SilverSummit Healthplan

2026
Quality Improvement Program Description

State of Nevada's
Internal Quality Assurance Programs (IQAP)

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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 Name 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 and workforce is educated, trained, and 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.

SilverSummit Healthplan's senior leadership fosters and creates an ongoing, dynamic culture of innovation, continuous quality improvement, and health care excellence through its Population Health Management Strategy and Quality Improvement Program. Leadership provides direction and oversight of all quality and population health improvement efforts, promote a culture that is focused on supporting an optimal health care delivery system through collaborative, cross-system health management strategies, ensures a focus on improving the quality of care and reducing health disparities at both individual and system-wide levels, and ensures that gaps in care are remedied at both the individual and system-wide levels. Leadership uses data and analytics consistently, frequently, and strategically to identify improvement opportunities, evaluate the effectiveness of improvement initiatives, and incorporate results and lessons learned into business processes. They engage relevant cross-organization leaders (e.g., Member Services, Provider Relations, UM staff, CM staff) in performance improvement efforts (e.g., care coordination and quality improvement efforts) to inform and address barriers to optimal care and health outcomes, and promote ongoing, rapid-cycle improvements within quality improvement projects, including PIPs and other activities performed by the health plan and its providers.

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, and 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 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 Department collaborates across the health plan with several functional areas including and not limited to Population Health and Clinical Operations (PHCO), Pharmacy, Provider Engagement/Provider Relations, Health Equity, Network/Contracting, Member Services, Compliance, and Grievances and Appeals.

The Quality Improvement Program Description addresses all State requirements, encompassing all levels of SilverSummit Healthplan's organization, and have a clear linkage to the State's Quality Strategy, and services urban counties of Clark and Washoe, and the rural service area. At the request of the State, the health plan will make changes to its program and provide the State with a revised draft for review and approval. SilverSummit Healthplan complies with all requirements outlined in the State's Quality Strategy, including but not limited to using the

Quality Strategy to inform the Population Health, Utilization Management, Case Management, and Pharmacy Management Programs that informs what our overall Population Health Strategy is annually, developing and implementing a Cultural Competency program, and participating in External Quality Review (EQR) activities. At the request of the State, the health plan will amend its program and provide the State with a revised draft for review and approval.

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 improving CLAS and equitable health outcomes, healthcare process measures, as well as 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.

SilverSummit Healthplan maintains an ongoing quality assessment and performance improvement program (Quality Improvement Program Description) known as an Internal Quality Assurance Program (IQAP), for the services it provides to its members. This program description includes initiatives to improve population health and reduce health disparities. The scope of the IQAP is comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of services. The scope also addresses availability, accessibility, coordination, and continuity of care. The IQAP is comprised of systematic activities to monitor and evaluate the care delivered to members according to predetermined, objective standards and to effect improvements, as necessary. The State will monitor the health plan's progress in achieving the goals and objectives of the Quality Improvement Program.

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 care and quality of services provided to SilverSummit Healthplan members including medical, behavioral health, dental, and vision care as applicable to the health plan's benefit package. SilverSummit Healthplan incorporates all demographic groups, lines of business, benefit packages, care settings, and services in its quality management and improvement activities. 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. In 2026, SilverSummit Healthplan expanded its reach and scope to include additional geographical service areas to include the rural and frontier counties for its Medicaid line of business. SilverSummit Healthplan's Quality Improvement Program, inclusive of its scope expansion, incorporates the following:

- Identification of priorities and goals aligning with Centene Corporation's mission and the health priorities defined by the CDC 6|18 Initiative, Healthy People 2020 and 2030, the National Institutes of Health, National CLAS Standards and other evidence-based sources;
- Identification of priorities and goals aligning with the States' 2025-2027 Quality Strategy;
- 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;
- Develop and maintain the ability to collect and report data on race, ethnicity, sex, primary language, and disability status for the member and the member's parents or legal guardians if the member is a minor or a legally incapacitated individual; a focus on cultural humility and health equity, including the identification of interventions to improve health disparities based on age, race, ethnicity, sexual orientation gender identity, primary language, member demographics and geographic location, etc. and by key population group;
- Assessment of the workforce to respond and provide services that are appropriate and accessible to the needs of the members, 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 support ongoing communication, cross collaboration, and evaluation 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 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;
- Collecting and submitting all quality performance measurement data per state, federal, and accreditation requirements, including robust performance management tracking and reporting such as:
  - The annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) (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 and accessible care for members in areas such as network adequacy, availability of services, timely appointment availability, transitions of coverage, coordination and continuity of care, etc.;
- Encouraging providers to participate in quality initiatives and giving support to providers, including a provider analytics system that delivers frequent, periodic quality improvement information to participating providers in order to support them in their efforts to provide high quality health care, and adoption and distribution of evidence-based practice guidelines;
- Conducting and assessing quality improvement and performance improvement projects based on demonstration of need and relevance to the population served, with improvement initiatives aligned with identified health priorities and state/federal requirements and applicable member population(s);
- Monitoring utilization patterns by performing assessment of utilization data to identify potential over- and under-utilization issues or practices using various data sources such as

medical, behavioral health, pharmacy, dental, and vision claim/encounter data to identify patterns of potential or actual inappropriate utilization of services;

- A PHM Strategy focused on four key areas of member health needs (keeping members healthy, managing members with emerging health risk, patient safety/outcomes across settings and managing multiple chronic illnesses) that offers interventions to address member needs in all stages of health and across all health care settings;
- Serving members with complex health needs, including members needing complex care management and long-term services and supports (LTSS), as applicable;
- Establish and maintain a Member Advisory Board and Provider Advisory Board;
- Achieving/maintaining NCQA accreditation and/or other applicable accreditations for appropriate products;
- Monitoring for compliance with all regulatory and accreditation requirements; and
- Collaboration with Compliance and other applicable departments concerning oversight of delegated functions and services, including approval of the delegate's programs, routine reporting of key performance metrics, and ongoing evaluation to determine whether the delegated activities are being carried out according to health plan and regulatory requirements and accreditation standards.

PRIORITIES AND GOALS

SilverSummit Healthplan's primary goal is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving the quality of care and services delivered. The Quality Improvement Program focuses on the health priorities defined by a combination of the State's Quality Strategy, 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 are 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 all of our membership by recognizing the significance of the lived experience our members represent and by forming partnerships in communities that bridge social, ethnic, and economic gaps.

SilverSummit Healthplan's quality assurance objectives are also aligned with the Nevada Medicaid 2025–2027 Quality Strategy. Consistent with Nevada's statewide quality priorities, SSHP will continue to implement and operationalize actionable, measurable objectives

throughout calendar year 2026, with formal evaluation of progress and outcomes conducted at the end of 2026 and again in 2027.

In support of the Nevada 2025–2027 Quality Strategy goals and objectives, SSHP's quality assurance activities include, but are not limited to, the following examples:

- **Improving Access to Care and Preventive Services:**
  SSHP implements targeted interventions to improve timely access to primary care, preventive screenings, and well-child visits, aligning with Nevada's goal to improve access to care and preventive services statewide. Activities include monitoring appointment availability, addressing network adequacy gaps, and tracking performance on preventive care quality measures.
- **Advancing Maternal, Child, and Family Health:**
  In alignment with Nevada's focus on maternal and child health outcomes, SSHP prioritizes quality assurance activities that support prenatal care, postpartum follow-up, and early childhood preventive services. Performance is monitored through applicable quality measures, member outreach effectiveness, and disparities analyses.
- **Strengthening Behavioral Health Integration:**
  SSHP supports Nevada's strategy to enhance access to behavioral health services by evaluating care coordination processes, follow-up after hospitalization for mental illness, and integration of behavioral health into primary care settings. Quality assurance reviews assess both access and continuity of behavioral health services.
- **Reducing Health Disparities and Promoting Health Equity:**
  Consistent with Nevada's quality strategy emphasis on health equity, SSHP incorporates stratified data analysis by race, ethnicity, geography, and other relevant factors to identify disparities and inform targeted quality improvement actions.
- **Improving Quality Outcomes and Accountability:**
  SSHP aligns with Nevada's objective to improve quality outcomes through systematic monitoring, performance measurement, and corrective action planning. Quality assurance activities include regular review of performance trends, implementation of performance improvement initiatives, and collaboration with providers to address identified gaps.

SSHP will continue to focus on the implementation and refinement of these actionable quality assurance objectives during 2026. Evaluation of effectiveness, progress toward targets, and outcome improvement will be conducted at the end of 2026 and 2027, with results used to inform ongoing quality improvement efforts and ensure continued alignment with the Nevada Medicaid 2025–2027 Quality Strategy.

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 and Clinical Operations (PHCO), Vice President/Director of Quality, and designated Quality Department staff;
- Peer Review Committee;
- External regulatory agencies, as mandated by applicable state/federal laws;
- Health plan legal executives; 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 and Clinical Operations (PHCO), Credentialing, and Pharmacy program activities are educated about maintaining the confidentiality of peer review documents;
- The Quality Vice President designates Quality Department staff responsible for taking minutes and maintaining confidentiality;
- For quality studies coordinated with, or provided to outside peer review committees, references to members are coded by identification number rather than a protected health information (PHI) identifier such as medical record number or ID number, with references to individual providers by provider code number;
- Records of review findings are maintained in secured files, which are made available only as required by law or specifically authorized in writing by the CEO, Chief Medical Officer/Director(s), Legal Counsel, Vice President of Population Health and Clinical Operations (PHCO), 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 is committed to meeting the needs of all members by providing care and services that are responsive to each person's cultural background, language preferences, and

lived experiences, and by recognizing how these factors influence access to care, engagement, and health outcomes.

The SilverSummit Healthplan Culturally and Linguistically Appropriate Services (CLAS) Program is a comprehensive cultural competency plan guided by policy QI.CLAS.29, 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 CLAS Program is also guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards), as developed by the U.S. Department of Health and Human Services Office of Minority Health, and Section 1557 of the Affordable Care Act.

The Cultural Competency Plan (CCP) aligns with the goals and objectives outlined in the State's Quality Strategy. The CCP is reviewed and updated annually and submitted to the State in accordance with the Reporting Requirements exhibit. The plan includes a defined process for obtaining member and stakeholder feedback, which is used to inform continuous improvement of the CCP and to enhance culturally appropriate clinical and member services programs.

The CCP describes the Health Plan's methodology for the ongoing evaluation of the cultural diversity of its membership, including the maintenance of an up-to-date demographic and cultural profile. SilverSummit Healthplan conducts regular assessments to identify member needs and health disparities and uses these assessments to plan and implement services that respond to the cultural, linguistic, and disability-related needs of its members. The Health Plan also routinely evaluates its provider network, outreach activities, and related programs to improve accessibility and the quality of culturally competent care. The CCP further outlines

requirements related to the provision and coordination of linguistic services, disability accommodations, and State-specific behavioral health requirements.

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SilverSummit Healthplan maintains a comprehensive training program to ensure staff at all levels and across all disciplines receive ongoing education in culturally and linguistically appropriate service delivery. Workforce-related insights, including aggregate data on staff experience, expertise, training, and employee feedback, are utilized by the CLAS Program to inform planning, implementation, and evaluation of culturally and linguistically appropriate services.

At least annually, the Health Plan provides training to all employees on topics designed to improve quality of care and service delivery and to reduce health disparities. Training topics include, but are not limited to:

- Culturally and linguistically appropriate practices
- Unique health and healthcare needs of relevant member subpopulations
- Practices that promote impartial and equitable care
- Strategies to reduce ableism in care and service delivery
- Inclusive and non-stigmatizing data collection practices
- Trauma-informed care approaches

Training is delivered through multiple modalities, including live webinars, recorded modules, and in-person sessions, and may be tailored to specific staff roles while ensuring all employees have access to training opportunities. The Health Plan tracks training offerings and participation through its Learning Management System (LMS).

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The Health Plan regularly assesses workforce training needs and updates the training program as appropriate. Training content is customized based on staff roles and the nature of their interaction with providers and/or members. In addition, SilverSummit Healthplan operates an education program for providers who have direct contact with members. This program is designed to promote awareness of the importance of delivering services in a culturally competent manner and includes sufficient efforts to train providers or support providers in obtaining training on culturally and linguistically appropriate service delivery.

Translation services that are offered will be provided by someone who is proficient and skilled in translating to and from the Member's preferred language(s). The availability and accessibility of translation services should not be predicated upon the non-availability of a friend or family member who is bilingual. Members may elect to use a friend or relative for this purpose, but they must not be encouraged to substitute a friend or relative for a translation service. The health plan uses a quality review mechanism to ensure that translated materials convey their intended meaning in a culturally appropriate manner. SilverSummit Healthplan will demonstrate that they use a quality review mechanism to ensure that translated materials convey their intended meaning in a culturally appropriate manner. The health plan provides translations for all materials when they are aware that a language is spoken by 3,000 or 10% (whichever is less) of the members who also have Limited English Proficiency (LEP). SilverSummit Healthplan translates all vital materials when they are aware that a language is spoken by 1,000 or 5% (whichever is less) of the members who also have LEP. Vital materials include, at a minimum, notices for denial, reduction, suspension or termination of services, and vital information from the Member Handbook. SilverSummit Healthplan translates all written notices informing

members of their right to interpretation and translation services into any language for which the health plan's caseload consists of 1,000 members that speak that language who also have LEP.

SilverSummit Healthplan will evaluate the CCP annually to determine its effectiveness and identify opportunities for improvement. This will include a summary report of the evaluation to the State with its annual submission of the CCP. The evaluation may, for example, focus on comparative member experience surveys, outcomes for certain cultural groups, member grievances, provider feedback, and/or health plan employee surveys. If issues are identified, SilverSummit Healthplan will track and measure trends over time and take actions to resolve the issue(s).

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.

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 quality initiatives and actions taken;
- Providing the resources, support, and systems necessary for optimum performance of quality functions;
- Designating a senior staff member as the health plan's senior quality executive;
- Designating a behavioral health professional to provide oversight of the behavioral health aspects of care to ensure appropriateness of care delivery and improve quality of service; and
- Evaluating the Quality Improvement Program Description and Quality Work Plan annually to assess whether program objectives were met and recommending adjustments when necessary.

The Board of Directors delegates the operating authority of the Quality Improvement Program to the Quality Improvement Committee. SilverSummit Healthplan senior management staff, clinical staff, and network practitioners, who may include but are not limited to, primary, specialty, behavioral, dental, and vision health care practitioners, are involved in the implementation, monitoring, and directing of the relative aspects of the quality improvement program through the Quality Improvement Committee, which is directly accountable to the Board of Directors.

The Chief Medical Officer/Director and the health plan's Quality Medical Director, or as designated by the SilverSummit Healthplan President/CEO, serve 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:

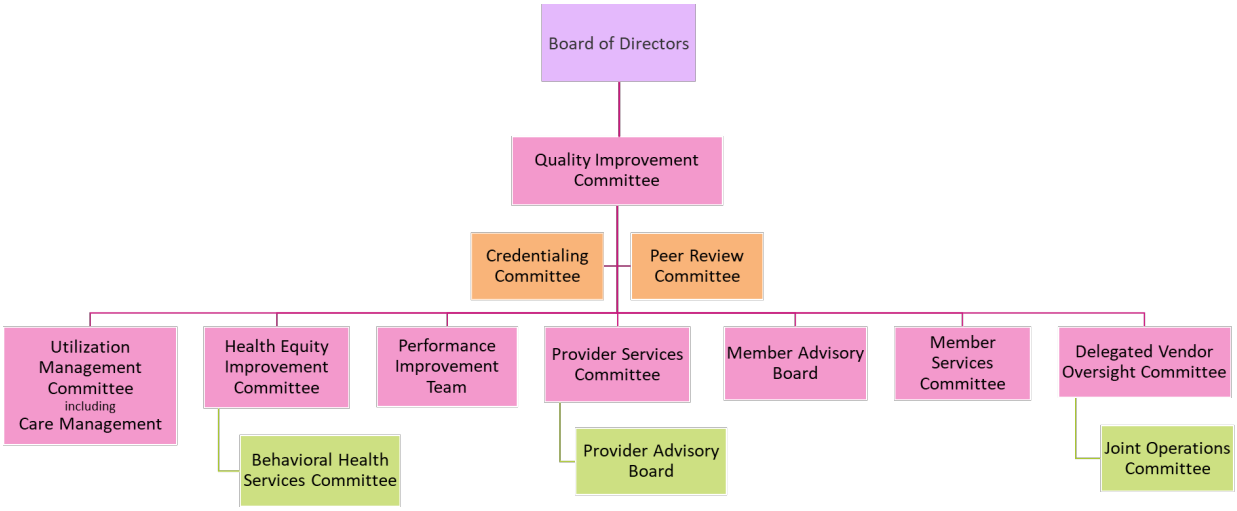
- Compliance with state, federal, and accreditation requirements and regulations related to behavioral health;
- Participating in the Quality Improvement Committee and various subcommittees reporting to the Quality Improvement Committee, as applicable to behavioral health;
- Monitoring and directing 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 represents a strong commitment to delivering and providing effective, equitable, understandable, and respectful quality care and services that are responsive to the diverse cultural health beliefs and practices of its 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 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.

SILVERSUMMIT HEALTHPLAN COMMITTEE ORGANIZATION CHART



SILVERSUMMIT HEALTHPLAN CORE COMMITTEE CHARTERS

Quality Improvement Committee (QIC)	
Charter Statement	The QIC is the senior leadership committee, accountable to the Board of Directors that reviews and monitors all clinical quality and service functions of the health plan and provides oversight of all subcommittees. The Chief Medical Officer is the senior executive for quality improvement and is responsible for the implementation of the Quality Improvement Program (the State's 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, and to continuously enhance and improve the quality of care and services provided to members through a comprehensive, health plan-wide system of ongoing, objective, and systematic monitoring of activities and outcomes using the quality process.
Responsibilities	• Oversight of the quality activities of the health plan to ensure compliance with contractual requirements, federal and state statutes and regulations, and requirements of accrediting bodies such as the National Committee for Quality Assurance (NCQA); • Annual development of the Quality Improvement Program Description and Work Plan incorporating applicable supporting department goals as indicated; • Development of quality and performance improvement studies and activities, and reporting of findings to the Board of Directors; • Annual review and approval or acceptance of the Credentialing, Pharmacy, Utilization Management, Care Management, and Population Health Management Strategy and Work Plans as developed by the appointed subcommittees to facilitate alliance with the strategic vision and goals; • Evaluation of the effectiveness of each departments' activities to include analysis and recommendations of policy decisions based on identified trends, barrier analysis, and interventions required to improve member quality of care and/or service, and member experience. Implements corrective actions as appropriate, and acts as a communication channel to the Board of Directors; • Prioritization of quality improvement efforts, facilitation of functional area collaboration, and assurance of appropriate resources to carry out quality activities;

Responsibilities	• Maintain records documenting each committee's activities, findings, recommendations, and actions, including meeting minutes, signatures, and dates reflecting decisions made follow-up actions.
	• Review and establishment of benchmarks and performance goals for each quality improvement initiative and service indicator;
	• Review and approval of due diligence information for any potential delegated entity and the annual oversight audit outcomes for delegated entities;
	• Adoption of preventive health and clinical practice guidelines to promote appropriate and standardized quality of care;
	• Monitoring of clinical quality indicators (such as HEDIS, adverse events, sentinel events, peer review outcomes, quality of care tracking, etc.) to identify deviation from standards of medical care, and supporting the formulation of corrective actions, as appropriate; and
	• Ongoing evaluation of the appropriateness and effectiveness of pay-for-performance and value-based contracting initiatives and support in designing and modifying the program as warranted.
	• Review operational policis and procedures at least annually and recommend modifictions as necessary
	• Member Appeals and Grievances
	  ○ Reviews appeals and grievance data, including trend analysis, administrative reviews, and requests for external reviews. Determines appropriate disposition and follow-up;
	  ○ Performs barrier and root cause analysis and make recommendations regarding corrective action as appropriate.

Reports To	Board of Directors, and the health plan's Executive Committee
Committee Chair	Chief Medical Officer, may delegate individual meetings to a Medical Director or Senior Quality Executive

Committee Composition	• Chief Executive/Operating Officer • Chief Medical Officer • Medical Director • Behavioral Health Medical Director • VP/Director of Quality • VP/Director of Population Health and Clinical Operations (PHCO) • VP/Director Network Development/Contracting • VP/Director of Member & Provider Services/Customer Service • VP/Director Compliance/Regulatory • Network practitioners, at least four (4) representing the range of practitioners within the network and across the regions in which the health plan operates, e.g., family practice, internal medicine, OB/GYN, behavioral health (i.e., physician or clinical PhD or PsyD), vision/dental care providers, and other high-volume specialists as appropriate • In addition, the committee may also have providers knowledgeable about members with disabilities; substance use, abuse of children, etc. • The provider representatives should have experience caring for the health plan membership, including a variety of ages and races/ethnicities, rural and urban populations, etc.
Frequency	Quarterly, with additional meetings scheduled per health plan need
Attendance Required	50% of scheduled meetings
Quorum	A minimum of four (4) committee members, including two health plan staff and two (2) external practitioners, must be present for a quorum. All permanent committee members are voting members; the Committee Chair is the determining vote in the case of a tie vote.
Agenda	Agenda items for the next meeting are developed by the Committee Chair in collaboration with the VP/Director of Quality. The committee receives regular reports from all subcommittees that are accountable to and/or advise the QIC.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are submitted to the Board of Directors and is stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable. Materials included in meeting packet are based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The QIC is authorized by the Board of Directors to make all decisions related to the Quality Improvement Program, with decisions made by consensus of the committee. Individuals are responsible to raise any issues at committee meetings.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable, to identify confidential information and/or situations when dissemination of information is to be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Peer Review Committee (PRC)	
Charter Statement	The Peer Review Committee (PRC) is an ad-hoc committee of the Quality Improvement Committee (QIC) and responsible for reviewing alleged inappropriate or aberrant services by a practitioner/provider, including potential quality of care incidents, adverse events, and sentinel events where initial investigation indicates a significant potential or significant, severe adverse outcome has occurred or other cases as deemed appropriate by the Medical 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 to best suit the situation.
Responsibilities	• To make determinations regarding appropriateness of care; • To make recommendations regarding corrective actions relating to provider quality of care; • To conduct the review by a practitioner of same or similar specialty as the practitioner and/or issue under review.
Reports To	Quality Improvement Committee
Committee Chair	Chief Medical Officer or Medical Director

Committee Composition	• Chief Medical Officer/Medical Director • VP/Director Quality • Peer practitioners; at least three (3) or more network practitioners who are peers of the practitioner being reviewed and who represent a range of specialties, including at least one practitioner with the same or similar specialty as the case under review, but whose presence does not indicate a conflict of interest. • No CC members involved in the PRC's recommendation will be included in the CC meeting when the PRC's recommendation is discussed
Frequency	Ad hoc, date and time to be determined based on need. Network practitioners serving on the committee may or may not be the same external practitioners serving on the QIC or CC. If the same practitioners are used, the QIC or CC meeting is adjourned and the Peer Review meeting started as an independent meeting with an independent agenda and minutes.
Attendance Required	100% of scheduled meetings. Network provider members are not standing members of the committee and their attendance may change based on type of case being reviewed.
Quorum	At least two (2) network providers and one (1) Medical Director must be present for a quorum. All permanent committee members are voting members; the Committee Chair is the determining vote in the case of a tie vote.
Agenda	Meetings are agenda driven. The Committee Chair and/or Quality designee develop agenda items for the next meeting.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials. All names and identifying information is redacted and information is distributed in a secure manner.
Decision Authority	The QIC authorizes the PRC to make decisions and recommendations regarding practitioner quality of care.
Evaluation	The committee reviews the charter annually.
Confidentiality	Peer review laws governing confidentiality of its proceedings 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.

Credentialing Committee	
Charter Statement	The Credentialing Committee (CC) is a standing subcommittee of the Quality Improvement Committee (QIC) and oversees and has operating authority of the Credentialing Program.
Purpose	The purpose of the CC is to provide oversight of the development and annual review/approval of credentialing policies. The CC has final authority for credentialing and recredentialing licensed medical and behavioral health practitioners, other licensed healthcare professionals, and organizational providers who have an independent relationship with the health plan. The Committee oversees the credentialing process to ensure compliance with regulatory and accreditation requirements and ensure network practitioners and organizational providers are qualified, properly credentialed, and available for access by health plan members.
Responsibilities	• Provide guidance to organization staff on the overall direction of the Credentialing Program; • Review and approve credentialing and recredentialing policies and procedures; • Review and recommend credentialing and recredentialing criteria; • Final authority to approve or disapprove applications by practitioners and organization providers for network participation status and recredentialing; • Provide clinical peer input to address standards of care for a particular type of practitioner; • Review oversight audits of delegates Credentialing Program performance; • Evaluate and report to management on the effectiveness of the Credentialing Program; and • Review potential QOC events and adverse events, including any corrective action plans from peer review committee, for recredentialing decisions.
Reports To	Quality Improvement Committee

Committee Chair	Chief Medical Officer/Director; as committee member leadership develops, a committee network provider may chair at the discretion of the CC
Committee Composition	• Chief Medical Officer/Medical Director(s) • Health plan Credentialing staff designee • Centene Corporate Credentialing Manager/Supervisor • Network practitioners from a range of specialties, e.g., family practice, internal medicine, OB/GYN, behavioral health, high-volume specialists, mid-level practitioners, etc. • Other executive leadership or health plan staff as determined. • The committee actively involves participating network practitioners in credentialing review activities as available and to the extent that there is not a conflict of interest.
Frequency	At least ten (10) times per year to facilitate timely review of practitioners/providers and to expedite network development; additional meetings scheduled as needed.
Attendance Required	50% of scheduled meetings
Quorum	A minimum of four (4) voting members, including the Chair, must be present for a quorum. Three (3) voting members must be appropriately licensed healthcare practitioners. Only healthcare practitioners are voting members; the Chair is the determining vote in the case of a tie vote.
Agenda	Meetings are agenda driven and follow a standard format. Agenda items for the next meeting are developed by the Corporate Credentialing Manager in collaboration with the Committee Chair.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are submitted to the QIC and is stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The Medical Director may approve clean files; the QIC has delegated responsibility for credentialing/recredentialing practitioners, facilities, and other organizational providers not meeting clean file criteria to the committee. The decision-making model is by consensus. Individuals are responsible and encouraged to raise any issues at committee meetings.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations of how dissemination of information is managed. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Utilization Management Committee (UMC)	
Charter Statement	The Utilization Management Committee (UMC) is a standing subcommittee of the Quality Improvement Committee (QIC) with oversight and operating authority of Population Health and Clinical Operations (PHCO) activities. The VP of PHCO is the senior executive for medical management, both physical health and behavioral healthcare, and is responsible for the implementation of the Population Health Strategy. The Chief Medical Officer serves as the committee chair.
Purpose	The purpose of the UMC is to review and monitor the appropriateness of care provided to health plan members. The UMC is responsible for the review and appropriate approval of medical necessity criteria and protocols, and utilization management policies and procedures, including a list of procedures requiring prior authorization.
Responsibilities	• Annually review and approve program descriptions, work plans and annual evaluations for Population Health Management, Utilization Management, and Case Management; • Development and implementation of UM and CM activities; • Review and maintain applicable policies/procedures and guidelines; • Annually review and approve the criteria for determination of medical appropriateness; • Review the utilization management process, including referrals, second opinions, prior authorization/pre-certification, concurrent and retrospective review, discharge planning, etc. • Review practitioner/facility/geographic area specific reports for trends/patterns in utilization; • Formulate recommendations for specific practitioners/providers for further study;

	• Examine reports of the appropriateness of care for trends or patterns of under- or over- utilization and refer for performance improvement or corrective action if indicated; • Review the Care/Case Management (CM) process, including referrals, care plan (prioritizing goals and barriers), and discharge planning, etc.; • Examine results of annual surveys of members and practitioners regarding satisfaction with UM processes and Population Health and Clinical Operations (PHCO) programs, including but not limited to CM, StartSmart for Baby, and Disease Management (DM); • Create and implement a feedback mechanism for communicating findings and recommendations, as well as a plan for implementing corrective actions; • Liaison with the QIC for ongoing review of indicators of clinical quality; • Evaluation of the effectiveness of activities to include analysis and recommendations of policy decisions based on identified trends, barrier analysis, and interventions required to improve member quality of care and/or service, and member experience, and implements corrective actions as appropriate; • Prioritization of quality improvement efforts, facilitation of functional area collaboration, and assurance of appropriate resources to carry out quality activities; • Maintain records documenting activities, findings, recommendations, and actions, including meeting minutes, signatures, and dates reflecting decisions made follow-up actions.
Reports To	Quality Improvement Committee
Committee Chair	Chief Medical Officer, individual meetings may be chaired by a Medical Director or network practitioner at the discretion of the Medical Director.
Committee Composition	• Executive Leadership • Chief Medical Officer/Medical Director • Designated Population Health and Clinical Operations (PHCO) staff • Designated Quality Improvement staff • Other operational staff as requested, e.g., Networking/Contracting, Member/Provider Services, Compliance, Pharmacy • Network practitioners representing the range within the network and across the service area may participate on the committee
Frequency	Quarterly, with additional meetings scheduled per health plan need
Attendance Required	50% of scheduled meetings.
Quorum	Minimum of 50% of committee members, including two (2) health plan staff and two (2) external practitioners (if included on the committee) must be present for a quorum. All permanent committee members are voting members; the Committee Chair is the determining vote in the case of a tie vote.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting are developed by the Committee Chair in collaboration with the VP/Director of Population Health and Clinical Operations (PHCO).
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are submitted to the QIC and is stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The UMC is authorized by the QIC to make all decisions related to the Population Health and Clinical Operations (PHCO) Program, with decisions made by consensus of the committee. Individuals are responsible to raise issues at committee meetings.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when information is managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Health Equity Improvement Committee (HEI)	
Charter Statement	SilverSummit Healthplan's Health Equity Improvement (HEI) Committee provides guidance and leadership to improve health outcomes and reduce costs associated with health inequities. This committee is focused on ensuring health equity and cultural and linguistic competency to assist in eliminating health care disparities when providing services to the health plan membership. Quality Improvement leadership in partnership with Population Health Management is responsible for the implementation of the Culturally and Linguistically Appropriate Services (CLAS) program (The State's Cultural Competency Plan).
Purpose	The purpose of the Health Equity Initiative (HEI) is to provide oversight and assess cultural awareness, social determinants of health needs, and the appropriateness of diversity- and disability-related considerations in the quality of services and member health outcomes. The HEI supports regulatory oversight through the evaluation of culturally responsive and linguistically appropriate services (CLAS), health equity initiatives, and drivers of health.
Definitions	• Health Equity – The attainment of the highest level of health and well-being for all people, by addressing the systemic and root causes of health disparities. • Health Care Disparity: A measurable difference in health outcomes and access to healthcare services among different populations.
Goals	• Use data to identify and evaluate key health inequities in Nevada using a comprehensive approach to all available data entry points. • Build organizational capacity through coordination across departments and educational opportunities • Direct and support health plan policies and initiatives that reduce disparities for SilverSummit Healthplan members. • Build and enhance partnerships and alliances to engage the communities we serve.
Objectives	• Evaluate data from internal and external sources to identify disparities in Nevada and within SilverSummit Healthplan's membership. • Establish appropriate goals, policies, and leadership accountability throughout the health plan's planning and operations as it relates to health equity, culturally and linguistically appropriate services, and ensuring a diverse, equitable and inclusive workforce and workplace. • Ensure diverse viewpoints are represented. • Ensure there are opportunities for members of culturally representative communities to help identify and prioritize opportunities for improvement. • Integrate strategies for identifying and addressing Drivers of Health into healthcare planning and member care. • Regularly review and communicate progress towards established goals. • Integrate member and community-based organizational perspectives to ensure the health plan is responsive to diverse beliefs and practices and other member needs. • Regularly review and communicate progress towards established goals. Seek out and integrate perspectives of both SilverSummit Healthplan members and representatives of community-based organizations with lived experience as part of historically marginalized and under-resourced communities.
Responsibilities	• Act as an ally for groups experiencing health inequities in Nevada. • Support community-based organizations that work with populations experiencing health inequities. • Evaluate mechanisms and goals to measure the effectiveness of health equity strategies. • Utilize evidence-based quality and performance improvement practices . • Identify and prioritize gaps and opportunities for CLAS and health equity efforts and establish enterprise priorities for health equity. • Review, approve, and support implementation of SilverSummit Healthplan's Health Equity Workplan. • Assist with and support quality improvement workgroups to implement the health equity lens within their work. • Evaluate and develop recommendations for SilverSummit Healthplan health equity and CLAS training needs.

	• Identify need for or support of enhancements to culturally relevant and Drivers of Health-related programs. • Include and empower those who have historically been excluded from decision-making and influential processes to co-develop, with the health plan, solutions for eliminating health inequities. • At least every two years, update the CCP to reflect changes in the population and submit the update to the State. • Post the CCP on SilverSummit Healthplan's member website. • At least every two years, post the CLAS Evaluation on SilverSummit Healthplan's member website, detailing achieved or progressing towards achieving set goals.
Reports To	Quality Improvement Committee
Chairs	Chief Medical Officer/Director or as designee
Composition	• Chief Medical Officer/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
Frequency	Quarterly, open to the public, with additional meetings scheduled per health plan need
Attendance Required	All designee functional areas are required to attend or send a proxy.
Quorum	50% of voting members +1
Agenda	Meetings are agenda driven. Agendas and minutes follow a standard format. Agenda items for the next meeting are developed by the executive sponsors and chairs.
Recorder	Delegated committee designee.
Minutes/Meeting Packets	Draft minutes are completed within 30 days of the meeting, or earlier if necessary to comply with regulatory reporting requirements. Minutes are submitted to the QIC and stored in a secure area. Meeting packets will be sent to committee members prior to the scheduled meeting date with
Minutes/Meeting Packets	sufficient time to provide review of meeting materials, as applicable, based on need for prior review and redacted as appropriate based upon privacy/sensitivity of materials.
Decision Authority	This is a voting committee empowered to set strategic initiatives and establish workgroups to address health disparities as identified in annual objectives. Each designee from all functional areas, or his/her/their proxy, will have 1 vote. If the vote is a tie, the chairs' vote will determine the outcome. All committee members are responsible to raise any issue(s) during committee meetings. The HEI reports to the QIC.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when information is managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Behavioral Health Services Committee (BHS)	
Charter Statement	The Behavioral Health Services Committee (BHSC) in partnership with Health Equity Improvement (HEI) team and Population Health and Clinical Operations (PHCO) department, provides guidance and leadership to ensure that behavioral healthcare is delivered with quality care and services in a culturally competent manner according to the annual Cultural Competency Plan (CCP).
Purpose	The BHSC provides oversight of reducing disparities in behavioral healthcare services to members, and conducts an ongoing review of CCP activities
Responsibilities	• Identify and strategize behavioral healthcare disparities of access, usage, and outcomes 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;

	• Evaluate the mechanisms and goals to measure the effectiveness of the strategies; • Implements a strategy for addressing trauma and providing services in a trauma-informed manner and creates opportunities for a member affected by trauma to rebuild a sense of control and empowerment; • Outreach to members receiving behavioral healthcare service for any feedback to improve the CCP.
Reports To	Health Equity Improvement Committee
Committee Chair	Behavioral Health Director or Medical Director
Committee Composition	• Chief Medical Officer/Director • Behavioral Health Medical Director • VP/Director of Behavioral Health • VP/Director Network Management • VP/Director of Member and Provider Services • Director/Manager of Health Equity • Other SSHP staff from each applicable functional area: Operations, Quality Improvement, Population Health Management, Network Management, and Human Resources • State/Local government officers/employees • Members of behavioral healthcare services, or member advocate • Providers of behavioral healthcare services
Frequency	Quarterly, with additional meetings scheduled per health plan need
Attendance Required	50% of scheduled meetings.
Quorum	Minimum of 50% of committee members, including two (2) health plan staff and one (1) external practitioners (if included on the committee) must be present for a quorum. All permanent committee members are voting members; the Committee Chair is the determining vote in the case of a tie vote.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting are developed by the Committee Chair in collaboration with the Director/Manager of HEI.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are submitted to the HEI and is stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The committee is authorized by the HEI to make decisions and recommendations regarding performance improvement processes. Decisions made by consensus. Individuals are responsible and encouraged to raise any concerns/issues at the committee meetings.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when information is managed in a specific manner.

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. Results from performance improvement efforts and activities planned/taken to improve outcomes compared with expected results and findings are evaluated by the PIT, using 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.

Responsibilities	• Review and evaluate key clinical quality and service performance indicators by collecting and analyzing HEDIS®, CAHPS®, EPSDT reports and other performance measure outcomes and trends such as performance improvements, accreditation file review, provider outreach, member outreach, quality of care concerns, and intervention spotlights; • Evaluate performance for adequate access to care against standards and make recommendations to adjust network as appropriate; • Prompt initiation of ad hoc performance improvement initiatives (including corrective action plans) to address any negative or static trends; • 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; • Overseeing the implementation, progress and effectiveness of the Performance Improvement Projects (PIPs) which are aligned with the Nevada Quality Strategy. • Monitor resource allocation to ensure appropriate support for the Quality Improvement Program; • Track progress of tasks in the annual Quality Improvement Work Plan, make recommendations to improve quality activities noted in the Work Plan as needed, in response to issues raised by the QIC; Provide ongoing reports to the QIC, as appropriate, on the progress of clinical and performance improvement initiatives.
Reports To	Quality Improvement Committee
Committee Chair	VP/Director of Quality
Committee Composition	• Chief Medical Officer / Medical Director • VP/Director of Quality • Designee (Director/Manager) from each applicable functional area, i.e., Population Health and Clinical Operations (PHCO), Network Development & Contracting, Provider Relations/Services, Member Services, Compliance & Regulatory Affairs, Pharmacy • Behavioral Health Provider/Representative • Additional staff may participate as requested by the Chair

Frequency	At a minimum ten (10) times per year
Attendance Required	50% of scheduled meetings
Quorum	50% of members. All permanent committee members are voting members; the Committee Chair is the determining vote in the case of a tie vote.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting will be developed by the Committee Chair.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are submitted to the QIC and stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The committee is authorized by the QIC to make decisions and recommendations regarding performance improvement processes. Decisions made by consensus. Individuals are responsible and encouraged to raise any concerns/issues at the committee meetings.
Evaluation	The Committee will review the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if dissemination of information will be managed in a specific manner.

Provider Services Committee	
Charter Statement	The Provider Services Committee (PSC) is a committee utilized to communicate the health plan's programs and processes to its provider network allowing for collaboration and feedback through discussion with the providers.
Purpose	The purpose of the PSC is to provide input on the health plan provider profiling and incentive programs, and other administrative practices, and supports development of the provider scorecard

	indicators, useful analyses of the data, and effective means of helping providers improve their performance.
Responsibilities	• To provide the health plan with feedback regarding programs and processes from a community provider-based perspective; • To allow providers to make recommendations related to the programs and processes; and • Assist the health plan to identify key issues related to programs that may affect community providers. • Create and implement a feedback mechanism for communicating findings and recommendations, as well as a plan for implementing corrective actions; • Prioritization of quality improvement efforts, facilitation of functional area collaboration, and assurance of appropriate resources to carry out quality activities; • Maintain records documenting activities, findings, recommendations, and actions, including meeting minutes, signatures, and dates reflecting decisions made follow-up actions.
Reports To	Quality Improvement Committee
Committee Chair	Chief Medical Officer/Director and/or VP of Networking/Contracting
Committee Composition	• Chief Medical Officer/Director • The Chair appoints members for committee representation from the provider network (serving one year terms) • Facilities representatives • Ancillary provider representatives • Director of Contracting and Network Management • Manager of Provider Relations, staff as appropriate
Frequency	Quarterly, with additional meetings scheduled per health plan need
Attendance Required	There is no minimum meeting attendance requirement.
Quorum	This is not a voting committee.
Agenda	Meetings are agenda driven. Agenda items for the next meeting are developed by the Committee Chair in collaboration with the applicable department leads.
Recorder	Delegated committee designee (i.e., provider relations staff)
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes submitted to the QIC and stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The PSC is a non-voting committee, intended to solicit direct feedback from the local provider network.
Evaluation	The committee will review the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information will be managed in a specific manner.

Provider Advisory Board (PAB)	
Charter Statement	The Provider Advisory Board (PAB) communicates the health plan's programs and processes to its provider network allowing for collaboration and feedback through discussion with the providers. The PAB serves as a consulting resource in policy and operational matters, and further strengthens the bride between the health plan 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.
Responsibilities	• Provider input on Quality Improvement Program activities, program monitoring, and evaluation; • To provide the health plan with feedback regarding programs and processes from a community provider-based perspective; • To allow providers to make recommendations related to the programs and processes;

	• Assist the health plan to identify key issues related to programs that may affect community Providers; • Establish and review process for responding to provider concerns; • Review and comment on quality and access standards, the Provider Manual, provider education material, policies, and Provider Incentive programs. • Create and implement a feedback mechanism for communicating findings and recommendations, as well as a plan for implementing corrective actions; • Prioritization of quality improvement efforts, facilitation of functional area collaboration, and assurance of appropriate resources to carry out quality activities; • Maintain records documenting activities, findings, recommendations, and actions, including meeting minutes, signatures, and dates reflecting decisions made follow-up actions.
Reports To	Quality Improvement Committee
Committee Chair	Chief Medical Director and/or VP Networking/Contracting
Committee Composition	• Chief Medical Officer/Director • The Chair appoints members for committee representation from the provider network (serving one year terms) • Facilities representatives • Ancillary provider representatives • Director of Contracting and Network Management • Provider Relations staff as appropriate
Frequency	Quarterly, with additional meetings scheduled per health plan need
Attendance Required	There is no minimum meeting attendance requirement.
Quorum	This is not a voting committee.
Agenda	Meetings are agenda driven. Agenda items for the next meeting are developed by the Committee Chair in collaboration with the applicable department leads.
Recorder	Delegated committee designee (i.e., provider relations staff)
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are submitted to the QIC and stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The PAB is a non-voting committee, intended to solicit direct feedback from the local provider network.
Evaluation	The committee will review the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information will be managed in a specific manner.

Member Advisory Board (MAB)	
Charter Statement	The Member Advisory Board (MAB) is a group of members, parents, legal representative or guardian, and SilverSummit Healthplan staff as appropriate, that reviews and reports on a variety of quality improvement issues, initiatives, and activities.
Purpose	The primary purpose of the MAB is to keep members informed of quality initiatives and results; review Member Satisfaction results, improve service quality and member experience in the program.
Responsibilities	The MAB solicits member input into the quality improvement program, quality initiatives and member experience with the quality improvement program. • The MAB recommends program enhancements, review satisfaction survey results, and provide feedback on the health plan performance levels. • Create and implement a feedback mechanism for communicating findings and recommendations, as well as a plan for implementing corrective actions; • Prioritization of quality improvement efforts, facilitation of functional area collaboration, and assurance of appropriate resources to carry out quality activities;

	• Maintain records documenting activities, findings, recommendations, and actions, including meeting minutes, signatures, and dates reflecting decisions made follow-up actions.
Reports To	Quality Improvement Committee
Committee Chair	Director/Manager of Quality Improvement
Committee Composition	• Manager of Quality Improvement • Manager of 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
Frequency	Quarterly, with additional meetings scheduled per health plan need
Attendance Required	A minimum of twelve (12) members and individuals representing the racial/ethnic and linguistic groups that constitute at least 5% of eligible individuals. 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, twelve (12) members. This is not a voting committee.
Agenda	Meetings are agenda driven. Agenda items for the next meeting are developed by the Committee Chair in collaboration with relevant member input.
Recorder	Delegated committee designee.
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are submitted to the QIC and stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The MAB is a non-voting committee to solicit feedback from Health Plan members.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information will be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Member Service Committee	
Charter Statement	The Member Service Committee (MSC) is a group of members, parents, guardians, member advocacy groups, and health plan staff as appropriate, that reviews and reports on a variety of quality and service issues. The health plan understands that the ability to effectively engage stakeholders, including members/family members/caregivers, advocates, and community organizations in the quality program is a crucial component of our collaborative efforts to enhance a patient-centered service delivery system, to optimize clinical outcomes, and to positively affect program operations.
Purpose	The purpose of the MSC is to solicit member input into the approach and effectiveness of the health plan programs, policies, and services, and to promote a collaborative effort to enhance the service delivery system in local communities. The MSC represents the geographic, cultural and racial diversity of our membership across the state. The committee provides input for quality improvement activities, program monitoring and evaluation, and member, family, and provider education, and/or other topics as defined by the Quality Improvement Committee (QIC).
Responsibilities	The MSC solicits member input into the quality programs. Based on the health plan size and distribution, the MSC may include regional level committees. • Members are randomly selected in accordance with the Managed Care Reform and Patient Rights Act; • Members may be informed about the committee through such materials as the member handbook, member newsletters, contacts at community events, and the health plan website;

	• The health plan will provide an orientation and ongoing training for MSC members, so they have sufficient information and understanding of the managed care program to fulfill their responsibilities; • The MSC preferably meets in-person to promote two-way communication where members can provide input and ask questions and the health plan can and obtain direct feedback from members; and • The MSC recommends program enhancements, review satisfaction survey results, and provide feedback on the health plan performance levels. • Prioritization of quality improvement efforts, facilitation of functional area collaboration, and assurance of appropriate resources to carry out quality activities; • Maintain records documenting activities, findings, recommendations, and actions, including meeting minutes, signatures, and dates reflecting decisions made follow-up actions.
Reports To	Quality Improvement Committee
Committee Chair	Director of Member Services
Committee Composition	• Director of Member Services • Members - may volunteer or be suggested by staff • Parents/foster parents/guardians of child members - may volunteer or be suggested by staff • Health plan staff as indicated • Quality Department designee • Members and families/significant others of members
Frequency	Quarterly, with additional meetings scheduled per health plan need
Attendance Required	No minimum attendance required.
Quorum	This is not a voting committee.
Agenda	Meetings are agenda driven. Agenda items for the next meeting are developed by the Committee Chair in collaboration with relevant member input.
Recorder	Delegated committee designee.
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes submitted to the QIC and stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The MSC is a non-voting committee to solicit feedback from Health Plan members.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information will be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

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 health plan 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.
Responsibilities	• Oversee the health plan 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 SilverSummit Healthplan. 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.
Subcommittee	Joint Operating Committees: One per subcontractor and responsible for the monitoring of the subcontractor performance.
Reports To	Quality Improvement Committee
Committee Chair	VP/Director of Compliance
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
Frequency	Quarterly, with additional meetings scheduled per health plan need
Attendance Required	50% of scheduled meetings
Quorum	50% of members. All permanent committee members are voting members; the Committee Chair is the determining vote in the case of a tie vote.
Agenda	DVOC chair with input from committee members and vendors will develop Agenda items for the meetings.
Recorder	Delegated committee designee.
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are submitted to the QIC and stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The QIC authorizes DVOC to make all recommendations regarding the status of the delegation agreement. Recommendations are by consensus of committee members. Committee members are responsible to raise any concerns/issues at the committee meetings.
Evaluation	The committee reviews the charter annually.

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

QUALITY DEPARTMENT STAFFING

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

Chief Medical Officer or Director	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 and Clinical Operations (PHCO) Programs, and the Grievance System.
Senior Medical Director, Quality	The health plan's Quality Medical Director has 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 and the Quality Improvement Program.
Quality Improvement VP or Director **Quality Improvement VP or Director**	The Vice President/Director of Quality Improvement is a registered nurse or other qualified professional with demonstrated experience in healthcare, data analysis, barrier analysis, and project management related to improving clinical quality of care and service delivery for members. This role reports to designated executive leadership and is responsible for directing quality staff activities related to monitoring and auditing the Health Plan's healthcare delivery system. Oversight includes, but is not limited to, internal processes and procedures, provider networks, service quality, clinical quality, equitable hiring and recruitment practices, and policies that promote diversity, equity, and inclusion reflective of the communities served. The Vice President/Director collaborates with leaders across all functional areas to ensure culturally and linguistically appropriate services (CLAS) are embedded and effectively implemented to support a diverse membership. This commitment is advanced through policy development, operational practices, and the strategic allocation of human and financial resources to ensure CLAS integration across departments such as medical management, customer service, provider services, quality, and information technology. This executive supports senior clinical and non-clinical leadership in overseeing operational activities to achieve the Health Plan's goal of improving member health status and outcomes. Responsibilities also include coordinating Quality Improvement Committee activities in collaboration with the Chief Medical Officer/Medical Director, participating in corporate committees and projects as requested, reviewing statistical analyses of clinical, service, and utilization data, and recommending performance improvement initiatives grounded in best practices.
Quality Improvement Manager	The Quality Improvement Manager holds a bachelor's degree in nursing or a related field, or possesses equivalent managed care experience. This role is responsible for the management and oversight of quality and performance monitoring activities across the Health Plan. The Quality Improvement Manager collaborates with multiple departments to establish objectives, policies, and strategies that support quality initiatives aimed at improving operational and program efficiencies and advancing member health outcomes. He or she develops and maintains systematic processes and governance structures to ensure quality, promote continuous improvement, and sustain organizational accountability. This role is also responsible for maintaining departmental documentation to support State contract requirements and accreditation standards, including but not limited to policies and procedures, quality focus studies, quality improvement activities, routine control monitoring reports, access and availability analyses, member experience analyses, continuity and coordination of care documentation, and the annual evaluation of the effectiveness of the Quality Improvement Program. Additionally, this manager oversees HEDIS activities,

	including the coordination of documentation, data collection, and reporting to the National Committee for Quality Assurance (NCQA) and the State, as required. A manager provides oversight of accreditation activities to ensure compliance with NCQA standards by conducting routine readiness assessments, evaluating policies and procedures, and reviewing operational processes and records. This role leads the development and implementation of strategies to achieve and maintain NCQA accreditation and ensures a continuous state of accreditation readiness. A manager is also responsible for implementing and overseeing the Cultural Competency Plan (Health Equity Program), with a focus on reducing health disparities through root cause analysis, targeted initiative development, implementation of Culturally and Linguistically Appropriate Services (CLAS), and the collection, measurement, and analysis of data to monitor progress. The Manager promotes efficiency, service excellence, and value within the Health Equity Program by monitoring performance, identifying improvement opportunities, and implementing strategies to address identified gaps. Managers plans, organizes, and leads multiple concurrent projects utilizing cross-functional teams to meet strategic objectives and deliver defined outcomes. The Quality Improvement Manager also collaborates with State, County, and local agencies to promote services that improve health outcomes, reduce health disparities, and lower the overall cost of care.
Quality Improvement Coordinator or Specialist **Quality Improvement Coordinator or Specialist**	Quality Improvement Coordinators/Specialists are highly trained clinical and non-clinical professionals with significant experience in healthcare settings, including expertise in data analysis and/or project management. At least one Quality Improvement Coordinator or Specialist employed by the Health Plan is a registered nurse. The scope of work for this staffer may include conducting medical record audits; collecting and analyzing data for quality improvement studies and activities; implementing improvement initiatives; reviewing, investigating, and resolving quality-of-care concerns; and responding to complaints, including follow-up review of risk management and sentinel or adverse events. Quality Improvement Coordinators/Specialists may specialize in a specific area of the quality program or be cross-trained across multiple functional areas. They collaborate with internal departments, as needed, to implement corrective actions and improvement initiatives identified through the Health Plan's quality improvement activities and quality-of-care reviews.
Quality Improvement Additional Staff	Member Experience Coordinator EPSDT Coordinator Member Outreach Coordinator Provider Quality Liaisons Quality of Care Coordinators Critical Incident Coordinators
HEDIS Director or Manager	The HEDIS Project Director/Manager is a highly experienced professional with expertise in managed health care, data analysis, and project management. This role is responsible for maintaining departmental documentation to support State contract requirements and accreditation standards, including but not limited to policies and procedures, quality focus studies, quality improvement activities, routine control monitoring reports, meeting minutes, access and availability analyses, member experience analyses, continuity and coordination of care documentation, delegated vendor oversight, and the annual evaluation of the Quality Improvement Program's effectiveness. He or she collaborates with internal departments to implement corrective actions and improvement initiatives identified through quality improvement activities and quality of care reviews. Additionally, this role oversees the coordination, documentation, collection, and reporting of HEDIS measures to the National Committee for Quality Assurance (NCQA) and the State, as required.
HEDIS Additional Staff	HEDIS Coordinator, HEDIS Abstractor, HEDIS Trainer Data Analytics & Reporting Manager Data Analysts
Quality Accreditation Specialist	The Accreditation Specialist reports to and supports the Quality Improvement Manager in achieving and maintaining the Health Plan's NCQA Accreditation and HEDIS reporting processes and requirements. This role is responsible for implementing objectives, policies,

	and strategies that promote a continuous state of accreditation readiness and support successful accreditation outcomes. The Accreditation Specialist leads and supports documentation preparation and submission for accreditation surveys and serves as the Health Plan's subject matter expert on accreditation standards and requirements.
Quality Health Equity Project Manager	The Project Manager reports to and supports the Quality Improvement Manager in achieving and maintaining the Health Plan's NCQA Health Outcomes Accreditation. This role is responsible for developing, implementing, and overseeing Health Equity programs and ensuring the integration of cultural competency across operational initiatives. The Project Manager oversees cultural competency and Health Equity requirements involving external stakeholders and government agencies, including Government Relations, network providers, and delegated entities. Responsibilities include leading and coordinating workforce development initiatives related to cultural competency and implementing and maintaining the Health Plan's Health Equity Plan with a focus on Culturally and Linguistically Appropriate Services (CLAS). Additionally, the Project Manager leads organizational health disparities initiatives by identifying root causes of inequities, developing and implementing targeted interventions, and collecting, measuring, and analyzing data to monitor progress in reducing disparities. This role collaborates with State, County, and local agencies to promote services that improve health outcomes, reduce health disparities, and lower the overall cost of care.

QUALITY IMPROVEMENT PROGRAM RESOURCES: INFRASTRUCTURE AND DATA ANALYTICS

SilverSummit Healthplan has the technology infrastructure and data analytics capabilities to support goals for improving health outcomes, cultural competency and linguistic assistance services, to provide appropriate and accessible quality care, quality management and value to members. SilverSummit Healthplan's health information systems collect, analyze, integrate, and report encounter data and other types of data to support quality analysis, demographic analysis, utilization, 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 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 Centene Data and Analytics Hub (CDAH), 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, 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 from Member Relations Manager and Provider Relations Manager systems; receives service authorization information in near real time from TruCare, the clinical documentation and authorization system; and is integrated with encounter production and submission software.

TRUCARE

Member-centric health management platform for collaborative care management, care coordination and behavioral health, condition, and utilization management. Integrated with Centelligence for access to supporting clinical data, TruCare and TruCare Cloud allow

Population Health 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 Assessment/Performance Improvement:
    - Quality Improvement Program Description;
    - Quality Work Plan; and
    - Quality Improvement Program Evaluation.

- Other ongoing documentation:
    - Performance Improvement Projects
    - Plans of Correction, as applicable/identified
    - Policies and Procedures

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 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 WORK PLAN

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

Quality Improvement leadership, or its designee, is responsible for reviewing data and reports used to monitor progress toward established goals for all measures throughout the year. SilverSummit Healthplan conducts an annual review of the Quality Work Plan to ensure continued alignment with organizational priorities, accreditation standards, and applicable State and federal requirements and deliverables related to the Quality Improvement Program.

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. Monthly performance metrics are reported by the Performance Improvement Team and documented within the Work Plan throughout the year (HEDIS, CAHPS, Disparity Variances, etc.) , along with associated evaluations and intervention updates. 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 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 all quality activities, the impact of effectiveness 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 Work Plan for the subsequent year. The senior quality executive and Quality VP/Director are responsible for coordinating the evaluation process and a written description of the evaluation and work plan is provided to the Quality Improvement Committee and Board of Directors for approval annually.

The annual Quality 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 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;
- Evaluation of completed and ongoing quality activities that address quality and safety of clinical care, quality of service, improvement in CLAS and reduction of healthcare disparities;
- Evaluation of processes to prevent, detect, and remediate critical incidents, including monitoring effectiveness and implementing corrective actions as needed.
- Assessment of the quality and appropriateness of care furnished to all members, including availability of services, second opinions, timely access (including access to specialists), and cultural considerations, with a report of aggregate data indicating methods used to monitor compliance;
- Evaluation of the quality and appropriateness of care provided to members receiving Long-Term Services and Supports (LTSS) using the State's Functional Needs Assessment tool;
- Evaluation of the quality and appropriateness of care provided to members with special health care needs and behavioral health conditions through comprehensive screening assessments. These assessments evaluate physical, behavioral, and co-morbid conditions, as well as psychosocial, environmental, and community support needs, to determine the need for care coordination and/or case management services;
- Demonstration of improvement in identified areas of poor care coordination by monitoring member progress against individualized treatment plans and goals at defined intervals, based on acuity level and plan of care, with particular focus on members with special health care needs and those receiving LTSS;
- Assessment of member grievances and appeals and the functionality of the process conducted throughout the year, with cross-departmental collaboration amount Member Experience, Provider Relations, Medical Management, and Claims.
- Description of mechanisms used to monitor and enforce consumer rights and protections that ensure consistent responses to complaints of violations of these rights and protections;
- Evaluation of collaboration with internal departments to identify and address ~~detect both~~ underutilization and overutilization of services. Analysis of utilization data trends is used to detect aberrant utilization patterns and promote the appropriate use of services through established utilization management process;
- Interventions implemented to address the issues chosen for performance improvement projects and focused studies;
- Measurement of outcomes;
- Measurement of the effectiveness of interventions;

- An analysis of whether there have been demonstrated improvements in the quality of clinical care and/or quality of services;
- Identification of limitations and barriers to achieving program goals;
- Recommendations for the upcoming year's Quality Work Plan;
- Description of meeting requirements for the development and dissemination of clinical practice guidelines;
- 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; 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 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. The Evaluation is submitted to the State in accordance with the Reporting Requirements exhibit.

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. The health plan adheres to Nevada's ADA Technology Accessibility Guidelines and the most current Web Content Accessibility Guidelines. 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 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, to facilitate External Quality Review Organization (EQRO) analytical review to assess the quality of care and service provided to members, and to identify opportunities for improvement, SilverSummit Healthplan supplies claims and encounter data to the appropriate EQRO and works collaboratively to assess and implement interventions for improvement.

MEMBER EXPERIENCE

SilverSummit Healthplan supports continuous ongoing measurement of member experience by monitoring member inquiries, complaints/grievances, and appeals; member satisfaction surveys; member call center performance; and direct feedback from member focus groups and other applicable committees. The Quality Department analyzes findings related to member experience and presents results to the 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. The annual CAHPS survey includes questions related to the quality, availability, and accessibility of care to provide insight into opportunities for improving the member experience. The survey sample may include members who have requested a change in their primary care physician or facility, as well as members who have requested to disenroll from the health plan. The sole sampling criterion is that members must have been enrolled in the health plan for at least six consecutive months. Once survey results are summarized, the health plan identifies areas requiring improvement and potential sources of member dissatisfaction. The plan then prepares follow-up actions based on the findings and develops internal, member-facing, and provider-facing interventions that drive performance improvement. The health plan collaborates with subcommittees of the Quality Improvement Committee to review and address aspects of the member experience that can be improved. Survey results are shared with members and providers via the health plan's website, and improvement plans are communicated to network providers to support and strengthen the overall member experience strategy.

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 Engagement 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 the 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 and Clinical Operations (PHCO) staff, member services staff, provider services staff, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, state partners, Medical Directors, or the Board of Directors may inform the Quality Department of potential quality of care issues and/or critical incidents. Potential quality of care issues require investigation of the factors surrounding the event to determine severity and need for corrective action, up to and including review by the Peer Review Committee as indicated. Potential quality of care issues and

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

In addition, the health plan monitors quality-of-care and/or adverse events through claim-based reporting mechanisms. An adverse event is defined as an event over which health care personnel could have exercised control and that is associated, as a whole or in part, with medical intervention rather than the underlying condition for which such intervention was provided. All potential adverse events and Provider Preventable Conditions (PPCs) are investigated by a clinical Quality Improvement (QI) Specialist. The Specialist conducts an initial review to determine whether the event meets criteria for further clinical investigation. When an event or PPC occurs in a facility setting, the review may be conducted in collaboration with the facility's quality management process to confirm awareness of the event and ensure alignment with facility level investigations. The Health Plan cooperates fully with facility quality management procedures.

If the event does not meet the definition of a quality-of-care concern or PPC (for example, if it represents an expected clinical outcome), no further investigation is conducted. When additional review is warranted, the QI Specialist prepares a confidential case file summarizing the findings for Medical Director review. Investigations may include, but are not limited to, analysis of claims data, utilization management documentation, medical record audits, and consultation with members, providers, or other individuals with direct knowledge of the event.

The Medical Director may request consultation from a board-certified practitioner with relevant clinical expertise and may assign a severity level or refer the case to the Peer Review Committee for further review and determination.

While the occurrence of an adverse event does not inherently indicate a preventable quality-of-care issue, SilverSummit Healthplan tracks and trends all adverse events by type, location, and other relevant factors to monitor member safety. When a quality-of-care issue is substantiated, the health plan initiates further investigation and, as appropriate, requires corrective action plans to address identified deficiencies.

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.).

CRITICAL INCIDENTS

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

SilverSummit Healthplan maintains an internal tracking grid in which all incidents are logged, monitored, and tracked through resolution. The tracking grid documents reporting timelines, investigation status, escalation actions, and resolution outcomes, providing evidence of compliance with the 24-hour reporting requirement in accordance with contractual expectations and prior feedback. The grid also supports ongoing monitoring for trends, identification of repeat provider concerns, and documentation of follow-up remediation activities.

Additionally, SilverSummit Healthplan submits an individual critical incident report for the following incidents:

- A major injury or trauma that has the potential to cause prolonged disability or death of a Member and occurs in a facility licensed by the State to provide publicly funded behavioral health services;
- An unexpected death of a Member that occurs in a facility licensed by the State to provide publicly funded behavioral health services;
- Unauthorized leave of a mentally ill, sexual, or violent offender from a mental health facility or secure Community Transition Facility (i.e., Evaluation and Treatment Centers, ICSS units, Secure Detox Units, and Triage Facilities) that accept involuntary admissions; and
- Any event involving a Member that has attracted or is likely to attract media attention related to their care and/or services covered under this Contract.

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

Critical incidents are reported to the State in accordance with the Reporting Requirements exhibit. The report must include:

- The date the health plan became aware of the incident;
- The date of the incident;
- A description of the incident;
- The name of the facility where the incident occurred or a description of the incident location;
- The name(s) and age(s) of member(s) involved in the incident;
- The name(s) and title(s) of facility personnel or other staff involved;
- The name(s) and relationship(s), if known, of other persons involved and the nature and degree of their involvement;
- The member's whereabouts at the time of the report if known (e.g., home, jail, hospital, etc.) or actions taken by the health plan to locate the member if their location is unknown;
- Actions planned or taken by the health plan to minimize harm resulting from the incident; and
- Any legally required notifications made by SilverSummit Healthplan.

Follow-up reports on individual critical incident resolution and closure is sent to the State using the Incident Reporting System and close the case within 45 calendar days after the critical incident is initially reported. A case cannot be closed until the health plan provides the following information to the State:

- A summary of any information gathered pertaining to the event/incident;
- Where the member is located (including prison, jail, a hospital or other inpatient facility, the community, etc.), or if the member cannot be located, the steps the health plan has taken to locate the member using available local resources;
- Whether the member is receiving services, including the types of services provided if applicable; and
- In the case of the death of a member, verification of death from official sources that includes the date, name, and title of the sources, or if official verification cannot be made, documentation of all the health plan attempts to retrieve it.

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.

The Plan has written policies and procedures for ensuring provider compliance. Selected physicians/practitioners sampled are informed of the upcoming audit with documentation guidelines and a list of patients whose records have been chosen for review. Communication is shared with the Provider to disclose the overall score, any areas of deficiency and a copy of the completed/scored audit tool within 15 business days of the audit. A letter also includes recommendations for improvement if the score was below 100%. Elements scoring below 80% are considered deficient and in need of improvement. Providers failing to meet the 80% compliance standard are placed on a corrective action plan (CAP).

Standards for medical records must, at a minimum, include requirements for:

- Patient Identification Information. Each page on electronic file in the record contains the patient's name or patient identification number;
- Personal/Demographic Data. Personal/biographical data includes: age, sex, race, ethnicity, primary language, disability status, address, employer, home and work telephone numbers, and marital status;
- Allergies. Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies-NKA) is noted in an easily recognizable location;

- Past Medical History [for patients seen three or more times]. Past medical history is easily identified including serious accidents, operations, and illnesses. For children, past medical history relates to prenatal care and birth;
- Vaccinations for Pediatric Records [ages 20 and under]. There is a completed immunization record or a notation that vaccinations are up to date with documentation of specific vaccines administered and those received previously (by history).
- Diagnostic information;
- Medication information;
- Identification of Current Problems. Significant illnesses, medical conditions and health maintenance concerns are identified in the medical record;
- Alcohol or SUD. Notation concerning cigarettes, alcohol and SUD is present for patients twelve (12) years and over and seen three or more times;
- Consultations, Referrals, and Specialist Reports. Notes from any consultations are in the record. Consultation, lab, and x-ray reports filed in the chart have the ordering physician's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging study results have an explicit notation in the record of follow-up plans;
- Emergency care;
- Hospitals and Mental Hospitals:
    - Identification of the Member; Physician name; Date of admission; Initial and subsequent stay review dates; Reasons and plan for continued stay if applicable; Date of operating room reservation if applicable; Justification for emergency admission if applicable; and Hospital Discharge Summaries. Discharge summaries are included as part of the medical record for all hospital admissions that occur while the Member is enrolled with the Contractor and prior admissions, as necessary.
- Advance Directive. For medical records of adults aged eighteen (18) and over, the medical record documents whether or not the individual has executed an advance directive and documents the receipt of information about advance directives by the Member and confirms acknowledgment of the option to execute an advance directive.
- Patient Visit Data. Documentation of individual encounters must provide at minimum adequate evidence of:
    - History and Physical Examination, Comprehensive subjective and objective information obtained for the presenting complaints; Plan of treatment; Diagnostic tests; Therapies and other prescribed regimens; Follow-up/Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. A specific time to return is noted in weeks, months, or as needed. Unresolved problems from previous visits are addressed in subsequent visits; Referrals and results thereof; and all other aspects of patient care, including ancillary services.
- Entry Date. All entries must have date and time noted;
- Provider Identification. All entries are identified as to author;
- Legibility. The record is legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.

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 ensures that at least 90% of members who have an identified need for ongoing home health, private duty nursing, and personal care services can initiate those services within 14 calendar days of the need(s) being identified. 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.

SilverSummit Healthplan implements targeted activities to improve access to covered services. Assessment on community resources and stakeholder feedback to identify the most significant access issues across its geographic service area(s) and focus access improvement activities on those issues. The health plan dedicates at least 40% of its access improvement efforts to the Rural Service Area. As part of its continuous quality improvement activities, the health plan collaborates with other MCOs to implement and sustain regional access collaboratives. SilverSummit Healthplan is required to develop Access Improvement Reports and submit them to the State on an annual basis.

The Quality Department report results to the Performance Improvement Team and/or the Quality Improvement Committee for consideration of corrective action if opportunities are identified. Results are included in the annual Quality 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, behavioral health practitioners, and high-volume and high-impact specialists, including OB/GYNs. 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. Primary Care and Behavioral Health Care offices are 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 COORDINAITON 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 medical practitioners and data on member movement across settings. Continuity and coordination between medical and behavioral healthcare practitioners 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.

Long-Term Services and Supports (LTSS) are available to members who require ongoing care due to age, physical or intellectual disability, or chronic illness. Services are delivered in the member's home or in a long-term care facility based on individual needs and preferences. Members are assessed for LTSS, including Personal Care Services (PCS) and Private Duty Nursing, using the State's Functional Needs Assessment tool and reviewed for clinical appropriateness. Members receiving LTSS are reevaluated periodically, typically every six months or annually, to determine continued need for services. Service receipt is confirmed through claims data and electronic workflow (EW) documentation for personal care or home health services. LTSS services include, but are not limited to:

- Personal Care Services (PCS): Assistance with activities of daily living, meal preparation, and light housekeeping.
- Private Duty Nursing: Skilled nursing services including medication management, wound care, and monitoring of vital signs.

SilverSummit Healthplan promotes the integration of members receiving LTSS into the community by approving services delivered in the home whenever appropriate, as this represents the least restrictive care setting. Members may self-refer for LTSS services, and referrals may also be received from practitioners, contracted agencies, or following hospitalization. Population Health Management (PHM) care managers conduct an initial telephonic screening and schedule a Functional Needs Assessment to determine service needs and appropriate service hours. The assessment and medical necessity determination guide authorization decisions and support the goal of maintaining member independence within the community. As part of the ongoing evaluation process, the assessment includes a comparison of the services and supports actually received by the member with those authorized in the approved treatment or service plan.

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

PREVENTIVE HEALTH REMINDER PROGRAMS

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

- General and supportive member and provider education such as articles in member and provider newsletters, face-to-face interactions, and written educational materials provided to members at health fairs, diaper distribution events, etc.;
- Targeted telephonic, 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 PHM Strategy Description and includes a comprehensive plan for managing the health of its enrolled population, reducing disparities, improving health outcomes, addressing health care opportunities, 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 90 days of enrollment by performing a health risk screening which includes assessing for member risk based on social determinants of health, emerging risk, and other risks. A universal screening tool is utilized that includes questions relating to social determinants of health such as housing, food, transportation, and interpersonal violence. Decision support encourages informed health care decisions by providing members with education about their condition(s) and treatment options, and by supporting members to make informed treatment decisions in collaboration with their providers. SilverSummit Healthplan's condition management and population health management programs help members understand their diagnoses, learn self-care skills, and adhere to treatment plans. 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 Directors. The goals and objectives of the behavioral health activities are congruent with the Population Health Solutions health model and are incorporated into the overall care management model program description, which involve efforts to monitor and improve behavioral healthcare.

SilverSummit Healthplan has at least one arrangement with a behavioral healthcare organization (as defined by NCQA) to share data that supports HEDIS reporting as specified by NCQA.

Special populations such as serious mentally ill (SMI) or serious emotional disturbance (SED) 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 shares quality program initiatives and results, 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 MAB/MAC is comprised of a diverse and demographically representative group of participants that reflect the community. As defined by the charter, the MAB/MAC consists of community members, health plan members from across the Rural, Urban Clark and Urban Washoe service areas, 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 MAB/MAC includes discussions focused on improving service quality and enhancing the members' experience. SilverSummit Healthplan encourages and supports meaningful member participation in quarterly meetings by implementing strategies that include, but are not limited to accommodating virtual participation, distributing meeting materials in advance, providing materials at literacy levels appropriate for participants, arranging transportation when appropriate, and offering childcare support when feasible to facilitate adequate participation

Both the MAB/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. Meeting minutes and supporting information are shared with Plan leadership and incorporated into QI initiatives, as appropriate, to address identified gaps and improve performance. Meeting minutes from the Member Advisory Board (MAB) are submitted to the State within thirty (30) days following each meeting and posted on the health plan's website.

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 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.

Network providers are include on the Utilization Management (PHM/UM/CM), and Provider Advisory Board that reports to the Quality Improvement Committee. The Provider Advisory Board must have broad representation of provider types in the network, including at least one PCP serving children and adolescents, one PCP serving adults, one OB/GYN, one psychiatrist, one licensed behavioral health clinical professional, one substance abuse professional, one community-based care coordinator or community case manager serving a network provider, one peer support specialist or a behavioral health case manager, and other practitioners, such that there is broad representation from across the geographic service areas. The Provider Advisory Board meets quarterly with meeting minutes posted on the health plan's website in accordance with the Reporting Requirements exhibit.

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. Clinical practice guidelines are communicated through multiple channels, including but not limited to, the Provider Manual, the SilverSummit Healthplan website, and provider newsletters. These guidelines are available to all members and prospective 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, and

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.

PERFORMANCE IMPROVEMENT ACTIVITIES

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

The Health Plan utilizes established quality, risk management, population health, and utilization management methodologies to identify activities relevant to Health Plan programs and specific member populations that address observable, measurable, and manageable issues. Improvement initiatives are identified through analysis of key clinical and non-clinical indicators of care and service, using reliable data that demonstrate opportunities for improvement.

Baseline data used to identify and prioritize initiatives may include, but are not limited to:

- Performance profiling of contracted providers, including mid-level, ancillary, and organizational providers
- Provider office site evaluations
- Focused studies
- Utilization data, including indicators of overutilization and underutilization
- Sentinel event monitoring
- Trends identified through member complaints, grievances, and appeals
- Issues identified through care coordination activities
- Referrals from internal and external sources indicating potential quality concerns, including those identified by affiliated hospitals and contracted providers

SilverSummit Healthplan monitors for potential underutilization of services to ensure that all Medicaid and Nevada Check Up covered services are provided as required. When underutilization is identified, the Health Plan conducts a timely investigation and implements corrective actions, as appropriate, to address the root cause of the issue.

Additional initiatives may be selected to evaluate innovative strategies or to meet State or federal contractual requirements. Projects and focused studies are designed to reflect the characteristics and needs of the population served, including consideration of cultural preferences, health equity and 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 (PIPs), focused studies, and other quality initiatives ~~are~~ designed to achieve and sustain significant improvement over time in both clinical and non-clinical care areas. These initiatives utilize ongoing measurement and targeted interventions and are conducted in accordance with principles of sound research design and appropriate statistical analysis. Validated, data-driven quality improvement methodologies such as the Plan-Do-Study-Act (PDSA) cycle, year-over-year trending, and statistical analysis are used to monitor PIP performance and evaluate the impact and effectiveness of quality improvement and health equity initiatives. Full PIP assessments incorporate PDSA cycles, longitudinal trend analysis, and statistical evaluation, with a focused emphasis on interventions designed to address disparities among specific populations.

When establishing PIPs, the health plan adheres to applicable Centers for Medicare & Medicaid Services (CMS) guidelines. PIPs are focused on clinical and non-clinical areas that are expected to have a favorable impact on health outcomes and Member experience and includes the following components:

- Measurement of performance using objective quality indicators;
    - Identify and use quality indicators that are objective, measurable, and based on current knowledge and clinical experience,
    - Monitor and evaluate quality of care through studies which include, but are not limited to, the quality indicators specified by CMS for the priority areas selected by the State,
    - Ensure sufficient methods and frequency of data collection, data accuracy, and data effectiveness in detecting the need for program changes.
- Implementation of system interventions, detailing support mechanisms to achieve improvements in access to and quality of care;
- Documentation of the processes used to assess the quality and appropriateness of care provided to members with Long-Term Services and Supports (LTSS) and special health care needs, including the methods used to evaluate and determine the need for direct access to specialists.
- Evaluation of the outcome and the effectiveness of interventions is conducted by comparing performance measure rates against established benchmarks and goals as part of the PIP or other identified performance measures; and

- Initiate activities for increasing or sustaining improvement by modifying, adding, or removing interventions and the reasons for the change.

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.

SilverSummit Healthplan conducts a minimum of three PIPs annually at the direction of the State. The health plan collaborates with other MCOs to identify and develop PIP topics for State review and approval on an annual basis. At least one PIP must address a non-clinical area. SilverSummit Healthplan reports the status and results of each PIP to the State in accordance with the Reporting Requirements exhibit. Each PIP is completed within a reasonable timeframe to allow the State to evaluate PIP outcomes as part of its annual review of the Quality Improvement Program or IQAP. Written guidelines for PIPs and related activities include a specification of clinical or health service delivery areas, how monitoring and evaluation of care reflects the populations served in terms of age groups, disease categories, and special risk status, including CYSHCN, and how monitoring and evaluation, of care and services reflect certain priority areas of concern selected by the State from those identified by CMS and the State's Quality Strategy.

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 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 Appeals & Grievance Committee (A&G) as well as 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 grievances are tracked, investigated, and resolved by the Appeals and Grievances (A&G) team and are reported at each A&G Committee meeting to identify trends and discuss improvement opportunities. The Provider Relations team conducts any required remediation and/or provider education based on identified issues. Provider appeals are managed by the appropriate team based on the appeal type or subcategory. Appeals related to medical necessity are handled by the A&G team, while appeals related to claims or payment in accordance with contract or program requirements are managed by the Claims team. All appeals are logged upon receipt and routed to the appropriate team for review and resolution.

REGULATORY COMPLIANCE AND REPORTING

SilverSummit Healthplan departments perform required quality of service, clinical performance, and utilization studies throughout the year based on contractual requirements, requirements of other state and regulatory agencies and those of applicable accrediting bodies such as NCQA. All functional areas utilize standards/guidelines from these sources and those promulgated by national and state medical societies or associations, the Centers for Disease Control, the federal government, etc. The Quality Department maintains a schedule of relevant quality reporting requirements for all applicable state and federal regulations and accreditation requirements and submits reports in accordance with these requirements. Additionally, the Quality 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 OUTCOME ACCREDITATION

SilverSummit Healthplan adheres to the belief that NCQA Health Plan and Health Outcome 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.

SilverSummit Healthplan has achieved NCQA Health Plan and Health Equity Accreditation in December 2025. Centene has achieved NCQA Health Plan and Health Outcome Corporate Accreditation for specific elements, which reduces the burden for affiliate health plans to become accredited. In addition, Centene 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.

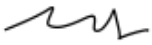
If the delegation arrangement includes the use of protected health information (PHI) the delegation agreement also includes PHI provisions, typically accomplished in the form of a Business Associate Agreement signed by the delegated entity.

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 and Clinical Operations (PHCO), Quality and/or Compliance designees, in conjunction with Centene Corporate Compliance designees, conduct an annual evaluation and documentation review that includes the delegate's program, applicable policies and procedures, applicable file reviews, and

review of meetings minutes for compliance with health plan, state and federal requirements and accreditation standards. The health plan retains the right to reclaim the responsibility for performance of delegated functions, at any time, if the delegate is not performing adequately.

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

ENDORSEMENT OF THE Quality Improvement Program Description
The Quality Improvement Program Description has been reviewed and endorsed by the quality senior leadership effective this day of 30, month of March, 2026.



Upinder Singh MD, Senior Quality Medical Director

Dr. Steven D. Evans

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Date: 2026.03.31 06:15:03 -07'00'

Steven Evans MD, Chief Medical Officer

Jennifer Tonges

Digitally signed by Jennifer Tonges
Date: 2026.03.31 09:55:51 -07'00'

Jennifer Tonges, VP Quality Improvement/Management