Frequency: Ad hoc – date and time to be determined based on need.

Committee Chair: SilverSummit Chief Medical Director

Committee Recorder: QI designee or PRC designee. If the PRC assessment results in recommendation for termination of the provider, the recommendation is presented to the Adverse Credentialing Committee for a final determination. Reviews resulting in the reduction, suspension, or termination of a provider's participation are reported to the National Practitioner Data Base (NPDB) as outlined in the *Practitioner Disciplinary Action and Reporting* Policy and Procedure.

Reports To: QIC and Adverse Credentialing Committee at least quarterly, the Chief Medical Director will then report quarterly to the BOD a summary of the activities and main findings, recommendations and actions presented and discussed at the QIC.

Committee Composition: The network providers serving on this committee may or may not be the same external providers serving on the Plan QIC or Adverse Credentialing Committee. If the same providers are used, the QIC/Adverse Credentialing Committee meeting is

adjourned and the Peer Review meeting started as an independent meeting with an independent agenda and minutes.

- SilverSummit Chief Medical Director
- VP/Director Quality Improvement
- Peer providers (at least three (3) or more network providers who are peers of the provider being reviewed and who represent a range of specialties, including at least one provider with the same or similar specialty as the case under review, but whose presence does not indicate a conflict of interest)
- No Adverse Credentialing Committee members involved in the Peer Review Committee's recommendation will be included in the Adverse Credentialing Committee meeting when the Peer Review Committee's recommendation is discussed
- The Chief Medical Director and VP/Director Quality Improvement are the only Plan staff to attend the PRC meeting

Scheduling PRC designee. PRC members are notified in writing of the date, time and location of a PCR meeting and should be given at least 2 weeks' notice to accommodate schedules.

Agenda: the QI designee will develop Agenda items for the meetings.

Meeting Packets: One week prior to the meeting, PRC packets are sent to the committee members via Fed-Ex or Certified Mail with delivery confirmation. All names and identifying information are blind and information is distributed in a secure manner.

Minutes: Draft minutes are completed within 30 days of the meeting, reviewed by the Chair, and amended/ corrected as needed by at least 10 days prior to the next meeting, or as needed for other regulatory reporting. Minutes are stored in a secure area with limited access. If the PRC assessment results in recommendation for termination of the provider, the recommendation is presented to the Adverse Credentialing Committee for a final determination. Reviews resulting in the reduction, suspension, or termination of a provider's participation are reported to the National Practitioner Data Base (NPDB) as outlined in the *Practitioner Disciplinary Action and Reporting* Policy and Procedure.

Attendance Requirement: 75% of schedule 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) SilverSummit provider must be present for a quorum.

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

Decision Authority: The QIC authorizes the PRC to make decisions and recommendations regarding provider quality of care. The PRC reports and is accountable to the QIC.

Evaluation: The Committee will review the charter annually. Complete documentation is maintained in the Quality Improvement Department files and is reviewed at a minimum of every six (6) months for trends and repeat occurrences. This information is incorporated into re-credentialing and other quality improvement processes. Aggregate reporting of peer review activities is reported to the QIC at least quarterly.

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.

Committee Name: Pharmacy & Therapeutics Committee (P&T)

Charter Statement: The Pharmacy & Therapeutics Committee (P&T) is a subcommittee of the Quality Improvement Committee (QIC) with oversight and operating authority of the Pharmacy Program. The P&T Committee communicates its activities to the Board of Directors (BOD) through the QIC.

Purpose: The P&T is responsible for development and annual review of the Pharmacy Program Description as well as the program has associated policies and procedures. The P&T reviews pharmacy utilization data; evaluates and recommends drugs for inclusion in or removal from the Preferred Drug List (PDL). The Committee also reviews and recommends formulary management activities such as prior authorizations, step therapies, age restrictions, quantity limitations, mandatory generics and other activities that affect access and patient safety. The P&T will make recommendations regarding drug utilization review (DUR) activities such as targeted prescriber and/or member education initiatives. Additionally, the P&T may assist with review of complaints/grievances regarding pharmacy issues and oversight of SilverSummit's Pharmacy Benefit Manager (PBM).

Objectives of the Committee and Relationship to Strategic Objectives:

- Continuous review of 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;
- Conduct member profiling to ensure appropriate utilization;
- Develop and review policies related to the pharmaceutical benefit program;
- Review of new drugs and current medical literature to assess appropriateness of adding to the formulary;
- Review requests from practitioners for additions or changes to formulary

Committee Structure and Operation:

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

Committee Chair: Chief Medical Director, although as committee member leadership develops, the Committee may be chaired by a network provider at the discretion of the P&T.
Committee Recorder: P&T designee
Reports To: QIC then to BOD.

Committee Composition:

- Chief Medical Director
- VP/Director of Population Health Management
- VP/Director of Quality Improvement
- VP/Director of Pharmacy
- Participating internal and external actively practicing Pharmacists
- SilverSummit internal and external actively practicing providers representing the range of practitioners within the network and across the regions in which it operates (including a behavioral health practitioner).

Other SilverSummit executive leadership and operational staff as requested **Scheduling:** to be completed by P&T designee.
Agenda: the P&T Chair in collaboration with the Director of Pharmacy will develop Agenda items for the next meeting.
Meeting Packets: Meeting packets will be distributed by secure means to committee members prior to the scheduled meeting date. Decisions are made prior to each meeting as to what materials will be included in the meeting packets based on need for prior review and privacy/sensitivity of materials.

Minutes: Minutes are taken during the meeting and reflect attendance and participant discussion. Each item for discussion includes the person responsible and a timeline for completion. SilverSummit Pharmacist maintains detailed records and minutes of all P&T meetings, activities, program statistics and recommendations made by the P&T. The P&T routinely submits meeting minutes as well as written reports regarding analysis of the above tracking and monitoring processes and status of corrective action plans (as applicable) to the QIC. Draft minutes will be completed within 30 days of the meeting, reviewed by the Chair, and amended/ corrected as needed by at least 10 days prior to the next meeting, or as needed for other regulatory reporting. Minutes are stored in a secure electronic file.

Attendance Requirement: 75% of schedule meetings. If a participant cannot attend, no replacement is needed; if participant is responsible for an agenda item, re-schedule item to the next meeting and/or use another avenue to update the group. Each participant is responsible to work with his/her peers to understand meeting events and assignments.
Quorum: 50% of voting members.

Committee Data/Document Responsibilities: Meetings will be agenda driven. All agendas and minutes will follow SilverSummit standard format.
Decision Authority: The committee is authorized by the QIC to make all decisions related to SilverSummit's Pharmacy Benefit. Decisions made by consensus. Individuals are responsible and encouraged to raise any concerns/issues at the committee meetings.
Evaluation: The Committee will review the P&T charter annually in conjunction with the annual Pharmacy & Therapeutics Program Description and Program Evaluation.

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.

Committee Name: Vendor Management Oversight Committee (VMOC)

Charter Statement: The Vendor Management Oversight Committee (VMOC) provides oversight and operating authority over the scope and functions of subcontracts. The VMOC works closely with the Joint Operating Committee (JOC) for each subcontractor and communicates its activities directly to the QIC.

Purpose: The purpose of the VWOC is to provide oversight and assess the appropriateness and quality of services provided on behalf of SilverSummit to the members. The Vendor Management Oversight Committee (VMOC) closely monitors the work of SilverSummit subcontractors to ensure constant communication and compliance with contract requirements. Auditing and monitoring of vendor performance is done to ensure that delegated services meet SilverSummit's standards for care and service as well as DHS, federal, and NCQA requirements. The VMOC will monitor all vendor activities, evaluations and corrective actions.

Objectives of the Committee and Relationship to Strategic Objectives:

- Oversee SilverSummit operations of the vendor to ensure compliance with contractual requirements, federal and state statutes and regulations, and requirements of accrediting bodies such as Utilization Review Accrediation Commission (URAC))/ National Committee for Quality Assurance (NCQA);
- Annually review and evaluate the applicable vendor Program Descriptions, interventions, processes, and ability to perform the proposed administrative or delegated activities prior to delegation
- Identify and address trends related to any vendor policies that pertain to the scope of delegated functions.
- Develop and review utilization and quality reporting, summary analysis of data, and specialized reports designed exclusively to describe the findings of vendor activities;
- Define and establish reporting deliverables for departmental business
- Establish effective departmental auditing tools to measure administrative/management performance to ensure compliance with regulatory mandates
- Assure the operational areas perform audits of external entities who are responsible for delegated functions on behalf of SilverSummit. The business owners are responsible for completing timely audits of their designated oversight area
- Review and evaluate vendor performance, identifies collaborative opportunities for performance improvement, recommend and issue corrective action plans when a deficiency identified
- Distribute information to the VMOC regarding findings, recommended changes to contracts and policies, and requested initiatives or project updates by the vendor

- Make recommendations to the Quality Management Committee, the Chief Medical Officer, and the Vice President of Network Development and Contracting regarding the approval and continuation of the delegated entity
- Impose sanctions up to and including the revocation and/or termination of delegation if the delegated entity's performance is inadequate

Committee Structure and Operation:

Frequency: Minimum of Quarterly, more frequently as determined by Chair

Committee Chair: VP of Compliance

Committee Recorder: as designated by VMOC Chair.

Reports To: QIC

Committee Composition:

- VP Compliance
- Senior Management/Executive Staff representing the functional areas associated with the delegated services

Scheduling: to be completed by VMOC designee

Agenda: the VMOC meeting chair with input from committee members and vendors will develop Agenda items for the meetings.

Meeting Packets: Meeting packets are distributed at the meeting.

Minutes: Minutes are taken during the meeting and reflect attendance and participant discussion. Each item for discussion includes the person responsible and a timeline for completion. Draft minutes will be completed within 30 days of the meeting, reviewed by the Chair, and amended / corrected as needed by at least 10 days prior to the next meeting, or as needed for other regulatory reporting. Minutes are stored in a secure area. The Chair is responsible for approving the documented proceedings that reflect all VMOC decisions/recommendations.

Attendance Requirement: 50% of committee members.

Quorum: 50% of voting members. All committee members have voting privileges.

Sub-Committees:

- Joint Operating Committees-one per subcontractor and responsible for the monitoring of the subcontractor performance;

Committee Name: Population Health Management and Clinical Operations Committee (PHMCOC)

Charter Statement: The Population Health Management Committee (PHMCOC) is a subcommittee of the Quality Improvement Committee (QIC) with oversight and operating authority of utilization management and case management activities. The utilization management process encompasses the following program components: 24-hour nurse triage, referrals, second opinions, prior authorization, and pre-certification, concurrent review, ambulatory review, retrospective review and discharge planning. The case management process encompasses active caseloads, major accomplishments, care coordination, and Start Smart for Baby. The PHMCOC communicates its activities to the Board of Directors (BOD) through the QIC.

Purpose: The purpose of the PHMCOC is to review and monitor the appropriateness of care provided to SilverSummit members. The PHMCOC 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, activities of case management and caseloads. The PHMCOC also monitors and analyzes relevant data to detect and correct patterns of potential or actual inappropriate under- or over-utilization, which may impact health care services, coordination of care and appropriate use of services and resources, as well as member and practitioner satisfaction with the PHM process.

Objectives of the Committee and Relationship to Strategic Objectives:

- Annually review and approve the UM and Case Management (CM) Program Descriptions, Work Plan and Annual Program Evaluations, guidelines, and procedures;
- Annually review and approve the criteria for determination of medical appropriateness to be used for nurse review;
- Responsible for developing and regularly reviewing Utilization Review (UR) and Prior Authorization (PA) policies and procedures to ensure consistency with Clinical Practice Guidelines (CPG), community practice standards, state and federal regulations, and evidence-based standards;
- Monitor key utilization measures that are based on industry standards, national HEDIS® Medicaid averages, EPSDT requirements, or DHCFP mandated thresholds; Adapt criteria for determination of medical appropriateness to work within the delivery system;
- Review provider specific reports for trends or patterns in over and under-utilization;
- Review reports specific to facility or geographic areas for trends or patterns;
- Formulate recommendations for specific providers for further study;
- Monitor the adequacy of the network to meet the needs of the patient population;
- Examine reports of the appropriateness of care for trends or patterns of under or over utilization and refer them to the proper provider group for performance improvement or corrective action;
- Examine results of annual surveys of members and providers regarding satisfaction with the UM program and CM program;
- Include a feedback mechanism for communicating findings and recommendations, and contain a plan for implementing corrective actions
- Report findings to the QIC;
- Liaison with the QIC for ongoing review of indicators of clinical quality.

Committee Structure and Operation:

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

Committee Chair: Chief Medical Director. The Chief Medical Director is responsible for the review and approval of medical necessity criteria: utilization management policies and procedures; after hours nurse advice line protocols, and monitoring and analyzing relevant data to detect and correct patterns of potential or actual inappropriate under or over utilization of that a

significant or severe adverse outcome has potentially occurred or other cases deemed appropriate by a Medical Director.

Committee Recorder: VP/Director of Population Health Management or Population Health Management designee maintains detailed records of all PHMCOC meeting minutes, UM activities, case management program statistics and recommendations for UM improvement activities made by the PHMCOC. The Chief Medical Director is responsible for approving the documented proceedings that reflect all PHMCOC decisions. The PHMCOC routinely submits meeting minutes as well as written reports regarding analysis of the above tracking and monitoring processes and status of corrective action plans (as applicable) to the QIC.

Reports To: QIC to the BOD

Committee Composition:

- Chief Medical Director
- Designated QI staff
- Designated Population Health Management staff
- SilverSummit Network providers representing the range of practitioners within the network and across the regions in which it operates representing various specialties, at least one being a behavioral health provider
- Other SilverSummit operational staff as requested

Scheduling to be completed by Population Health Management designee as directed by the PHMCOC Chair.

Agenda: the Committee Chair in collaboration with the Director of Population Health Management will develop Agenda items for the next meeting.

Meeting Packets: Meeting packets distributed at the meeting.

Minutes: Minutes are taken during the meeting and reflect attendance and participant discussion. Each item for discussion includes the person responsible and a timeline for completion. Draft minutes are completed within 30 days of the meeting, reviewed by the Chair, and amended/corrected as needed by at least 10 days prior to the next meeting, or as needed for other regulatory reporting. The PHMCOC routinely submits meeting minutes as well as written reports regarding analysis of the above tracking and monitoring processes and status of corrective action plans (as applicable) to the QIC. Minutes are stored in a secure area.

Attendance Requirement: 75% of schedule meetings.

Quorum: A minimum of 50% of the committee members, including two (2) SilverSummit staff and two (2) external practitioners must be present for a quorum. The Chief Medical Director is the determining vote in the case of a tie vote.

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

Decision Authority: The QIC authorizes PHMCOC to make all decisions regarding the utilization of clinical care and services provided on behalf of SilverSummit to SilverSummit members. Decisions are by consensus. Individuals are responsible to raise any concerns/issues at the committee meetings.

Evaluation: The Committee will review the PHMCOC 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.

Committee Name: Performance Improvement Team (PIT)

Charter Statement: SilverSummit Performance Improvement Team (PIT) is an internal, cross-functional quality improvement team that facilitates the integration of a culture of quality improvement throughout the organization. Performance measure results from performance improvement efforts and activities planned/taken to improve outcomes compared with expected results and findings. SilverSummit will use an industry-recognized methodology for analyzing data.

Purpose: The purpose of the PIT 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 PIT is also responsible for overseeing the implementation of recommended corrective actions or interventions from the Quality Improvement Committee (QIC) and/or its supporting subcommittees, monitoring the outcomes of those improvement efforts, and reporting results to the designated committee. The PIT communicates its activities to the Board of Directors (BOD) through the QIC.

Objectives of the Committee and Relationship to Strategic Objectives:

- Review and evaluate key clinical and non-clinical quality and service performance indicators by collecting and analyzing HEDIS® , CAHPS®, EPSDT reports and other performance measure outcomes and trends;
- Evaluate performance for adequate access to care against standards and make recommendations to adjust network as appropriate; Oversee the implementation of recommended corrective actions/interventions from the QIC and/or its supporting subcommittees, monitoring the outcomes of those improvement efforts, and reporting results to the designated committee; and overseeing the implementation, progress and effectiveness of the PIPs which are aligned with the Nevada Quality Strategy;
- Prompt initiation of ad hoc performance improvement initiatives (including corrective action plans) to address any negative trends;
- Review, categorize, track, and trend grievances and appeals, administrative reviews, and requests for external reviews. Determines appropriate disposition and follow-up;
- Monitor resource allocation to ensure appropriate support for the Internal Quality Assurance Program (IQAP);
- Track progress of tasks in the annual IQAP Work Plan, make recommendations to improve quality activities noted in the Work Plan as needed, in response to issues raised by the QIC;
- Provide ongoing reports to the QIC, as appropriate, on the progress of clinical and performance improvement initiatives;
- Review SilverSummit operational policies and procedures at least annually and recommend modifications as necessary;
- Review and discuss all proposed materials and potential strategies, supported by review and recommendations by the Member Advisory Committee;

- Oversee the activities of the PIT subcommittees and report the status of these activities and report to the QIC.

Committee Structure and Operation:

Frequency: At a minimum ten (10) times per year.

Committee Chair: Chief Medical Director or designee.

Committee Recorder: PIT designee

Report To: QIC

Committee Composition:

- Chief Medical Officer/Medical Directors
- VP/Director of Quality Improvement (QI)
- VP and/or Director Population Health Management
- VP and/or Director Network Development & Contracting
- Director Provider Relations/Services
- Director Member Services
- Director, Health Equity
- VP Community Engagement
- Population Health Management Representative, as applicable
- Manager of Grievance and Appeals
- VP Compliance
- Director of Pharmacy
- Behavioral Health Provider/Representative, as applicable
- Community Health Worker Staff
- Management Staff as needed from functional areas
- Additional staff may participate as requested by the Chair

Scheduling: to be completed by PIT Chair.

Agenda: the PIT Chair will develop Agenda items for the next meeting.

Meeting Packets: Meeting packets are distributed at the meeting.

Minutes: Minutes are taken during the meeting and reflect attendance and participant discussion. Each item for discussion includes the person responsible and a timeline for completion. Draft minutes will be completed within 30 days of the meeting, reviewed by the Chair, and amended/corrected as needed by at least 10 days prior to the next meeting, or as needed for other regulatory reporting. Minutes to include detailed records of the PIT meetings, activities, statistics and recommendations for improvement activities. The PIT routinely submits meeting minutes as well as written reports regarding analysis of findings and status of corrective action plans (as applicable) to the QIC. Minutes are stored in a secure area.

Attendance Requirement: 75% of schedule meetings.

Quorum: 50% of voting members.

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

Decision Authority: The QIC authorizes the PIT to make decisions and recommendations regarding performance improvement processes. The Performance Improvement Team reports to the QIC.

Evaluation: The Committee will review the PIT charter annually.

Confidentiality: Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information is managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Committee Name: Provider Advisory Board (PAB)

Charter Statement: The Provider Advisory Board Committee serves as a consulting resource to SilverSummit Health Plan in policy and operational matters, and further strengthen the bridge between SilverSummit and the provider community.

Purpose: The purpose of the Provider Advisory Board Committee is responsible to represent the interest and viewpoint of the provider population to ensure that providers have a direct voice in developing and monitoring clinical policies and operational issues in addition to quality and safety of clinical care, quality of services, and access standards. The Committee is comprised of external providers and Plan representation

Objectives of the Committee and Relationship to Strategic Objectives:

- Provide input on planning and delivery of services
- Provider input on QIC activities, program monitoring, and evaluation
- Establish and review process for responding to provider concerns
- Provide review and comment on quality and access standards
- Provide review and comment on Grievance and Appeals Process
- Providing review and comment on Provider Manual
- Providing review and comment on provider education materials
- Providing review and comment on policies that affect providers
- Providing review and comment on Provider Incentive programs

Sub-Committees:

- Provider Advisory Committee (PAC)-will report to the PABC at least quarterly or as often as the subcommittee meets

Committee Structure and Operation:

Frequency: Quarterly.

Committee Chair: Chief Medical Director.

Committee Recorder: PAB designee

Reports To: QIC

Committee Composition:

- Chief Medical Officer
- VP of Quality Improvement
- VP of Network Contracting & Development
- VP and/or Director of Population Health
- Medical Director of Behavioral Health

- Designee(s) from each applicable functional area-Operations, Quality, Human Resources, Compliance, network, case management
- Network practitioners as prescribed by the State of Nevada

Scheduling PAB designee.

Agenda: the PAB Chair or designee will develop Agenda items for the next meeting.

Meeting Packets: 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.

Minutes: Draft minutes are completed no later than within 10 calendar days of the meeting and provided to the DHCFP within 30 calendar days of meeting. Minutes are stored in a secure area.

Attendance Requirement: There is no minimum meeting attendance requirement.

Quorum: This is not a voting committee.

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

Decision Authority: The PAB is a non-voting committee to solicit feedback from the local provider network. This Committee reports to the Quality Improvement Committee (QIC).

Evaluation: The Committee will review the PAB charter annually.

Confidentiality: Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information needs to be managed in a specific manner. Members must agree to and sign a committee confidentiality statement on an annual basis.

Committee Name: Provider Advisory Committee (PAC)

Charter Statement: The Provider Advisory Committee (PAC) is a committee utilized to communicate SilverSummit's programs and processes to its provider network allowing for immediate and face-to-face reaction and discussion with the providers.

Purpose: The purpose of the PAC is to provide input on SilverSummit 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.

Objectives of the Committee and Relationship to Strategic Objectives:

- To provide SilverSummit with feedback regarding programs and processes from a community provider-based perspective;
- To allow providers to make recommendations related to SilverSummit's programs and processes;
- Assist SilverSummit to identify key issues related to programs that may affect community providers.
- Provide input on development of member outreach and education

Committee Structure and Operation:

Frequency: Quarterly.

Committee Chair: Chief Medical Director.

Committee Recorder: PAC designee or VP and/or Director of Contracting and Network Management.

Reports To: QIC

Committee Composition:

- Chief Medical Director
- The Chair appoints members for committee representation from the provider network that reflects all SilverSummit demographics (serving one year terms
- Facilities representatives
- Ancillary provider representatives
- Director of Contracting and Network Management
- Provider Relations staff as appropriate

Scheduling PAC designee.

Agenda: the PAC Chair will develop Agenda items for the next meeting.

Meeting Packets: Meeting packets will be distributed at the meeting.

Minutes: Minutes are taken during the meeting and reflect attendance and participant discussion. Each item for discussion includes the person responsible and a timeline for completion. Draft minutes will be completed within 30 days of the meeting, reviewed by the Chair, and amended / corrected as needed by at least 10 days prior to the next meeting or as needed for other regulatory reporting. The Director of Contracting & Network Management maintains detailed records of all Provider Advisory Committee meetings, activities and recommendations for improvement activities. Minutes are stored in a secure electronic file.

Attendance Requirement: There is no minimum meeting attendance requirement.

Quorum: This is not a voting committee.

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

Decision Authority: The PAC is a non-voting committee to solicit feedback from the local provider network. This Committee reports to the Quality Improvement Committee (QIC).

Evaluation: The Committee will review the PAC charter annually.

Confidentiality: Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information needs to be managed in a specific manner. Members must agree to and sign a committee confidentiality statement on an annual basis.

Committee Name: Member Advisory Board (MAB)

The Member Advisory Board is a group of members, parents, legal representative/guardian, and SilverSummit Healthplan staff as appropriate, that reviews and reports on a variety of quality improvement issues, initiatives and activities

Purpose: The primary purpose is to keep members informed of quality initiatives and results; review Member Satisfaction results, improve service quality and member experience in the program

Objectives of the Committee and Relationship to Strategic Objectives: Solicit member input into the quality improvement program, quality initiatives and member experience with the quality improvement program

Committee Structure and Operation:

Frequency: Quarterly.

Committee Chair: VP Quality

Committee Recorder: MAB designee.

Reports To: QIC quarterly

Committee Composition:

- Chief Medical Officer
- VP Quality
- Manager Legislative & Government Affairs
- VP of Network Contracting & Development
- Justice Liaison
- VP and/or Director of Population Health
- Behavioral Health designee
- Designee(s) from each applicable functional area-Operations, Quality, case management
- Enrollees*/Representatives (Parents/foster parents/guardians/representatives) - may volunteer or be suggested by staff
- *At a minimum, the committee involves 12 members and individuals representing the racial/ethnic and linguistic groups that constitute at least 5 percent of eligible individuals.

Scheduling: MAC designee

Agenda: Meetings are agenda driven. The Committee Chair develops agenda items for the next meeting or designee in collaboration with the applicable department leads.

Meeting Packets: Meeting packets are distributed at the meeting. Decisions are made prior to each meeting as to what materials will be included in the meeting packets based on need for prior review and privacy/sensitivity of materials.

Minutes: Draft minutes are completed no later than within 15 days of the meeting. Meeting minutes are provided to the State within 30 calendar days of the meeting. Minutes are stored in a secure area.

Attendance Requirement: Members may not be standing members of the committee. Therefore, there is no minimum meeting attendance requirement.

Quorum: This is not a voting committee.

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

Decision Authority: The committee is a non-voting committee, intended to solicit direct feedback from members and stakeholders This committee reports to the QIC and meeting minutes forwarded to the Board of Directors (BOD).

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 is managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Committee Name: Member Advisory Committee (MAC)

Charter Statement: The Member Advisory Committee (MAC) is a group of members, parents, guardians, member advocacy groups and SilverSummit staff as appropriate, that reviews and reports on a variety of Internal Quality Assurance Program (IQAP) issues. SilverSummit understands that our ability to effectively engage stakeholders, including members/family members/caregivers, advocates, and community organizations in our IQAP is a crucial component of our collaborative efforts to enhance a patient-centered service delivery system, optimize clinical outcomes, and positively affect our program operations. There will be one MAC per region.

Purpose: The purpose of the MAC is to solicit member input into the approach and effectiveness of the SilverSummit programs, policies, and services, and to promote a collaborative effort to enhance the service delivery system in local communities. The MAC will allow member engagement in the quality program and operational performance. The MAC will represent the geographic, cultural and racial diversity of our membership across Nevada. SilverSummit's MAC will provide input for quality improvement activities, program monitoring and evaluation, and member, family, and provider education. MAC responsibilities may include review and discussion of topics such as member satisfaction results, customer service and/or quality improvement efforts, member education materials for relevance, understanding and ease of use, and/or other topics as defined by the Performance Improvement Team (PIT) or Quality Improvement Committee (QIC).

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

- Members are randomly selected in accordance with the Managed Care Reform and Patient Rights Act;
- SilverSummit will inform its members about this committee through such materials as the Member Handbook, Member Newsletters, and through contacts at community events. Information about these committees will also be available on the SilverSummit website;
- SilverSummit will provide an orientation and ongoing training for MAC members so that they have sufficient information and understanding of the managed care program to fulfill their responsibilities;
- The MAC meets in-person to promote 2-way communication where members can provide input and ask questions and SilverSummit can ask questions and obtain feedback from members;
- The MAC shall recommend program enhancements, review satisfaction survey results and provide feedback on SilverSummit performance levels.
- Review of member education; materials for relevance, understandability, and ease of use for culturally appropriate member communication materials.

Committee Structure and Operation:

Frequency: Quarterly

Committee Chair: Director of Member Services

Committee Recorder: MAC designee

Reports To: QIC quarterly

Committee Composition:

- SilverSummit Director of Member Services
- Members-may volunteer or be suggested by staff

- Parents/Foster Parent/Guardians of children members- may volunteer or be suggested by staff
- SilverSummit staff as indicated
- VP and/or Director/Coordinator Quality Improvement
- Members and families/significant others of SilverSummit members. SilverSummit will pay travel costs for committee members.
- Additional members as outlined.

Scheduling: MAC Chair

Agenda: MAC Chair will develop Agenda items for the next meeting in collaboration with relevant member input.

Meeting Packets: Meeting packets are distributed at the meeting. Decisions are made prior to each meeting as to what materials will be included in the meeting packets based on need for prior review and privacy/sensitivity of materials.

Minutes: Minutes are taken during the meeting and reflect attendance and participant discussion. Each item for discussion includes the person responsible and a timeline for completion. Draft minutes will be completed within 30 days of the meeting, reviewed by the Chair, and amended/corrected as needed by at least 10 days prior to the next meeting, or as needed for other regulatory reporting. Minutes are stored in a secure electronic file.

Attendance Requirement: Plan members may not be standing members of the MAC. No minimum attendance required.

Quorum: This is not a voting committee.

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

Decision Authority: The MAC is a non-voting committee to solicit feedback from SilverSummit membership perspective. This committee reports to the QIC and meeting minutes forwarded to the Board of Directors (BOD).

Evaluation: The Committee will review the charter and MAC Plan annually.

Confidentiality: Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information is managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Committee Name: Community Advisory Committee (CAC)

Charter Statement: The Community Advisory Committee (CAC) is a community-wide advisory committee that is responsible for providing SilverSummit feedback and make recommendations regarding health plan performance from a community-based perspective.

Purpose: The purpose of the CAC will be to assist SilverSummit in identifying key issues related to programs that may affect specific community groups and provide community input on potential Plan service improvements. In addition, the CAC will offer effective approaches from reaching or communicating with members or other issues related to SilverSummit's member population. Based on the Plan size and distribution, the CAC may include regional level committees that will report up to the central office CAC.

Objectives of the Committee and relationship to Strategic Objectives:

- Convene pre-implementation with DHCFP to obtain input into program, process and network design; work through start-up issues; ensure all Contract requirements are met; and guarantee the ability to deliver service excellence to members and providers for all service areas;
- Provide SilverSummit 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 SilverSummit to identify key issues related to State programs that may directly impact specific community groups;
- Provide community input on potential health plan service improvements and offer effective approaches for reaching or communicating with members or other issues related to SilverSummit's member population.

Committee Structure and Operation:

Frequency: Quarterly.

Committee Chair: VP Operations

Committee Recorder: CAC designee.

Reports To: QIC

Committee Composition: The Chair appoints members of the Committee with approval from Chief Executive Officer.

- Director of Member Services
- Church leaders
- Local business leaders
- Hospital representatives
- Representatives from advocacy groups
- Other community based organizations, including those providing services for children and adults with special needs

Scheduling: to be completed by CAC Chair.

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

Meeting Packets: Meeting packets are distributed at the meeting. Decisions are made prior to each meeting as to what materials will be included in the meeting packets based on need for prior review and privacy/sensitivity of materials.

Minutes: Minutes are taken during the meeting and reflect attendance and participant discussion. Each item for discussion includes the person responsible and a timeline for completion. Draft minutes will be completed within 30 days of the meeting, reviewed by the Chair, and amended/corrected as needed by at least 10 days prior to the next meeting, or as needed for other regulatory reporting. Minutes are stored in a secure electronic file.

Attendance Requirement: No minimum attendance required.

Quorum: This is not a voting committee.

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

Decision Authority: The CAC is a non-voting committee to solicit feedback from SilverSummit community stakeholders. This Committee reports to the QIC and meeting minutes forwarded to the Board of Directors (BOD).

Evaluation: The Committee will review the charter and CAC Plan annually.

Confidentiality: Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information is managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Committee Name: Health Equity Improvement Committee

Charter Statement: The Health Equity Improvement Committee provides guidance and leadership to ensure health equity and cultural and linguistic competency to assist in eliminating health care disparities when providing services to the health plan membership.

Purpose: The purpose of the Health Equity Improvement Committee is to provide oversight on health equity strategy and priorities including assessing and implementing strategies for Cultural and Linguistic Appropriate Services (CLAS), social determinants of health and implementation of state and geographic health equity pilots.

Objectives of the Committee and relationship to Strategic Objectives:

- Establish appropriate goals, policies, and leadership accountability throughout the health plan's planning and operations;
- Understand and align local strengths and barriers with health equity opportunities including partnering with communities to conduct regular health needs assessments to design, implement, and evaluate policies, practices and services to address social determinant of health related factors;
- Identify place based health equity model priorities and establish targeted ad hoc health equity workgroups to implement pilots in neighborhoods/communities;
- Recruit, promote and secure diverse viewpoints in governance decisions, and to support a culture and practice with social determinant sensitive governance, leadership, and workforce;
- Act as focus committee to facilitate perspectives from interested stakeholders outside the health plan, to ensure the health plan is responsive to diverse beliefs and practices and other membership communication or resource needs;
- Communicate the organization's progress in implementing and sustaining culturally competent, activities to all stakeholders and constituents

Committee Structure and Operation:

Frequency: Quarterly.

Committee Chair: Sr. Director, Health Equity

Committee Recorder: Health Equity Committee designee

Reports To: QIC

Committee Composition:

- Chief Medical Officer
- VP of Quality Improvement

- Manager Legislative & Government Affairs
- VP of Network Contracting & Development
- Justice Liaison
- VP and/or Director of Population Health
- Medical Director of Behavioral Health
- Designee(s) from each applicable functional area-Operations, Quality, Human Resources, Compliance, network, case management
- Enrollees*/Representatives (Parents/foster parents/guardians/representatives) - may volunteer or be suggested by staff
- Network practitioners

*At a minimum, the committee involves consumers and individuals representing the racial/ethnic and linguistic groups that constitute at least 5 percent of eligible individuals.

Scheduling: to be completed by Health Equity Chair/Designee

Agenda: Meetings are agenda driven. Agenda items for the next meeting are developed by the Committee Chair or designee in collaboration with the applicable department leads

Meeting Packets: Meeting packets are distributed at the meeting. Decisions are made prior to each meeting as to what materials will be included in the meeting packets based on need for prior review and privacy/sensitivity of materials.

Minutes: 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

Attendance Requirement: No minimum attendance required.

Quorum: This is not a voting committee.

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

Decision Authority: The committee is a non-voting committee, intended to solicit direct feedback from community stakeholders. This Committee reports to the QIC and meeting minutes forwarded to the Board of Directors (BOD).

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 is managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Committee Name: Social Determinants of Health Committee (SDoH)

Charter Statement: Social Determinants of Health (SDoH) Committee is comprised of interdisciplinary and cross-functional SilverSummit staff, with a focus on determinants of health and identified barriers occurring outside of the individual member that impact outcomes, such as their built environment or socio-economic conditions.

Purpose: The purpose of the Social Determinants of Health Committee is to address barriers at both the member and community level. To understand the importance of diversity (i.e. Cultural

Competency) and make Social Determinants of Health sensitive policy and practices central to SilverSummit' s service, administrative, and supportive functions.

Objectives of the Committee and relationship to Strategic Objectives:

- Establish appropriate goals, policies, leadership accountability, and infuse throughout the organization's planning and operations;
- Recruit, promote mentoring opportunities to ensure diverse viewpoints are represented in governance decisions, and to support a culture and practice that is social determinant sensitive governance, leadership, and workforce responsive to the population in the service delivery areas;
- Evaluate staff/Provider SDoH training needs, integrate local community-based organizational perspective regarding SilverSummit' s performance and offer SDoH-related program enhancements;
- Act as focus Committee to facilitate perspectives from interested stakeholders outside the health plan, to ensure Plan is responsive to diverse beliefs and practices and other member and provider communication or resource needs;
- Conduct ongoing assessments of the SilverSummit's SDoH-related activities and integrate quality improvement activities;
- Monitor & evaluate performance levels for identification/selection of educational opportunities and to enhance health care outcomes;
- Partner with communities to conduct regular health needs assessments to design, implement, and evaluate policies, practices and services to address Social Determinant of Health related factors;
- Communicate the organization's progress in implementing and sustaining SDoH activities to all stakeholders

Committee Structure and Operation:

Frequency: Quarterly

Committee Chair: VP, Population Health Management and Clinical Operations

Committee Recorder: SDoH Committee designee

Reports To: QIC

Committee Composition:

- Sr. Director of Health Equity
- Chief Medical Officer and/or Medical Director
- VP of Quality and Risk Adjustment
- Manager Legislative & Government Affairs
- Manager, Marketing
- Director of Customer Service
- Director, Provider Engagement
- Director of Network Contracting & Development
- Justice Liaison
- Manager of Utilization Management

- Designee(s) from each applicable functional area-Operations, Quality, Human Resources, Compliance, network, case management

Scheduling: to be completed by SDoH/Designee

Agenda: Meetings are agenda driven. Agenda items for the next meeting are developed by the Committee Chair or designee in collaboration with the applicable department leads

Meeting Packets: Meeting packets are distributed at the meeting. Decisions are made prior to each meeting as to what materials will be included in the meeting packets based on need for prior review and privacy/sensitivity of materials.

Minutes: 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

Attendance Requirement: 50% of committee composition for any voting meetings.

Quorum: at a minimum of 5 members if voting is to occur

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

Decision Authority: The committee is a voting committee. This Committee reports to the Health Equity Committee and meeting minutes forwarded to the QIC.

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 is managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Committee Name: Cultural Competency Committee

Charter Statement: Cultural Competency Committee is comprised of interdisciplinary and cross-functional SilverSummit staff, with a focus on cultural competency and identified barriers occurring outside of the individual member that influence outcomes and/or access to health care.

Purpose: The purpose of the Cultural Competency Committee is to address barriers at both the member, provider and community level. To understand the importance of diversity (i.e. Cultural Competency) and make Cultural Competency sensitive policy and practices central to SilverSummit' s service, administrative, and supportive functions.

Objectives of the Committee and relationship to Strategic Objectives:

- Establish appropriate goals, policies, leadership accountability, and infuse throughout the organization's planning and operations;
- Recruit, promote mentoring opportunities to ensure diverse viewpoints are represented in governance decisions, and to support a culture and practice sensitive governance, leadership, and workforce responsive to the population in the service delivery areas;
- Evaluate staff/Provider Cultural Competency training needs, integrate local community-based organizational perspective regarding SilverSummit's performance and offer culturally relevant program enhancements;

- Act as focus committee to facilitate perspectives from interested stakeholders outside the health plan, to ensure Plan is responsive to cultural beliefs and practices and other member or provider communication or resource needs;
- Conduct ongoing assessments of the SilverSummit's cultural competency related activities and integrate quality improvement activities;
- Monitor & evaluate performance levels for identification/selection of educational opportunities and to enhance health care outcomes;
- Partner with communities to conduct regular health needs assessments to design, implement, and evaluate policies, practices and services to address Cultural Competency related factors;
- Communicate the organization's progress in implementing and sustaining culturally competent activities to all stakeholders

Committee Structure and Operation:

Frequency: Quarterly

Committee Chair: VP, Quality Improvement

Committee Recorder: Cultural Competency Committee designee

Reports To: QIC

Committee Composition:

- Sr. Director of Health Equity
- Chief Medical Officer and/or Medical Director
- Manger, Quality
- Manager Legislative & Government Affairs
- Manager, Marketing
- Director of Customer Service
- Director, Provider Engagement
- Director of Network Contracting & Development
- Justice Liaison
- Manager of Utilization Management
- Designee(s) from each applicable functional area-Operations, Quality, Human Resources, Compliance, network, case management

Scheduling: to be completed by Cultural Competency designee

Agenda: Meetings are agenda driven. Agenda items for the next meeting are developed by the Committee Chair or designee in collaboration with the applicable department leads

Meeting Packets: Meeting packets are distributed at the meeting. Decisions are made prior to each meeting as to what materials will be included in the meeting packets based on need for prior review and privacy/sensitivity of materials.

Minutes: 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

Attendance Requirement: No requirement**.** Non-voting committee

Quorum: No requirement

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

Decision Authority: The committee is a non-voting committee. This Committee reports to the Health Equity Committee and meeting minutes forwarded to the Health Equity Committee

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 is managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Committee Name: 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.
Objectives of the Committee and relationship to Strategic Objectives: • 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.
Committee Structure and Operation: **Frequency:** Quarterly **Committee Chair:** VP, Quality Improvement **Committee Recorder**: Designated committee member **Reports To:** QIC **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

Scheduling: to be completed by G&A designee

Agenda: Meetings are agenda driven. Agenda items for the next meeting are developed by the Committee Chair or designee in collaboration with the applicable department leads

Meeting Packets: Meeting packets are distributed at the meeting. Decisions are made prior to each meeting as to what materials will be included in the meeting packets based on need for prior review and privacy/sensitivity of materials.

Minutes: 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

Attendance Requirement: 50% of members.

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

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

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 is managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

QUALITY PROGRAM METHODOLOGY (RESOURCES: INFRASTRUCTURE AND DATA ANALYTICS)

SilverSummit Healthplan has the adequate staff resources with the necessary education, experience or training to effectively carry out its specified activities, including, VP of Quality, QI Manager, Quality Specialist Sr. (2), Quality Improvement Coordinator, data analyst and a Sr. Director of Health Equity. SilverSummit also 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.

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.

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.

SPECIFIC ACTIVITIES AND CONTINOUS ACTIVITY

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. SilverSummit Healthplan designates a staff person to be responsible for administering the incident management system and ensuring compliance with the requirements. SilverSummit will submit an individual Critical Incident Report as designated in the Contract and in the Critical Incident Policy. SilverSummit Healthplan will report Critical Incidents within one (1) Business Day of becoming aware of the event and will include all elements as noted in the Contract and within the Critical Incident Policy. SilverSummit Healthplan will submit follow-up reports using the Incident Reporting System and close cases within forty-five (45) Calendar Days after the critical incident was initially report and according to criteria for closing a case as noted in the Contract and Critical Incident Policy.

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.

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, and related to Children with Special Health Care Needs, 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. SilverSummit Healthplan will report the status and results of each performance improvement project to the State as requested, including those that incorporate the requirements of 42 CFR 438.330(a)(2).

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.

PROVIDER REVIEW

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. SilverSummit Healthplan quality studies and other activities monitor the quality of care against clinical care or health services delivery standards or practice guidelines.

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.

HEALTH OUTCOMES (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.

SUMMARY

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'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

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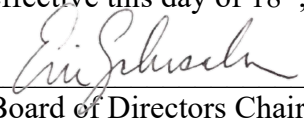
SilverSummit Healthplan Quality Improvement Committee has reviewed and adopted this document, including the Quality Work Plan (Program Approval Signature on file within the Quality Department).

ENDORSEMENT OF THE Quality Program Description
The Quality Program Description has been reviewed and endorsed by the quality senior leadership effective this day of 24th, month of January, 2022.

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 18th, month of March, 2022.



Board of Directors Chairman