SilverSummit Healthplan

2025
Quality Improvement Program Description

Revised 05/2025

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

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

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

This type of methodology supports SilverSummit Healthplan to develop targeted, measurable locally tailored, culturally relevant 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, inequities in care and member and provider satisfaction. These systematic approaches provide a continuous cycle for improving the quality of care and service for members.

The Quality Improvement Department maintains strong inter/intradepartmental working relationships, with support integrated throughout SilverSummit Healthplan to address the priorities and goals of the Quality Improvement 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 Improvement Program. The Quality Improvement Department collaborates across the health plan with several functional areas including and not limited to Population Health Management and Clinical Operations (PHMCO), Pharmacy, Provider Relations, Health Equity, Network Development & Contracting, Member Services, Compliance, and Grievances and Appeals.

PURPOSE

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

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

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

SCOPE

The scope of the Quality Improvement Program is comprehensive and addresses both the quality and safety of clinical and non-clinical care and quality of services provided to SilverSummit Healthplan members including medical, behavioral health, dental, and vision care as applicable to the health plan's benefit package. SilverSummit Healthplan incorporates all demographic groups, lines of business, benefit packages, care settings (e.g., inpatient, ambulatory, including care provided in private practice offices and home care), and services in its quality management and improvement activities. Areas addressed by the Quality Improvement 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; CLAS; continuity and coordination of care; patient safety; social determinants of health; and administrative, member, and network services as applicable.

SilverSummit Healthplan's Quality Improvement Program and entire range of care has multiple review periods which occurs no less than annually and includes the following:

- At minimum, an annual review of the entire rage of care provided to its members
- 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, National CLAS Standards and other evidence-based sources;
- Conducting quality activities, including peer review activities, in accordance with all applicable state and federal confidentiality laws and regulations and taking conflicts of interest into consideration when conducting peer review activities;
- A focus on cultural competency and health equity, including the identification of interventions to improve health disparities based on age, race, ethnicity, sexual orientation, gender identity, primary language, etc. and by key population group; Assessment of Governance, Leadership, and Workforce, Communication and Language Assistance, Practitioner Network Cultural Responsiveness, data and infrastructure, and identification of interventions to address health disparities at the community and statewide level, including identifying internal priorities for disparity reduction and quality measure improvement and addressing inequalities;
- Collecting and analyzing data regarding social risks of the broader population and social needs of members served; including prioritizing social risks to mitigate, social needs to address, and establishing partnerships with external organizations to assist in mitigating identified social risks and addressing identified social needs.
- 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 Improvement Program, including data analysis and reporting;
    - Meet the educational needs of members, providers, and staff relevant to quality improvement efforts; and
    - Meet all regulatory and accreditation requirements;
- The technology infrastructure and data analytics capabilities to support goals for quality management and value include health information systems that provide data collection, integration, tracking, analysis, and reporting of data that reflects performance on standardized measures of health outcomes;
- An ongoing documentation cycle that includes the Quality Improvement Program Description, the Quality Improvement Work Plan, and a Quality Improvement Program Evaluation; these documents demonstrate a systematic process of quality assessment, identification of opportunities, action implementation as indicated, and ongoing evaluation;
- Prioritizing the scope of services as set forth by Nevada Department of Health and Human Services' Division of Health Care Financing and Policy (DHCFP), including but not limited to

    - Providing a comprehensive approach to healthcare delivery in all aspects of primary, secondary, and complex care including quality, accessibility, availability, level of care, continuity, appropriateness, timeliness, and clinical effectiveness of care and services (e.g., health and disease management, health promotion);
    - Covering or offering services of preventive care, specialty care, ancillary care, emergency services, chronic disease and special needs care, dental services, mental health services, diagnostic services, pharmaceutical services, skilled nursing care, home healthcare, and prescription drugs;
- Prioritizing quality goals as set forth by Nevada Department of Health and Human Services' Division of Health Care Financing and Policy (DHCFP) by December 31, 2027:
    - Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services;
    - Increase use of evidence-based practices for members with chronic conditions;
    - Reduce misuse of opioids and other prescribed medications;
    - Improve the health and wellness of pregnant women and infants;
    - Increase use of evidence-based practices for members with behavioral health conditions;
    - Increase utilization of dental services;
    - Reduce and/eliminate health care disparities for Medicaid members;
    - Improve positive outcomes for members with long-term services and supports (LTSS) needs;
- Collecting and submitting all quality performance measurement data per state (including DHCFP), federal, and accreditation requirements, including robust performance management tracking and reporting such as:
    - The annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) (CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ));
    - 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 overtime; and/or
    - Administering an annual provider satisfaction survey and identifying improvement activities based on identified areas of provider need/dissatisfaction;
- Monitoring, assessing, and promoting patient safety including efforts to prevent, detect, and remediate quality of care and critical incidents and a peer review process that addresses deviations in the provision of health care and action plans to improve services;
- Ensuring culturally responsive 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 and health equity 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, culturally and linguistically appropriate

health care through Area Health Education Centers which offers cultural competency training, and adoption and distribution of evidence-based practice guidelines;

- Conducting and assessing quality improvement and performance improvement projects based on demonstration of need and relevance to the population served, with improvement initiatives aligned with identified health priorities and state/federal requirements and applicable member population(s);
    - Review of performance metrics, including subpopulations of members with special health care needs and members needing the support of long-term services, to identify barriers and development of targeted interventions.
- Monitoring utilization trends and patterns at weekly "huddles" with cross-functional leadership to collaborate and review utilization data to identify potential over- and under-utilization issues or practices. Examples of this process include utilization of the following resources;
    - Using UM Program components: 24-hr nurse triage, telemedicine, prior authorization/precertification, second opinion, concurrent review, ambulatory review, retrospective review, and discharge planning for both medical and behavioral health (BH) care services;
    - 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;
    - Metrics are reviewed at quarterly Utilization Management Committee meetings and analyzed in annual quality monitoring reports which are approved at the Quality Improvement Committee meetings.
- 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;
- 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.
- Serving members with complex health needs such as Children with Special Health Care Needs (CSHCN) as children who have, or are at risk for, chronic physical, developmental, behavioral, or emotional conditions; and also require health and related services of a type and amount beyond that required by children in general; and are receiving services through family-centered, community-based, coordinated care systems receiving grant funds, under Section 501 (a)(1)(D) of Title V of the SSA (known as Nevada Early Intervention Program). Services include but are not limited to;
    - Creates and implements treatment plan for members with special health care needs who are determined through an assessment by its network practitioners/providers to need a course of treatment or regular care monitoring.

    - Treatment plan is developed by the member's PCP or case manager (if receiving care management services) with member participation, and in consultation with any specialists caring for the member.
    - Members may include but are not limited to juveniles temporarily detained by a state or county agency; children with SED; adults with SMI and individuals with SUD; children with special health care needs; homeless members; members with chronic conditions; the correction-involved population; and women with high-risk pregnancies.
    - Care coordination must address critical issues such as out-of-home placement, specialized mental health services and therapies, and needs that may typically be filled by community resources and social services programs.
- SilverSummit Healthplan Offering Long-term Services and Support (LTSS) services to those members who need ongoing care due to age, physical or intellectual disability or chronic illness. Comprehensive services are delivered in a home and community based settings long term care facility depending upon the needs and preferences of the member. Services include but are not limited to;
    - Personal Case Assistance Services (PCA) is available to members who have difficulty with performing activities of daily living, need assistance with meal preparation and or need assistance with light housekeeping.
    - Member can self-refer for these services. Referrals are also received from contracted agencies and can include members that have had a recent hospitalization. Upon receipt of the referral, the health plan's social workers will schedule a meeting with the member to conduct The Functional Assessment, to determine the appropriate hours for the PCA services. Authorizations for the approved hours are entered as units which then translates to hours per week. A total number of units is included in the authorization along with the duration of the authorization.

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 Improvement 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, the National CLAS Standards, and other evidence-based sources. Performance measures are aligned to specific priorities and SMART goals used to drive quality improvement and operational excellence.

SilverSummit Healthplan's Quality Improvement Program priorities and goals support the Centene Corporation mission: Transforming the health of the communities we serve, one person at a time. This single overarching mission explains our goals as a business and is applied across our organization. It is reinforced by our values of Accountability, Courage, Curiosity, Trust and Service.

We believe that we must treat the whole person, not just the physical body. We will treat people with kindness, respect, and dignity to empower healthy decisions. We have a responsibility to remove barriers and make it simple to get well, stay well, and be well. We believe local

partnerships enable meaningful, accessible healthcare. We know healthier individuals create more vibrant families and communities.

We successfully provide high quality, whole health solutions for our diverse membership by recognizing the significance of the many different cultures our members represent and by forming partnerships in communities that bridge social, ethnic and economic gaps.

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 Quality Improvement Committee and its subcommittees have the responsibility to review quality of care and resource utilization, as well as conduct peer review activities as appropriate. The Quality Improvement Committee and related peer review committees conduct such proceedings in accordance with SilverSummit Healthplan's bylaws and applicable federal and state statutes and regulations.

The proceedings of the 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 Population Health Management and Clinical Operations (PHMCO), Vice President/Director of Quality, and designated Quality Improvement Department staff;
- Peer Review Committee;
- External regulatory agencies, as mandated by applicable state/federal laws;
- Health plan legal executives; and
- Compliance leadership.

Quality Improvement Committee correspondence and documents may be made available to another health care entity's peer review committee, and/or any regulatory body as governed by law, for the purpose of carrying out or coordinating quality improvement/peer review activities; this may include a Quality and/or Credentialing Committee of a health plan-affiliated entity or that of a contracted medical group/independent physician association.

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, Population Health Management and Clinical Operations (PHMCO), Credentialing, and Pharmacy program activities are educated about maintaining the confidentiality of peer review documents;
- The Quality Improvement Vice President designates Quality Improvement 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 Officer/Director(s), Legal Counsel, Vice President of Population Health and Clinical Operations (PHMCO), 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.

CLAS AND HEALTH EQUITY

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

Whenever possible, the health plan's Quality Improvement Program supports processes and activities designed to achieve demonstrable and sustainable improvement in the health status of its members. This systematic approach to quality improvement provides a continuous cycle for

assessing the quality of care and services by addressing both medical and non-medical drivers of health and promoting health equity. The health plan ensures communications are culturally sensitive, appropriate, and meet federal and state requirements. SilverSummit Healthplan also promotes the delivery of services through a cultural humility lens to all members, including those who have limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. Population Health Management initiatives are reviewed to ensure cultural issues and social determinants of health (SDOH) are identified, considered, and addressed. Additionally, the health plan is committed to improving inequities in care as an approach to improving Healthcare Effectiveness Data and information Set (HEDIS) measures, reducing utilization costs, and delivering locally tailored, culturally relevant care.

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

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

To achieve our purpose and mission of better health outcomes at lower costs for our members and the communities we serve, SMART goals are identified, and activities and timelines are documented in an annual workplan to achieve the following:

- To ensure meaningful access and positive health outcomes through the provision of culturally and linguistically responsive services to members and providers.
- To ensure that members and potential enrollees are active participants in their own health and health care through clear and effective communication.
- To advance and sustain cultural and linguistic innovations.

On an annual basis or as needed, data are reported, analyzed, and modified by the Performance Improvement Team, the Population Health Management & Clinical Operations Committee, and the Health Equity Improvement Committee, all reporting up to the Quality Improvement Committee to identify trends, reflect changes in the population, new programs, and services, projects completed, and sets SMART goals to meet the needs of the targeted population.

AUTHORITY

SilverSummit Healthplan Board of Directors has authority and oversight of the development, implementation, and evaluation of the Quality Improvement Program and is accountable for oversight of the quality of care and services provided to members. The Board of Directors supports the Quality Improvement Program by:

- Adopting the initial and annual Quality Improvement Program which requires regular reporting (at least annually) to the Board of Directors, and establishes mechanisms for monitoring and evaluating quality, utilization, and risk;
- Supporting Quality Improvement Committee recommendations for proposed health equity, CLAS and quality studies and other 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 Improvement Program Description and Quality Improvement Work Plan annually to assess whether program objectives were met and recommending adjustments when necessary.

The Board of Directors delegates the operating authority of the Quality Improvement Program to the Quality Improvement Committee and receives quarterly committee meeting summaries throughout the year. 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 Quality Improvement Committee, which is directly accountable to the Board of Directors.

The Chief Medical Officer, 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 Quality Improvement Committee, or designating an appropriate alternate chair, and participating as appropriate;
- Monitoring and directing quality activities among personnel and among the various subcommittees reporting to the Quality Improvement Committee;
- Coordinating the resolution of outstanding issues with the appropriate leadership staff, pertaining to Quality Improvement Committee recommendations, subcommittee recommendations, and/or other stakeholder recommendations;
- Being actively involved in the SilverSummit Healthplan's Quality Improvement 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; and
- Reporting the Quality Improvement Program activities and outcomes to the Board of Directors at least annually.

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

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

QUALITY IMPROVEMENT PROGRAM STRUCTURE

Quality and equity are integrated throughout SilverSummit Healthplan and represent the strong commitment to delivering equitable, quality care and services to members. The Board of Directors is the governing body designated for oversight of the Quality Improvement Program and has delegated the authority and responsibility for the development and implementation of the Quality Improvement Program to the Quality Improvement Committee.

The Quality Improvement Committee is the senior management lead committee accountable directly to the Board of Directors and reports Quality Improvement 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 Improvement 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 Improvement Work Plan, throughout the organization and to providers, members, and stakeholders. The Quality Improvement Committee serves as the umbrella committee through which all subcommittee activities are reported and approved. The Quality Improvement Committee directs subcommittees to implement improvement activities based on performance trends, and member, provider and system needs. Additional committees may also be included per health plan need, including regional, state and community level committees, as needed, based on distribution of membership. These committees assist with monitoring and supporting the Quality Improvement Program.

The SilverSummit Healthplan committee structure is outlined below:

SilverSummit Healthplan Committee Structure

SilverSummit Healthplan Core Committee Charters

Quality Improvement Committee (QIC)	
Charter Statement	The Quality Improvement Committee (QIC) is SilverSummit Healthplan's (SSHP) 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 Officer/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), Population Health Management (Utilization Management, and Case Management), Credentialing, and Pharmacy programs.
Objectives of the Committee and Relationship to Strategic Objectives	• Oversight of the QI activities of SSHP 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 SSHP 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 SSHP Credentialing, Pharmacy, Population Health Management (Utilization 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 to improve the quality of care and/or service to members and

	implement corrective actions as appropriate, and function as a communication channel to the BOD. • Prioritization of quality improvement efforts, facilitation of functional area collaboration and assurance of appropriate resources to conduct 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 SSHP Cultural Competency Plan (Culturally and Linguistically Appropriate Services).
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:** SSHP Chief Medical Officer/Director, may delegate individual meetings to a Medical Director or a Senior Quality Executive as designated by the BOD. **Committee Recorder:** QI designee **Reports To:** BOD **Committee Composition:** • Chief Executive Officer • Chief Medical Officer/Director • Medical Director • VP/Director of Quality Improvement • VP/Director of Population Health • VP/Director Network Management • VP/Director of Member and Provider Services • VP/Director Compliance • Manager/Director Case Management • Other SSHP 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: o Family Practice o Internal Medicine o OB/GYN o Pediatrics o Behavioral Health o 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:** 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 through a consent agenda. **Meeting Packets:** Meeting packets with consent agenda will be distributed by secure means to committee members 1-2 weeks prior to the scheduled meeting date. Decisions will be 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 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. 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 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 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:** 50% of scheduled meetings. **Quorum:** A minimum of four (4) committee members, including two SSHP staff and two (2) external providers, must be present for a quorum. All permanent committee members are voting members; the Chief Medical Officer/Director is the determining vote in the case of a tie vote.
Document Responsibilities	Meetings will be agenda driven. All agendas and minutes will follow SSHP standard format.
Decision Authority	The QIC is authorized by the SSHP BOD to make all decisions related to the IQAP, quality activities and processes. Decisions will be made 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.
Credentialing Committee (CC)	
Charter Statement	The Credentialing Committee (CC) 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 CC is responsible for development, annual review and approval of the Credentialing Program Description and its associated policies and procedures. The CC 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 CC 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 Healthplan (SSHP) 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 SSHP management on the effectiveness of the Credentialing Program. • Review potential Quality of Care (QOC) events and adverse events, including any 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: The Corporate Medical Director and/or SSHP Chief Medical Officer/Director; committee network provider may chair at the discretion of the Credentialing Committee.
	
	Committee Recorder: CC designee or Director of Credentialing. SSHP Medical Director is responsible for approving the documented proceedings that reflect Credentialing decisions.
	
	Reports To: QIC
	
	Committee Composition:
	• Chief Medical Officer/Director or Medical Director(s)
	• SSHP Credentialing designee
	• Corporate Credentialing Manager
	• SSHP network providers from the following specialties to include statewide regional representation:
	  o Family Practice/Internal Medicine
	  o OB/GYN
	  o Behavioral Health Providers
	  o High-Volume Specialists (defined according to geographic benchmarks for each specialty)
	  o Mid-Level Practitioners- referencing Advanced Nurse Practitioners, Physician Assistants, Advanced Practice Nurses etc.
	• Other executive leadership or staff as determined.
	
	Scheduling: Credentialing designee, as directed by CC Chair
	
	Agenda: Agenda items for the next meeting are developed by the Corporate Credentialing Director in collaboration with the CC chair.
	
	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 CC 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.

Document Responsibilities	Meetings will be agenda driven. All agendas and minutes will follow SilverSummit standard format.
Decision Authority	The Medical Director may approve files if providers Silver Summit's criteria and have been practicing within SSHP's guidelines without any potential Quality of Care (QOC) incidents.

	If providers do not meet the SSHP's criteria or have any potential QOC events, the QIC has delegated to the CC 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 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.
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. These 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 Officer/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 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	• Review providers that are potentially out of compliance with standards of care. • Make determinations regarding appropriateness of care. • Make recommendations regarding corrective actions relating to provider quality of care. • 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 Healthplan (SSHP) Chief Medical Officer/Director **Committee Recorder:** Quality Improvement (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 (CC) 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 CC. The Chief Medical Officer/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:** • SSHP Chief Medical Officer/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 Credentialing Committee members involved in the PRC's recommendation will be included in the Credentialing Committee meeting when the PRC's recommendation is discussed • The Chief Medical Officer/Director and QI designee 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:** QI designee will develop Agenda items for the meetings. **Meeting Packets:** PRC packets are sent to the committee members one week prior to the meeting. 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 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) SSHP provider must be present for a quorum.
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 QI 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 and 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.
Delegated Vendor Oversight Committee (DVOC)	
Charter Statement	The Delegated Vendor Oversight Committee (DVOC) provides oversight and operating authority over the scope and functions of subcontracts. Each Joint Operating Committee (JOC) reports to the DVOC to communicate its activities for each subcontractor. The DVOC reports up the Quality Improvement Committee (QIC).
Purpose	The purpose of the DVOC is to provide oversight and assess the appropriateness and quality of services provided on behalf of SilverSummit Healthplan (SSHP) to the members. The DVOC closely monitors the work of SSHP subcontractors to ensure constant communication and compliance with contract requirements. Auditing and monitoring of vendor performance is done to ensure that delegated services meet SSHP's standards for care and service as well as DHS, federal, and NCQA requirements. The DVOC will monitor all vendor activities, evaluations, and corrective actions.
Objectives of the Committee and Relationship to Strategic Objectives	• Oversee SSHP 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 Accreditation 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 needs. • 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 SSHP. 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 is identified. • Distribute information to the DVOC regarding findings, recommended changes to contracts and policies, and requested initiatives or project updates by the vendor. • Make recommendations to the QIC and the Chief Medical Officer 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. **Agenda, Minutes and Reports:** The Compliance Staff responsible for Vendor Oversight shall be responsible for setting the agenda for the meetings. The Compliance designee shall assist the Committee in maintaining minutes or other records of meeting and activities. Minutes will be taken and uploaded to the Compliance System within 30 days after meeting occurrence.
Subcommittee	• Joint Operating Committees (one per subcontractor and responsible for the monitoring of the subcontractor performance).
Committee Structure and Operation	**Frequency:** Minimum of Quarterly, more frequently as determined by Chair **Committee Chair:** VP/Director of Compliance **Committee Facilitator:** Compliance designee **Committee Recorder:** DVOC Chair designee **Reports To:** QIC **Committee Composition:** The DVOC includes but is not limited to Senior Management/Executive Staff representing the functional areas associated with the delegated services. • VP/Director Compliance • VP/Director Quality Improvement • VP/Director Population Health Management • VP/Director Operations • VP/Director Network Development and Contracting • Director Pharmacy • Director Customer Service • Compliance designee • Personnel as deem appropriate to provide additional information and consultation • Other SSHP operational staff as requested **Scheduling**: Compliance designee **Agenda:** DVOC 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. The Chair is responsible for approving the documented proceedings that reflect all DVOC decisions/recommendations. **Attendance Requirement:** 50% of committee members. **Quorum:** 50% of voting members. All committee members have voting privileges.
Document Responsibilities	Meetings will be agenda driven. All agendas and minutes will follow SSHP standard format.
Decision Authority	The QIC authorizes DVOC to make all recommendations regarding the status of the delegation agreement. Recommendations are by consensus of SSHP committee members. Committee members are responsible to raise any concerns/issues at the committee meetings.
Evaluation	The Committee will review the DVOC 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. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.
Population Health Management and Clinical Operations Committee (PHMCOC)	
Charter Statement	The Population Health Management and Clinical Operations 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: prior authorization, and pre-certification, concurrent review, ambulatory review, retrospective review, discharge planning, and care coordination. 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. The PHMCOC also shares data for prior authorization analysis on an annual basis which may impact health care services, coordination of care and appropriate use of services and resources.
Objectives of the Committee and Relationship to Strategic Objectives	• Annually review the Utilization Management (UM) and Case Management (CM) Program Descriptions, Work Plan and Annual Program Evaluations, guidelines, and procedures. • 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. • Review reports specific to facility or geographic areas for trends or patterns. • Review and monitor case management satisfaction scores to identify areas of opportunities and develop strategies for improvement. • 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:** A network provider at the discretion of the PHMCOC may chair as designated by the SSHP Chief Medical Officer/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 Officer/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 **Committee Composition:** • Chief Medical Officer/Director • Designated QI staff • Designated Population Health Management staff • SSHP 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 SSHP operational staff as requested **Scheduling**: Population Health Management designee as directed by the PHMCOC chair. **Agenda:** The Committee Chair in collaboration with the VP/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) SSHP staff and two (2) external practitioners must be present for a quorum. The Chief Medical Officer/Director is the determining vote in the case of a tie vote.
Document Responsibilities	Meetings will be agenda driven. All agendas and minutes will follow SSHP standard format.
Decision Authority	The QIC authorizes the PHMCOC to make all decisions regarding the utilization of clinical care and services provided on behalf of SSHP 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.
Performance Improvement Team (PIT)	
Charter Statement	The Performance Improvement Team (PIT) is an internal, cross-functional quality improvement team that facilitates the integration of a culture of quality improvement throughout the organization. Performance measure results from performance improvement efforts and activities planned/taken to improve outcomes compared with expected results and findings. SilverSummit Healthplan (SSHP) 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 Performance Improvement Plan (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 reservations 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 SSHP 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 (MAC). • Oversee the activities of the PIT subcommittees and report the status of these activities and report to the QIC.
Subcommittee	• Work Groups will address identified issues related to care or service as needed. o All subcommittees will report to the PIT at least quarterly or as often as the subcommittee meets.
Committee Structure and Operation	**Frequency:** At a minimum eight (8) times per year. **Committee Chair:** Chief Medical Officer/Director or designee. **Committee Recorder:** Chief Medical Officer/Director or QI designee **Report To:** QIC **Committee Composition:** • Chief Medical Officer / Medical Directors • VP/Director of Quality Improvement • VP/Director Population Health Management • VP/Director Network Development & Contracting • VP/Director Compliance • Director of Pharmacy • Director Member Services • Manager of Grievance and Appeals • Behavioral Health Representative • Member Connection Staff • Management Staff as needed from functional areas • Additional staff may participate as requested by the Chair **Scheduling:** PIT designee, as directed by the PIT Chair. **Agenda:** PIT Chair or designee 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:** 50% of schedule meetings. **Quorum:** 50% of voting members.
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.
Provider Advisory Board (PAB)	
Charter Statement	The Provider Advisory Board (PAB) serves as a consulting resource to SilverSummit Healthplan (SSHP) in policy and operational matters and further strengthen the bridge between SSHP and the provider community.
Purpose	The PAB 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	• 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
Subcommittee	• Community Advisory Workgroup: This group identifies key issues related to programs that may affect specific community groups and provide community input on potential service improvements. They offer effective approaches from reaching or communicating with members or other issues related to the member population. They are responsible for making recommendations regarding health plan performance from a community-based perspective.
Committee Structure and Operation	**Frequency:** Quarterly. **Committee Chair:** Chief Medical Officer/Director **Committee Recorder:** PAB designee or VP/Director of Contracting and Network Management. **Reports To:** QIC **Committee Composition:** • Chief Medical Officer

	• VP/Director of Quality Improvement • VP/Director of Network Contracting & Development • VP/Director of Population Health • Medical Director • 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:** PAB Chair or designee will develop Agenda items for the next meeting. **Meeting Packets:** Meeting packets will be distributed at the meeting. **Minutes:** Draft minutes are completed no later than within ten calendar days of the meeting and provided to the DHCFP within thirty calendar days of meeting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials. **Attendance Requirement:** 75% of scheduled meetings **Quorum:** A minimum of (1) PCP serving children & adolescents, (1) PCP serving adults, (1) OB/GYN, (1) psychiatrist, (1) licensed behavioral healthcare clinical professional, (1) substance abuse professional, (1) community-based care coordinator or community case manager serving a Network Provider, and (1) peer support specialist from all recommendations from this committee will be presented to the operational areas within the Healthplan. Both the majority and minority opinions will be documented.
Document Responsibilities	Meetings will be agenda driven. All agendas and minutes will follow Silver Summit'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 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.
Provider Advisory Committee (PAC)	
Charter Statement	The Provider Advisory Committee (PAC) is a committee utilized to communicate Silver Summit Healthplan's (SSHP) 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 SSHP 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 SSHP with feedback regarding programs and processes from a community provider-based perspective. • To allow providers to make recommendations related to SSHP's programs and processes. • Assist SSHP 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:** Bi-Annually. **Committee Chair:** Chief Medical Officer/Director. **Committee Recorder:** PAC designee or VP/ Director of Contracting and Network Management. **Reports To:** QIC

	Committee Composition: • Chief Medical Officer/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.
Document Responsibilities	Meetings will be agenda driven. All agendas and minutes will follow SSHP'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 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.
Semi-Annual Member Focus Group (MFG)	
Charter Statement	The Semi-Annual Member Focus Group (MFG) serves as a consulting resource to SilverSummit Healthplan (SSHP) in compliance and network access matters and further strengthen the bridge between SSHP members and the provider community.
Purpose	The Semi-Annual Member Focus Group is responsible to represent the interest and viewpoint of SSHPs' member population as part of the Access to Care Monitoring Plan to identify appointment standards and access to services for PCPs, Behavioral Health, Prenatal Obstetrics providers consistent with the standards in the Contract. The Member Focus Group is comprised of SSHP members and Plan representatives.
Objectives of the Committee and Relationship to Strategic Objectives	• Share network and availability standards with SilverSummit members • Gain insight from members on access barriers • Identify opportunities for SilverSummit to improve member's access and experience when accessing care • Identify opportunities for SilverSummit to better promote and share network standards
Committee Structure and Operation	**Frequency:** Semi-Annually. **Committee Chair:** VP/Director of Provider Relations **Committee Recorder:** MFG designee, Director of Behavioral Health, or Director of Provider Relations. **Reports To:** Compliance Committee **Committee Composition:** • VP/Director of Network Contracting & Development

	• VP/Director of Behavioral Health • VP/Director of Provider Relations • Director of Maternal Health • Designee(s) from each applicable functional area- Quality Improvement, Member Experience, Compliance, Network Development, Case Management **Scheduling:** MFG designee. **Agenda:** Agenda items are determined per the State Contract year. **Meeting Packets:** N/A **Report:** A report is due to the State of Nevada sixty (60) calendar days after the end of each Contract Year. The report must address: • The barriers identified by the focus groups related to accessing care. • The compliance percentage with the appointment standards in the contract • A description of any actions taken by SSHP to address compliance issues. • A description of planned oversight activities going forward • Any other Appointment Standard oversight elements as requested by the State. **Attendance Requirement:** Members not otherwise engaged in any advisory group are able to be in attendance. **Quorum:** At minimum, one SSHP member.
Document Responsibilities	Meetings will be driven by contract requirements. All agendas and minutes will follow Silver Summit's standard format.
Decision Authority	The Member Focus Groups is a non-voting state requirement to solicit feedback from members. This group reports to the Compliance Committee semi-annually.
Evaluation	The committee will review network availability, member barriers and behavioral health for contract year 2025.
Confidentiality	Each member is accountable to identify confidential information or situations when/if the dissemination of the information needs to be managed in a specific manner.
Member Advisory Board (MAB)	
Charter Statement	The Member Advisory Board (MAB) is a group of members, parents, legal representative/guardian, and SilverSummit Healthplan (SSHP) 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/Director of Quality **Committee Recorder**: MAB designee. **Reports To:** QIC **Committee Composition:** • Manager Legislative & Government Affairs • Manager, Quality Improvement • Manager, Justice Systems • Population Health Management designee • Healthy Equity designee • Behavioral Health designee

	• Designee(s) from each applicable functional area: Operations, Quality, Member Experience and potentially Case Management • Enrollees*/Representatives (Parents/foster parents/guardians/representatives) - may volunteer or be suggested by staff **At a minimum, the committee involves twelve members and individuals representing the racial/ethnic and linguistic groups that constitute at least 5 percent of eligible individuals* **Scheduling:** MAB Chair **Agenda:** MAB Chair will develop Agenda items for the next meeting in collaboration with relevant member input. Agenda and presentation will need to go to Compliance and the State for approval before sharing with committee members. **Minutes:** Draft minutes are completed no later than within 15 days of the meeting. Meeting minutes are provided to the State within thirty calendar days of the meeting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials. **Attendance Requirement:** Members may not be standing members of the committee. Therefore, there is no minimum meeting attendance requirement. Members are encouraged to attend by accommodating virtual participation, arranging transportation and providing childcare when appropriate. **Quorum:** At minimum, (12) SSHP members in attendance.
Document Responsibilities	Meetings will be agenda driven. All agendas and minutes will follow SSHP standard format. Meeting materials will be provided ahead of time and in literacy level appropriate for participants when applicable.
Decision Authority	The MAB is a non-voting committee to solicit feedback from SilverSummit membership perspective. This committee reports to the QIC, and meeting minutes forwarded to DHCFP.
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.
Member Advisory Committee (MAC)	
Charter Statement	The Member Advisory Committee (MAC) is a group of members, parents, guardians, member advocacy groups and SilverSummit Healthplan (SSHP) 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.
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 represent the geographic, cultural, and racial diversity of our membership across Nevada. SSHP'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, case management, grievance/complaint metrics 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 SSHP 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.

	• SSHP 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. • SSHP 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 preferably 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 SSHP 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
	
	Committee Composition:
	• Director of Member Services
	• VP/ Director of Quality Improvement or designee
	• Members may volunteer or be suggested by staff
	  o Parents/Foster Parent/Guardians of children members may volunteer or be suggested by staff
	  o Members and families/significant others of SilverSummit members.
	• SSHP staff as indicated
	
	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: No minimum attendance required.
	
	Quorum: This is not a voting committee.

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 SSHP 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 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.

Health Equity Improvement Committee (HEI)	
Charter Statement	The Health Equity Improvement Committee (HEI) 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. SilverSummit Healthplan's (SSHP) Quality Leadership in partnership with Population Health Management is responsible for the implementation of the Culturally and Linguistically Appropriate Services (CLAS) program.
Purpose	The purpose of the HEI is to provide oversight and assess cultural awareness, social determinants of health needs, the appropriateness of diversity and disability-related needs in the quality of services provided on behalf of the health plan to the members.
Objectives of the Committee and Relationship to Strategic Objectives	• Establish appropriate goals, policies, and leadership accountability throughout the health plan's planning and operations; • Recruit, promote mentoring opportunities to ensure diverse viewpoints are represented in governance decisions, and to support a culture and practice with social determinant sensitive governance, leadership, and workforce; • Evaluate staff/practitioner cultural competency and social determinants of health training needs, integrate local community-based organizational perspective regarding the health plan's performance and offer culturally relevant/social determinants of health-related program enhancements; • 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; • Conduct ongoing assessments of the health plan's social determinants of health-related activities and integrate quality improvement activities; • Monitor & evaluate performance levels for identification/selection of educational opportunities and to enhance health care outcomes; and • Communicate the organization's progress in implementing and sustaining cultural, competent activities to all stakeholders and constituents.
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:** SSHP Chief Medical Officer/Director or as designee **Committee Recorder:** HEI designee **Reports To:** QIC **Committee Composition:** • Chief Executive Officer • Chief Medical Officer/Director or Medical Director • VP/Director of Quality Improvement • VP/Director of Population Health • VP/Director Network Management • VP/Director of Member and Provider Services • Other SSHP staff from each applicable functional area: Operations, Quality Improvement, Population Health Management, Network Management, and Human Resources **Scheduling:** HEI Designee, as directed by the HEI Chair. **Agenda:** Meetings are agenda driven. Agenda items for the next meeting are developed by the Committee Chair in collaboration with the applicable departments. **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: 50% of scheduled meetings. **Quorum:** This is not a voting committee.
Document Responsibilities	Meetings will be agenda driven. All agendas and minutes will follow SSHP standard format.
Decision Authority	The HEI is a non-voting committee, intended to solicit direct feedback from internal stakeholders.
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.
Cultural Competency Behavioral Health Committee (CCBH)	
Charter Statement	The Cultural Competency Behavioral Health Committee (CCBH) provides guidance and leadership to ensure care and services will be delivered in a culturally competent manner. SilverSummit Healthplan's Health Equity leadership in partnership with Population Health Management is responsible for the implementation of the Cultural Competency Plan and this Committee.
Purpose	The purpose of the CCBH is to provide oversight and assess cultural competency of network/staff, coordination for linguistic and disability-related services and the quality of services provided on behalf of the health plan to the members.
Objectives of the Committee and Relationship to Strategic Objectives	• Establish appropriate goals, policies, and leadership accountability throughout the health plan's planning and operations. • Regularly evaluate Network, outreach services and other programs to improve accessibility and quality of care for its membership. • Describe the provision and coordination needed for linguistic and disability-related services. • Guide efforts for timely access to culturally and linguistically appropriate, integrated, behavioral health services. • Assist with the development, ongoing review, and approval of the cultural competence plan. • Demonstrate how SSHP plans to recruit and retain staff who can meet the cultural needs of the Contractor's membership and cultural competence. • Create a process to obtain Member and stakeholder feedback to improve the cultural competency program and cultural support provided by clinical and member services programs. • Develop culturally responsive strategies for reduction in health disparities in access to or usage of behavioral health services based on race, color, ancestry, national origin, disability, familial status, sex, sexual orientation, gender identity or expression, immigration status, primary language and income level, to the extent that data is available to identify such disparities.
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:** Behavioral Health Director or Health Equity (HE) Designee **Committee Recorder:** CCBH designee **Reports To:** QIC **Committee Composition:** • Chief Medical Officer/Director or Medical Director • VP/Director of Behavioral Health • VP/Director Network Management • VP/Director of Member and Provider Services

	• Other SSHP staff from each applicable functional area: Operations, Quality Improvement, Population Health Management, Network Management, and Human Resources **Scheduling:** CCBH designee **Agenda:** Meetings are agenda driven. Agenda items for the next meeting are developed by the Committee Chair in collaboration with the applicable departments. **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:** 50% of scheduled meetings. **Quorum:** The committee must include, without limitation, state and local government officers and employees (1), consumers of behavioral health services (1), advocates for consumers of behavioral health services (1), experts on reducing disparities in behavioral health (1) and providers of behavioral health services (1).
Document Responsibilities	Meetings will be agenda driven. All agendas and minutes will follow SSHP standard format.
Decision Authority	The CCBH is a non-voting committee, intended to solicit direct feedback from internal stakeholders.
Evaluation	The Committee will review the Cultural Competency Plan (CCP) annually. The CCBH must evaluate the CCP annually to determine its effectiveness and identify opportunities for improvement. A summary report of the evaluation must be sent to the State. If issues are identified, they must be tracked and trended, and actions must be taken to resolve the issue(s).
Confidentiality	Each committee member is accountable for identifying confidential information or situations when/if the dissemination of the information is managed in a specific manner.
Policy Committee (PC)	
Charter Statement	The Policy Committee (PC) is an internal, cross-functional committee that is responsible for oversight of the creation, dissemination, and implementation, of all SilverSummit Healthplan's (SSHP) Policies and Procedures.
Purpose	The purpose of the PC is to ensure that policies are in compliance with contractual requirements, Federal and State regulations, and National Committee for Quality Assurance (NCQA) Standards.
Objectives of the Committee and Relationship to Strategic Objectives	• Oversight of the development, dissemination, and implementation, of all SSHP policies. • Ensure all policies are in compliance with contractual requirements, federal and state statutes and regulations, and requirements of accrediting bodies such as NCQA. • Annual review and approval of all SSHP policies.
Committee Structure and Operation	**Frequency:** Monthly and ad hoc as needed. **Committee Chair:** SSHP Compliance Officer and Quality Improvement Director **Committee Recorder:** Compliance Analyst or PC designee **Reports To:** QIC **Committee Composition:** • Chief Medical Officer/Director • VP/Director Compliance • VP/Director of Quality Improvement • VP/Director of Population Health Management • VP/Director Network Development & Contracting • VP/Director Operations

	• VP/Director Finance • Director/Manager Provider Relations • Director/Manager Grievance & Appeals • Director/Manager Marketing • Shared Services (UM, Pharmacy, Behavioral Healthcare, and/or other applicable areas) • SSHP staff who are identified as a Policy Manger • Additional staff as needed, may participate as requested by the Chairs **Scheduling:** PC designee, as directed by the PC Chair. **Agenda:** Agenda items for the meetings will be developed by the committee chair with input from functional areas when provided. Standing agenda items will include at a minimum: • Administrative policy review • Clinical policy review and approval **Minutes & Meeting Packets:** 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. A designee is responsible for maintaining detailed records and minutes of all PC meetings. Draft minutes are completed within 30 days of the meeting, reviewed by the Chair, and amended/corrected as needed prior to the next meeting, or as needed for other regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed at or prior each meeting. **Attendance Requirement:** At least one member from each functional area should attend each meeting; however, clinical policies can be approved by vote with attendees present, as long as a Medical Director is also present and approves. **Quorum:** NA – all attendees are voting members
Document Responsibilities	Meetings will be agenda driven. All agendas and minutes will follow SSHP standard format.
Decision Authority	The Quality Improvement Committee (QIC) authorizes the PC to make decisions and recommendations on all policies. Individuals are responsible to raise any concerns/issues at the committee meetings. The PC reports 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 dissemination of information is managed in a specific manner.

QUALITY IMPROVEMENT DEPARTMENT STAFFING

The Quality Improvement 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 Officer/Medical Director(s)	The health plan's Chief Medical Officer 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 Improvement Program, the Population Health Management and Clinical Operations (PHMCO) Programs, and the Grievance System.
Quality Improvement VP/Director(s)	The VP/Director of Quality Improvement 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 Improvement VP/Director reports to identified executive leadership and is responsible for directing the activities of the

	quality staff in monitoring and auditing the health plan's health care delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality, clinical quality, equitable hiring and recruitment practices, and related policies, promotion of diversity, equity, and inclusion at all levels that reflect the composition of the community served. The Quality Improvement VP/Director, or designee, collaborates with the heads of all functional units to ensure that culturally and linguistically appropriate services are included and properly executed to support a diverse membership. Leadership promotes this through policy, practices, and the allocation of human and financial resources to ensure integration and alignment of CLAS opportunities across the health plan and functional areas (e.g., medical management, customer service, provider services, quality, Information Technology, etc.). The Quality Improvement 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 Improvement VP/Director coordinates the Quality Improvement Committee proceedings in conjunction with the Chief Medical Officer/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 Improvement Manager(s)	The Quality Improvement Manager holds a bachelor's degree in nursing or a related field or has equivalent managed care experience. The Quality Improvement 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. The Quality Improvement Manager is also 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, access and availability analysis, member experience analysis, continuity and coordination of care, and annual evaluation of effectiveness of the Quality Improvement Program. The Manager has direct oversight of Culturally and Linguistically Appropriate Services (CLAS) programs, and collecting, measuring, and analyzing data to track progress in disparity reduction efforts. Additionally, the Quality Improvement Manager coordinates the documentation, collection and reporting of HEDIS measures to both National Committee for Quality Assurance (NCQA) and the State as required. 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 Improvement 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.
Quality Improvement Coordinator/Specialist	Quality Improvement 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 Improvement Coordinators/Specialists is a registered nurse. Quality Improvement 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 Improvement Coordinator/Specialist may specialize in one area of the quality process or may be cross trained across several areas. The Quality Improvement 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.
Quality Additional Staff	Data Analytics & Reporting Manager Data Analysts HEDIS Supervisor HEDIS Abstractor/Coordinator/Trainer Patient Care Advocate Provider Quality Liaison Quality Practice Advisor Quality Reporting Specialist
Accreditation Specialist	The Accreditation Specialist reports to and supports the Quality Improvement Manager in the achievement of as well as the ongoing maintenance of health plan NCQA Accreditation, Health Equity Accreditation and HEDIS reporting processes and requirements. The incumbent ensures compliance with NCQA accreditation requirements, conducting routine readiness assessments, evaluating policies and procedures, and reviewing processes and records. He or she develops, implements, and leads a process for ensuring that the health plan achieves and maintains NCQA accreditation. The incumbent establishes and implements objectives, policies, and strategies to maintain a continual state of accreditation readiness and to achieve successful accreditation status for the health plan. The Accreditation Specialist supports the document prep and submission for the accreditation survey and services as the Subject Matter Expert for accreditation for the health plan. Additionally, the Accreditation specialist is responsible for implementing the health plan's Health Equity plan focused on Culturally and Linguistically Appropriate Services (CLAS) and leading its health disparities efforts such as: developing, implementing and providing oversight for Health Equity programs, ensuring the integration of cultural competency into operational programs and coordinating workforce staff development in cultural competency.
Senior Health Equity Specialist	Responsible for maintaining compliance with regulations and contractual obligations pertaining to Culturally and Linguistically Appropriate Services (CLAS) and Health Equity within State Health Programs, Commercial and Medicare product lines. The Senior Health Equity Specialist ensures that culturally and linguistically appropriate services are provided to members, including identifying and implementing health equity initiatives, representing the health plan on national, regional, and multi-plan initiatives and assessing operations for gaps. The Senior Health Equity Specialist leverages feedback from providers, members, vendors and community-based organizations in the development of strategy and implementation and makes

	recommendations for CLAS and Health Equity efforts as aligned with contractual, accreditation and quality improvement opportunities to senior management.
Program Coordinator	The Program Coordinator is a highly motivated and engaging member of the Quality Improvement that conducts outreach to members to educate, coordinate and support quality of care initiatives. The Program Coordinator facilitates ongoing engagement and collaboration with members and is a direct connection from the Quality Improvement department to health plan members. The Program Coordinator will also review member experience survey results to drive initiatives targeted at CAHPS or other related member surveys and is responsible for coordinating participation in member boards.

Grievance & Appeals Manager	The Grievance & Appeals Manager is responsible for the appropriate processing of member grievances 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 Improvement 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. The Grievance & Appeals Coordinator reports to the Grievance & Appeals Manager.
Grievance & Appeals Additional Staff	Clinical Appeals Coordinator

QUALITY PROGRAM RESOURCES: INFRASTRUCTURE AND DATA ANALYTICS

SilverSummit Healthplan has the technology infrastructure and data analytics capabilities to support goals for health outcomes, cultural competency and linguistic assistance services, quality management and value. SilverSummit Healthplan's health information systems collect, analyze, integrate, and report encounter data and other types of data to support quality analysis, demographic analysis, disparity outcomes and analysis, utilization (including but not limited to language services), complaints/grievances and appeals, care management/coordination, and all quality activities. The IT infrastructure makes data, including race, ethnicity, language, sexual orientation and gender identity, available for effective monitoring, analysis, and evaluation toward improving the delivery, quality, and appropriateness of health care furnished to all members, including those with special health care needs. SilverSummit Healthplan IT systems and informatics tools support advanced assessment and improvement of quality, cultural competency and linguistic assistance services, and value, including collection of all quality performance data, with the ability to stratify data at the regional level, across provider types, and across member populations. These systems capture, store, retrieve, and analyze data from internal, subcontractor, and external sources and for effective use through a suite of data informatics and reporting solutions.

Demographic data is requested from members, including race, ethnicity, language, sex, sexual orientation, gender identity and preferred pronouns. Sexual orientation, gender identity and pronoun data for minors (those younger than 13 years of age) are not collected in compliance with Children's Online Privacy Protection Act (COPPA). Direct methods of data collection include methods for which a member, or a parent, guardian or caregiver on behalf of a member,

self-reports race, ethnicity, preferred language, sex, and alternate format through survey or enrollment data. In an effort to not stigmatize individuals, and recognizing the complexity, sensitivity, and fluidity of contemporary terminology related to sexual orientation and gender identity, members may self-identify and report their personal pronouns, sexual orientation, and gender identity through a secure member portal at any time.

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

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

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

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

Centelligence - Internal monitoring processes are supported by Centelligence, a family of integrated decision support and health care informatics solutions that facilitates use of data by collecting, integrating, storing, analyzing, and reporting data from all available sources. Centelligence also powers the 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, ethnicity, language, sexual orientation and gender identity, region, and primary care provider assignment; member outreach), and provider information (e.g., participation status; specialty; demographics that are provided on a voluntary basis, such as race, ethnicity, languages spoken).

The Centelligence analytic and reporting tools provide 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 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; 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 and TruCare Cloud allow Population Health Management and Clinical Operations (PHCO) and Quality Improvement department staff to capture utilization, care, and population health management data, to proactively identify, stratify, and monitor high-risk enrollees, to consistently determine appropriate levels of care through integration with InterQual® medical necessity criteria and

clinical policies, and capture the impact of programs and interventions. TruCare also houses an integrated appeals management module, supporting the appeals process from initial review through to resolution, and reporting on all events along the process, and a quality-of-care module to track and report potential quality of care incidents and adverse events.

Certified HEDIS Engine - a software system used to monitor, profile, and report on the treatment of specific episodes, care quality, and care delivery patterns. The HEDIS Engine is certified by NCQA and produces NCQA-certified HEDIS measures; its primary use is for the purpose of building and tabulating HEDIS, and other state required performance measures. The Engine enables the health plan to integrate claims and member, provider, and supplemental data into a single repository by applying a series of clinical rules and algorithms that automatically convert raw data into statistically meaningful information. Additionally, the system provides an integrated clinical and financial view of care delivery, which enables the health plan to identify cost drivers, help guide best practices, and to manage variances in its efforts to improve performance. Data is updated at least monthly by using an interface that extracts claims, member, provider, and financial information and then summarized with access for staff to view standard data summaries and drill down into the data or request ad-hoc queries.

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

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

Clinical Decision Support - State-of-the-art predictive modeling software is used to identify members who may be at risk for high future utilization through risk score assignment. The

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

Customer Relationship Management (CRM) Platform - The Customer Relationship Management (CRM) platform enables SilverSummit Healthplan to identify, engage, and serve members, providers, and federal/state partners in a holistic and coordinated fashion across the wellness, clinical, administrative, and financial matters. The CRM platform captures, tracks, and allows SilverSummit Healthplan staff to manage complaints, grievances, and appeals for all required reporting.

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

DOCUMENTATION CYCLE

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

Quality Improvement Program Description - The Quality Improvement 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, quality of services provided to members, culturally and linguistically appropriate services for the reduction of disparities and better health outcomes. The Quality Improvement Program Description includes the following at minimum: the scope and structure of the Quality Improvement Program, including the behavioral health aspects, measurable goals and a plan for monitoring trends; the specific role, structure, function, and responsibilities of the Quality Improvement Committee and subcommittees/work groups, including meeting frequency and accountability to the governing body; a description of dedicated Quality Improvement 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 Improvement Department staff prepares, reviews, and revises as needed the Quality Improvement Program Description. The Quality Improvement Program Description is reviewed and approved by the Quality Improvement Committee and Board of Directors on an annual basis. Changes or amendments are

noted in the "Revision Log." SilverSummit Healthplan submits any substantial changes to its Quality Improvement Program Description to the Quality Improvement Committee and appropriate state agency for review and approval as required by state contract, if applicable.

At the discretion of SilverSummit Healthplan, the Quality Improvement Program Description may include structure, and process outlines for applicable functional areas within the health plan, or departments may maintain their own program description. In either case, all program descriptions are formally approved or accepted by the Quality Improvement Committee at least annually.

Quality Improvement Work Plan - To implement the comprehensive scope of the Quality Improvement Program, the Quality Improvement Work Plan clearly defines the activities to be completed by each department and all supporting committees throughout the program year, based on the Quality Improvement Program Evaluation of the previous year.

The Work Plan is developed annually after completing the Quality Improvement 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, including measurable goals, for improving quality of clinical care, safety of clinical care, quality of services, including CLAS, member experience, and the network's cultural responsiveness;
- Timeframe for each activity's completion;
- Staff members responsible for each activity;
- Monitoring of previously identified issues; and
- Evaluation of Quality Improvement Program.

QI leadership, or designee, is responsible for review of data collected and/or reports used to monitor progress against goals, for all measures, throughout the year. 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 Improvement Program, as applicable.

The Work Plan is a fluid document, and status is monitored and updated through the Quality Improvement Committee on a quarterly basis to reflect progress on activities within the program priorities. The designated Quality Improvement Department staff make frequent updates to document progress of the Quality Improvement Program throughout the year.

At the discretion of SilverSummit Healthplan, the Quality Improvement 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 Quality Improvement Committee at least annually.

Quality Improvement Program Evaluation - The Quality Improvement Program Evaluation includes an annual summary of quality assurance studies and all quality activities, the impact the

program has had on member care, an analysis of the achievement of stated goals and objectives, and the need for program revisions and modifications. The Program Evaluation outlines the completed and ongoing activities of the previous year for all departments within the health plan, including activities regarding provider services and network responsiveness, language and member services, utilization management, care management, complex case management, condition management, and safety of clinical care. Program Evaluation findings are incorporated in the development of the annual Quality Improvement Program Description and Quality Improvement Work Plan for the subsequent year. The senior quality executive and Quality Improvement VP/Director are responsible for coordinating the evaluation process and a written description of the evaluation and work plan is provided to the Quality Improvement Committee and Board of Directors for approval annually.

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

- Analysis and evaluation of the overall effectiveness of the Quality Improvement Program, including progress toward influencing network-wide culturally competent care, safe clinical practices, and:
    - An evaluation of the adequacy of resources (e.g., staffing, analytic tools, etc.) and training related to the Quality Improvement Program;
    - The effectiveness of the Quality Improvement Committee structure, including subcommittees and workgroups;
    - Effectiveness of health plan leadership and external practitioner involvement in the Quality Improvement Program; and
    - Conclusions regarding the need to restructure the Quality Improvement Program for the following year;
- A description of completed and ongoing quality activities that address quality and safety of clinical care, quality of service, including culturally and linguistically appropriate services;
- Trending of measures (clinical and service indicators) collected over time to assess performance in quality of clinical care, quality of service, improvement in CLAS and reduction of healthcare disparities;
- Interventions implemented to address the issues chosen for performance improvement projects and focused studies;
- 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, demonstrated improvements in quality, areas of deficiency and recommendations for corrective action;
- Identification of limitations and barriers to achieving program goals;
- Recommendations for the upcoming year's Quality Improvement Work Plan;
- An evaluation of the scope and content of the Quality Improvement Program Description to ensure it covers all types of services in all settings and reflects demographic and health characteristics of the member population;
- A description of State initiated improvement projects including the annual Performance Improvement Project (PIP) and the outcomes and trended results for each improvement project, including documentation of successful and unsuccessful interventions;

- A description of mechanisms used to detect both underutilization and overutilization;
- A description of efforts to prevent, detect, and remediate critical incidents Summary of quality committee structure and activity providing structure, at a minimum for the internal quality improvement committee that monitors the annual quality strategy and work plan, and an internal Utilization Management oversight committee that monitors utilization against practice guidelines and treatment planning protocols and policies;
- A description of how the health plan meets the requirements for the development and dissemination of clinical practice guidelines;
- An assessment of the quality and appropriateness of care furnished to all members, availability of services, second opinions, timely access and cultural considerations, with a report of aggregate data indicating methods used to monitor compliance;
- A description of mechanisms used to assess the quality and appropriateness of care furnished to members with special health care needs and members receiving long-term services and support;
- An assessment of the quality and appropriateness of care furnished to members with special health care needs, with a report of aggregate data indicating the number of members identified and methods used to evaluate the need for direct access to Specialist;
- A demonstration of improvement in an area of poor performance in Care Coordination for Members with special health care needs and behavioral conditions;
- A report on the Member Grievance and Appeal system. Monitoring and enforcement of consumer rights and protections that ensures consistent response to complaints of violations of consumer rights and protections; 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 Improvement Program cycle each year (calendar year, unless otherwise specified by state contract), the Quality Improvement Department facilitates and prepares the Quality Improvement 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 Improvement Program. Recommended changes in program strategy or administration and commitment of resources that have been forwarded and considered by the Quality Improvement Committee should be included in the document.

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

SilverSummit Healthplan provides general information about the Quality Improvement 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 Improvement 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 Improvement Program Description and/or Quality Improvement Program Evaluation, or summary documents.

PERFORMANCE MEASUREMENT

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

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

HEDIS is a collaborative process between SilverSummit Healthplan, the Centene Corporate Quality Improvement 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 Improvement Department analyzes findings related to member experience and presents results to the Quality Improvement Committee and appropriate subcommittees.

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

Provider Experience - Provider satisfaction is assessed annually using valid survey methodology and a standardized comprehensive survey tool. The survey tool is designed to assess provider satisfaction with the network, claims, quality, utilization management, and other administrative services. The Provider Experience Department is responsible for coordinating the provider satisfaction survey, aggregating and analyzing the findings, and reporting the results to appropriate committees. Survey results are reviewed by Quality Improvement Committee, with specific recommendations for performance improvement interventions or actions. Provider experience may also be assessed through monitoring of provider grievances and appeals as well as point-in-time provider surveys following call center and in-person interactions. Provider surveys, monitoring of provider grievances and appeals, and input from various quality committees and advisory workgroups provide ongoing data to the Performance Improvement Team and 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 Improvement 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 Improvement Program. Monitoring and promoting member safety is integrated throughout many activities across the health plan, including through identification of potential and/or actual quality of care events and critical incidents, as applicable. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of member care, is not compliant with evidence-based standard practices of care, or signals a potential sentinel event, up to and including death of a member. Employees (including Population Health Management and Clinical Operations (PHMCO) staff, Member Services staff, Provider Relations 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 Improvement 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 reports are processed by the health plan's Grievance & Appeals and Quality of Care team to track and monitor 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 include participation in efforts by DHCFP to prevent, detect, and remediate critical incidents consistent with assuring beneficiary health and welfare that are based, at a minimum, on the requirements for home and community-based waiver programs.

Critical incidents address events or occurrences that cause harm to a member or that indicate risk to a member's health or welfare. Critical incidents may include but not limited to, events or occurrences that cause harm to a member with LTSS services or indicate risk to a member's health and welfare, such as abuse, neglect, and exploitation. Other events impacting members with LTSS services such as health and wellness, or potential risk, may be addressed through the quality-of-care process. To ensure timeliness with remediating critical incidents, the health plan's critical incident manager initiates the critical incident reporting within 1 business day of becoming aware of the event. Upon the initiation of the critical incident report, the critical incident manager is to investigate the event and close the case within forty-five (45) calendar days after the initial report.

Additionally, the critical incident manager communicates and partners with other teams (inclusive of Grievances & Appeals and Quality of Care) to identify any potential trends with cases and barriers for members. They also partner together to develop actions and next steps with escalations inclusive but not limited to practitioner/provider corrective actions.

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.

WORKFORCE AND ORGANIZATIONAL READINESS

Inclusive Business Practices Framework

At SilverSummit Healthplan and our parent company, Centene, contributions from individuals from various backgrounds, cultures, and perspectives empower us to deliver better healthcare outcomes for our members and support long-term community growth. Guided by the core pillars of our strategic inclusive business practices framework — Our People, Our Business and Our Communities — we work across our organization to build an inclusive workplace culture, foster strategic partnerships and investments, drive economic impact, and offer access to opportunities for all. To ensure organizational governance, leadership, and workforce are responsive and drive impact with our Participant population, SilverSummit Healthplan hiring and recruitment practices, and related policies, promote fairness, inclusion and access to opportunity for all, at all levels and positions, and encompass contributions from individuals from various backgrounds, cultures, and perspectives. Our Talent Attraction (TA) team, in partnership with hiring leaders and human resources, nurtures a talent pipeline that connects us to a broad pool of qualified talent. At SilverSummit Healthplan, we are committed to recruiting the most outstanding talent to advance our mission. To accomplish this, we partner with several organizations that bring unique expertise and networks that accelerate our growth through exposure to talent from all backgrounds. Our TA team continues to advance its efforts to deliver a more human-centric and personalized approach to attracting and cultivating the best talent. Recruitment and hiring practices that support this recruitment strategy include:

- developing and posting online job descriptions emphasizing our organizational values and culture,
- broadly advertised job fairs to engage candidates across a range of backgrounds,
- engagement with local community leaders, community-based organizations (CBO), universities, community colleges, and faith-based organizations to promote opportunities within the organization,
- provide resources for hiring leaders to further their competency in identifying and hiring the best talent for their opportunities.

Advancing Our Framework and Measuring Impact

Our success in healthcare depends on the trust we build with our members, stakeholders, and partners. It starts with our commitment to creating and maintaining a workforce that can best support our Participants. Strategically integrating this commitment across SilverSummit Healthplan and our enterprise, One CenTeam enables us to respond more effectively to the unique cultural, social, and linguistic needs of Participants from all backgrounds. Our dedicated team members play an integral role in transforming the health of the communities we serve, and we believe a workforce with deep competency in understanding the spectrum of our Participants' circumstances and lived experiences is vital to that mission. The People Team and their partners across the organization work diligently to build community, opportunity, and psychological safety for all SilverSummit Healthplan team members, empowering them to bring their authentic selves to work and employ their individual talents and skills in support of Centene's mission as One CenTeam.

To help our employees maintain their level of excellence in support of our Participants, we provide programs, resources, and tools to ensure employee development and growth. Every individual is a leader, and as such, all staff set goals around and are measured against our

Leadership Model. This process enables staff from all backgrounds and cultures to collaborate, contribute, and provides opportunities for development and advancement. We actively track the progress and impact of our support programs, leadership development programs, and other initiatives across the employee life cycle (Corporate Policy CC.HUMR.12) through our People Analytics Hub.

Another monitoring activity involves the deployment of our Centene Voice enterprise-wide surveys to obtain employee feedback on what is most important to them while measuring employee engagement and sentiment on their teams, leaders and overall experience with the organization. Our continuous listening strategy creates opportunities for employees to feel valued and heard throughout the year, and the insights gathered serve as an important catalyst in how we further improve our employee experience.

Additional support of our workforce includes the opportunity to participate in enterprise-wide employee networks such as our Employee Inclusion Groups (EIGs) and Centene Professional Networks. Open to all employees, our networks are voluntary, employee-led groups that drive impact by enhancing the attraction, development and retention of the best talent at all levels. These networks provide access to professional and leadership development programs, contribute to community impact initiatives, and support business innovation and corporate best practices. The groups include CENVET, our Veterans and Military Families network; MOSAIC, our Multicultural network; I.N.S.P.I.R.E., our Women and Allies network; ABILITY, our People with Disabilities & Caregivers network; cPRIDE, our LGBTQIA+ network; and STAGES, our Intergenerational network. Furthermore, the company maintains an Executive Council comprised of senior leaders from our business divisions, which focuses on strategic direction and accountability across our inclusive business practices framework. The Council ensures that our processes, policies, and practices drive fair and sustainable results across the enterprise, in alignment with our organization's mission.

SilverSummit Healthplan's Business Unit Council plays a critical role in advancing inclusive business practices at the local level. By focusing on sustainable and scalable initiatives, the SilverSummit Healthplan Council integrates these practices into everyday operations, enhancing both employee engagement and the quality of care for Participants. SilverSummit Healthplan Council leadership includes a Chair, Vice-Chair, and the SilverSummit Healthplan CEO as Executive Sponsor, who is consistently engaged in all the SilverSummit Healthplan council's work.

Other individuals who serve on the SilverSummit Healthplan Council model our organizational values and behaviors while overseeing health equity and DOH population and program intervention data to monitor, engage in meaningful dialog, and inform strategy and continuous improvement.

Our strategic priorities are translated into SMART goals and supported by a formal project plan. The project plan has specific owners for each goal area to ensure that the responsibilities are balanced, inclusive, action-oriented and routinely updated to reflect progress on goals. Our SilverSummit Healthplan Council strategic plan, project plan, and all supporting documents and materials are posted to our centralized Business Unit Council Teams site and are routinely used

within and between SilverSummit Healthplan Council meetings. The SilverSummit Healthplan Council Chair & Vice-Chair submit quarterly reports on progress relative to goals. SilverSummit Healthplan's Council identified priorities include:

- Locally advancing the enterprise commitment to a fair, inclusive workplace where all employees feel they belong as part of One CenTeam
- Integrating fairness, inclusion, access to opportunity for all and health equity across business and talent process
- Driving impact and outcomes through local investments and partnerships
- Shared enterprise calendar of events

Annually, SilverSummit Healthplan identifies and evaluates opportunities to improve fairness, inclusion, access to opportunity and competency around culturally appropriate care for staff, leadership, committees, and governance bodies.

Training and Development

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

To ensure education and development opportunities are relevant to Participant needs and barriers to care, the health plan reviews membership demographic profiles and ensures that training topics and consulting services integrate concepts relevant to the population. SilverSummit Healthplan provides all employees, regardless of position within the organization, with training and educational opportunities at least annually on culturally and linguistically appropriate services, reducing bias or promoting inclusion, and reports and evaluates completion rates. Examples of education and development opportunities available to employees include:

- Culturally Appropriate Care Learning Path & Moving from Cultural Competence to Culturally Appropriate Care
- Cultivating Equity and Inclusion Learning Path & Language Access
- Introduction to Unconscious Bias & Tribal Sovereignty 101
- Unconscious Bias Fundamentals & Unnatural Causes: Is Inequality Making Us Sick?
- Inclusive Leadership & Using Gender Inclusive Language
- Health Equity 101& Writing in Plain Language

SilverSummit Healthplan staff, at all levels of employment, are assigned the Culturally Appropriate Care learning. Health Equity Operations (HE Ops) collaborates with the People Business Solutions Digital Learning team to assign training on an annual basis. To ensure an accurate staffing list is provided to the Learning team, HE Ops contacts the health plan to confirm participation prior to the assignment list being provided. Training is assigned, via email notification, each September with 30 days to complete, and reporting is available in October showing the completion list. Exclusions include contingent workers and those on Leave of Absence (LOA). Upon return to work, the training is automatically reassigned, and the employee is given full opportunity to complete.

The health plan provides all employees training and educational opportunities at least annually on inclusion, recognizing and reducing the effects of bias, and culturally appropriate care and evaluates completion rates. The goal for completion of culturally appropriate care training for staff and leadership is 100%.

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 Improvement Department report results to the Performance Improvement Team and/or the Quality Improvement Committee or consideration of corrective action if opportunities are identified. Results are included in the annual Quality Improvement 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 and drivers 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 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, Specialists (including behavioral health, high-volume OB/GYNs and high-impact oncologists), and home health/PCAs (to maintain efficacy such as PT/OT/ST services). 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.

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

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

Language Access and Availability - The CC.QI.CLAS.29 policy addresses the provision of language access services with guidance to departments that interact with members and providers to ensure a continuum of language services to members and/or caregivers who have limited English proficiency (LEP); are deaf, deaf-blind, or hard of hearing; and/or those who request language services. Language Services include:

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

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

clearly identify the toll-free number for members who are deaf and/or hard of hearing to provide to the 711-relay operator to reach the call center.

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

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

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

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

The health plan provides required translated materials in threshold/prevalent languages in accordance with state and federal requirements for mailed materials and materials available electronically. At a minimum, these materials are provided upon request by the member. Written translations are available as required by contract or regulation and ensures that all non-English

translations and alternate formats meet the standards of quality required by law, regulatory agency, contract, or oversight agency. The organization uses contracted vendors for all non-English translations and braille. Translation vendors provide an attestation of quality for all materials and adhere to agreed-upon standards for timeliness in producing translations, as documented in contracts.

Notification of Language Access Services (Standard 6)
Member Notification: Communication and dissemination of the health plan's availability of language assistance services is critical to ensure members with limited English proficiency, are deaf, and/or hard of hearing can meaningfully access program services. The health plan works to ensure that members are informed on how to access language services at all points of contact (member services, claims, utilization management, disease management, care management, and/or grievances and appeals).

The organization disseminates notice of Language Access Services using Taglines on printed and electronic materials. Taglines are designed to inform individuals with limited English proficiency about the availability of language assistance services. For example, a tagline written in Spanish might say: "If you speak Spanish, language assistance services are available free of charge. Call 844-366-2880 for assistance." Members also receive written materials informing them of the availability of language services in threshold languages. Threshold languages are all languages other than English spoken by 5 percent of the population or by 1,000 individuals, whichever is less. Threshold languages are evaluated at least every three years using census or community-level data.

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

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

Practitioner Notification: Communication and dissemination of the health plan's availability of language assistance services to practitioners is critical to ensure members with limited English proficiency, are deaf, and/or hard of hearing can meaningfully access program services. To facilitate language access services, information about the language patterns of the community or

service area are provided and individual member level data is available through the Provider Portal to prepare the practitioner for interaction and educates contracted practitioners on how members can get access to no-cost interpreter services and oral translation services.

The organization disseminates information and resources on Language Access Services to Practitioners to assist in the provision of services. Practitioners receive information on the availability of language assistance services contracted through the health plan, language composition of the service area and/or state, and how to access services . Information is disseminated through the Provider Manual, Provider Portal, and online provider newsletter. Additionally, materials and resources are available for practitioners to deploy at their locations to educate members about language services. Resources and materials include:

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

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

POPULATION HEALTH MANAGEMENT

SilverSummit Healthplan's Population Health Management (PHM) strategy is guided by the SilverSummit Healthplan Population PHM Strategy Description and includes a comprehensive plan for managing the health of its enrolled population, reducing disparities, improving health outcomes and controlling health care costs and is coordinated with activities addressed in this program description. The PHM Strategy is closely aligned with the Quality Improvement 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 framework has three pillars: whole health, focus on individuals, and active local involvement. The PHM Strategy aims to reduce inequities and prevent health risk and manage existing conditions including outlining how member health needs are identified and stratified, and segmented for intervention; details the PHM programs and services offered to address those needs for all stages of health and across health care settings; explains how members are informed of the programs and services and their eligibility to utilize them; and describes proven prevention interventions and tactics used to promote the transition to value-based care in the health plan's network. PHM programs, activities, resources and outcomes are reported to the Quality Improvement Committee for review, recommendations, and approval.

Care Management and Coordination of Services - 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 60 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. Eligibility for PHM programs and services varies by the members' conditions and needs but is not limited to risk stratification, population segmentation, provider referral, self-referral, and care giver referral. All clinical management programs include the use of general awareness and targeted outreach and educational interventions, including but not limited to, newsletter articles, advertising regarding available programs, direct educational/informational mailings, and care management. Members that are eligible for participation in PHM programs are informed about how they became eligible to participate in the specific program, how to use program services and how to opt-in or opt-out of the program. The Care Management team will complete a health risk screening and or care management assessment as needed and explain their role, function, and benefits of the program. Programs also include written communication to primary care providers informing of members on their 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.

BEHAVIORAL HEALTH SERVICES

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

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

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

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

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

COMMUNITY ENGAGEMENT

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

The MAC is comprised of a diverse and demographically representative group of participants that reflect the community. As defined by the charter, the MAC consists of community members, health plan members, representatives of community-based organizations (CBOs), providers, and other invested stakeholders, representing ≥ 5% of the geographic, cultural, racial/ethnic, and linguistic diversity of the membership. The MAC meets quarterly to share issues and

opportunities with the health plan. Meeting minutes and information are shared with plan leadership and incorporated into quality improvement projects to close gaps as appropriate.

PROVIDER SUPPORTS

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

Included is a multidimensional assessment of a PCP or other practitioner's performance using clinical and administrative indicators of care that are accurate, measurable, and relevant to the target population. To support providers in their delivery of robust preventive and interventive care, 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 linguistically appropriate, timely, efficient and evidence-based care to members. Claims data is used to create a detailed profile of each member with the ability to organize members by quality measures and disease conditions. This provider analytics tool includes:

- Member demographics, including race, ethnicity, language, sexual orientation and gender identity
- Disease registries
- Care gap reporting at member and population levels
- Claims-based patient histories 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 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 Improvement Program, valid and reliable clinical evidence or a consensus of health care professionals in the particular field and needs of the members. Decisions on member education topics and materials are based on information contained in adopted guidelines to ensure consistency. Clinical and preventive health guidelines are updated upon significant new scientific evidence or change in national standards, or at least every two (2) years. Guidelines are distributed to providers via the Provider Manual, the 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 reduction of healthcare disparities and practitioner compliance with adopted guidelines. If performance measurement rates fall below SilverSummit Healthplan, State, or accreditation goals, SilverSummit Healthplan implements interventions for improvement as applicable.

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

To support this effort, demographic data is collected from practitioners and practice. Race, ethnicity, and language proficiency is obtained through the credentialing and/or enrollment process as outlined in the CC.PRVR.47 policy. Self-reported, practitioner demographic information is available upon request for member access preferences. Through data, we can expose and analyze deficiencies in our practitioner network and make adjustments as

appropriate. The health plan is committed to ensuring that its policies and infrastructure are attuned to the diverse needs of all members, thereby taking active steps to obtain practitioner data to reduce known healthcare disparities that stem from cultural and linguistic issues.

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

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

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

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

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

PERFORMANCE IMPROVEMENT ACTIVITIES

SilverSummit Healthplan's Quality Improvement Committee reviews and adopts an annual Quality Improvement Program and Quality Improvement Work Plan that aligns with the health plan's strategic vision and goals and appropriate industry standards. The Quality Improvement Department implements and supports performance/quality improvement activities as required by state or federal contract, including quality improvement projects and/or chronic care improvement projects as required by state or federal regulators, and accreditation needs. Focus studies and health care initiatives to identify and reduce inequities also include behavioral health care issues and/or strategies.

The health plan utilizes traditional quality/risk/population health and utilization management approaches to identify activities relevant to the health plan programs or a specific member population and that describe an observable, measurable, and manageable issue. Initiatives are identified through analysis of key indicators of care and service based on reliable data which

indicate the need for improvement in a particular clinical or non-clinical area. Baseline data may come from: performance profiling of contracted providers, mid-level providers, ancillary providers and organizational providers; provider office site evaluations; focus studies; utilization information (over-and under-utilization performance indicators); sentinel event monitoring; trends in member complaints, grievances and/or appeals; issues identified during care coordination; and/or referrals from any source indicating potential problems, including those identified by affiliated hospitals and contracted providers. Other initiatives may be selected to test an innovative strategy or as required by state or federal contract. Projects and focus studies reflect the population served with consideration of cultural preferences, disparity reduction, social determinants and drivers of health, age groups, disease categories, and special risk status.

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

The 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.

Performance Improvement Projects (PIP)

The health plan evaluates the technical structure of State PIPs to ensure that SilverSummit Healthplan designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. The health plan determines whether the PIP design (e.g., PIP Aim statement, population, sampling methods, performance indicator, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.

DHCFP selected five clinical and one non-clinical PIPs for the 2022-2025 cycle. The health plan uses the PDSA (plan, do, study, act) approach to monitor measurement performance and evaluate the effectiveness of interventions.

- (IET) Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Collaborate with practitioner partners for member outreach, education on telehealth services; partnering with behavioral healthcare partners to outreach, assess and refer members to community resource centers.
- (AAP) Adults' Access to Preventive/Ambulatory Health Services: Promoting telehealth services; increasing telephonic member outreach; coordinate with community health workers to perform member outreach in targeted zip codes through disparity analysis.
- (WCV) Child and Adolescent Well-Care Visit: Collaborate with practitioner partners for member outreach and education and perform direct member outreach from the health plan's quality team.
- (FUM) Follow-Up After Emergency Department Visit for Mental Illness: Whole health approach to coordination and engagement of care with Strategic Partners; distribute and discuss attribution reports with practitioners; utilize certified behavioral healthcare community health works.
- (PPC) Prenatal and Postpartum Care: Promote high-risk member self-monitoring of blood pressure (Project Guardian); collaborate with Strategic and Community Partners to effectively engage and support members; lengthen member post-delivery engagement timeline (StartSmart for Baby); continue to improve on capturing Notice of Pregnancy (NOP) forms from practitioners.
- (PCR) Plan All-Cause Readmissions: Create a Transition of Care (TOC) team to improve staffing of discharge planners; review daily emergency department (ED) discharge report with case managers; hold a monthly review of high ED utilizers for case management engagement.

GRIEVANCE AND APPEAL SYSTEM

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

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

All member grievances and appeals data is tracked, trended, analyzed and reported to the Population Health Management and Clinical Operations Committee and/or the Quality Improvement Committee and applicable subcommittees on a regular basis to identify trends and to recommend performance improvement activities as appropriate. In addition, member grievances associated with specific practitioners and/or providers and related to quality of care and service are tracked, classified according to severity, and reviewed by the Medical Director if needed. Member grievances by associated practitioner/provider are analyzed and reported on a routine basis to the Quality Improvement Committee and applicable subcommittees (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 Quality Improvement Committee on a regular basis to identify trends and to recommend performance improvement activities as appropriate. Provider complaint reports are submitted to the Quality Improvement Committee, along with recommendations for quality improvement activities based on results.

REGULATORY COMPLIANCE AND REPORTING

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 Improvement 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 Improvement Program and all health plan departments fully support every aspect of the federal privacy and security standards, Business Ethics and Code of Conduct, Compliance Plan, and Waste, Fraud and Abuse Plan.

NCQA HEALTH PLAN & HEALTH EQUITY ACCREDITATION

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

DELEGATED SERVICES

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

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

ENDORSEMENT OF THE Quality Improvement Program Description
The Quality Improvement Program Description has been reviewed and endorsed by the quality senior leadership effective this day of __11th__, month of _June_, _2025_.

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Vice President Quality Improvement – Jennifer Tonges

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Chief Medical Officer – Dr. Steven Evans

ENDORSEMENT OF THE Quality Improvement Program Description
The Quality Improvement Program Description has been reviewed and endorsed by the Board of Directors effective this day of __30th___, month of __June____, _2025_.

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Board of Directors Chairman – Eric Schmacker