Culturally and Linguistically Appropriate Services (CLAS) Program Description

INTRODUCTION

Centene Corporation is a diversified, healthcare enterprise that provides a portfolio of services to government-sponsored healthcare programs, focusing on under-insured and uninsured individuals. Founded as a single health plan in 1984, Centene Corporation (Centene) established itself as a national leader in the healthcare field. Today, through a comprehensive portfolio of innovative solutions, we remain deeply committed to delivering results for our stakeholders: state governments, members, providers, uninsured individuals and families, and other healthcare and commercial organizations through a holistic, customized approach to care for our members based on their unique physical, behavioral, pharmaceutical, cultural and social needs.

For purposes of this document, "the health plan" refers to SilverSummit, a Centene Corporation health plan. The health plan is contracted to deliver services to Medicaid recipients. It operates as a managed care organization and does not operate licensed clinical facilities or directly deliver in-person or synchronous clinical care. The health plan is committed to the practical application of strategies and innovative interventions to transform the health of the community, one person at a time.
The health plan is committed to providing every member with care that meets recognized professional standards and is delivered in the safest, most appropriate setting. The health plan supports physicians and other providers in delivering high-quality, equitable care that aims to reduce gaps in health outcomes and strengthen the well-being of all members by ensuring services are clinically appropriate, timely, and accessible.
The health plan recognizes and respects each member's background, health beliefs and practices, language needs, abilities, and preferred ways of receiving health information. This commitment applies to all members, regardless of race and ethnicity, national origin, sex, sexual orientation, preferred language, disability status and accommodation needs, social risks factors, or level of health literacy.
The health plan is committed to collecting and using member data to identify and monitor disparities, stratify quality and experience measures, and guide targeted improvement activities. These data are used to inform program design, evaluate progress, and support accountable, transparent reporting to leadership.

The health plan leadership team is committed to aligning clinical, network, and operational processes to improve accessibility of services, the delivery of culturally and linguistically appropriate care, and improved health outcomes for all members. These efforts include goals to enhance each member's experience of care and service, reduce the per-person cost of care, and improve the work life, experience, and satisfaction of network providers and their staff.

The health plan systematically monitors service accessibility, including appointment availability, timeliness of care, physical and digital accessibility, language access services, and network adequacy. Identified barriers related to access or appropriateness of care are used to guide targeted interventions and improvement activities. The health plan engages members, caregivers, and community partners to understand local needs, incorporate member perspectives, and collaborate on the design and evaluation of programs that reduce inequities and improve access, experience, and health outcomes.

The health plan CLAS Program applies a systematic approach to quality and the advancement of health equity. The approach uses reliable and valid methods for monitoring, analysis, evaluation, and improvement science across health care delivery systems and processes to promote service appropriateness and accessibility. Methods such as "Plan, Do, Study, Act (PDSA)" and other validated, data-driven approaches to quality

improvement, are used to monitor performance and assess the effectiveness of equitable, quality improvement initiatives.

This type of methodology enables the health plan to develop targeted, measurable, locally tailored, culturally relevant interventions and to quickly evaluate the impact of an activity on improvement goals. In many instances, the health plan uses rapid cycle improvement activities designed to produce immediate process improvements that enhance member outcomes, reduce inequities in care, and improve member and provider satisfaction. These systematic approaches create a continuous cycle for improving the quality of care and service for members.

The CLAS Program Description is a written document that outlines the health plan's structure and process to monitor and improve service appropriateness and accessibility through the delivery of culturally and linguistically appropriate services. The CLAS Program Description includes:

- The program's purpose, scope, and organizational framework, including program leadership, roles, and accountability for implementation
- State of Nevada Cultural Competency Program & Plan requirements
- Program goals and objectives for improving service appropriateness, accessibility, and reducing disparities
- The annual work plan used to operationalize activities
- Outlines systematic approach for monitoring and tracking trends, evaluating progress through an annual program evaluation, and guiding improvement activities
- Review and oversight through established governance bodies (including annual review/approval as applicable)

I. PROGRAM PURPOSE

The CLAS Program serves as the health plan's program to improve the appropriateness and accessibility of services, including addressing cultural, linguistic, disability-related, and other access needs. The health plan is committed to delivering culturally and linguistically appropriate services (CLAS) that support equitable access to care, effective communication, and responsive service delivery for all members. The CLAS Program is designed to ensure that policies, processes, and practices that affect member experience are culturally appropriate, linguistically accessible, responsive, and inclusive to the needs of the populations served, including individuals with limited English proficiency, disabilities, varied health beliefs and practices, and differing levels of health literacy.

The CLAS Program is aligned with and supported by the organization's Quality Improvement framework, utilizing systematic and reliable methods to monitor, evaluate, and improve culturally and linguistically appropriate service delivery across applicable points of contact. Activities focus on improving access, communication, and member and provider experience and are implemented in coordination with broader quality, health equity, and population health initiatives.

State Contract Requirement 6.3 & 6.3.2.A

The CLAS Program incorporates the state-required Cultural Competency Program requirements as per Contract Section 6.3.

Throughout this CLAS Program Description state contract requirements will be added to ensure alignment between the CLAS Program and the Cultural Competency Program and Plan. Moving forward the term CLAS Program is utilized to incorporate both plans unless specified otherwise.

A. OVERALL PROGRAM OBJECTIVES

The CLAS Program aims to ensure that all members, including those from various cultural and linguistic backgrounds, receive equitable, culturally responsive, and linguistically appropriate care and services that improve access, experience and health outcomes and reduce inequities. The CLAS Program objectives are to:

- **Ensure equitable access to health care services and information** by delivering member-facing communications, programs, and service interactions that are culturally appropriate, linguistically accessible, and responsive to diverse accessibility needs across all applicable points of contact including administrative, clinical, and service interactions.

- **Improve the appropriateness of care and services** by systematically recognizing and addressing cultural beliefs, language preferences, health literacy levels, disability-related needs, age-related considerations, and social factors that influence members' ability to access, understand, and engage in care and services.

- **Identify and reduce barriers to access, experience, and service utilization** by using reliable and repeatable methods to collect, analyze, and act on data related to cultural, linguistic, communication, and accessibility-related barriers that may contribute to disparities in care or member experience.

- **Support informed and meaningful member engagement** by ensuring that health information, communications, and service interactions are clear, understandable, culturally responsive, and delivered in formats that enable active participation in health care and service-related decisions.

- **Integrate service appropriateness and accessibility principles into organizational operations** by aligning policies, processes, workforce readiness, digital and physical accessibility practices, and practitioner-facing activities to support consistent, responsive service delivery across the health plan.

- **Improve outcomes through continuous improvement** by using performance data, member feedback, grievance and appeals trends, community input, and evaluation findings to inform targeted, culturally relevant improvement activities that address identified needs and opportunities across the member population.

State Contract Requirement 6.3.1.A, 6.3.1.B, 6.3.1.C, 6.3.1.F, 6.3.2.B & 6.3.2.I

Additional objectives determined by the State Contract and 2025-2027 Quality Strategy are:

- **Participate in State and federal efforts** to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

- **Provide accessible and high-quality services in a culturally competent manner** including providing effective, equitable, understandable, and respectful quality care and services that is responsive to the languages, health literacy, and other communication needs of the health plan membership

- **Support the state of Nevada** in meeting the 2025-2027 NV Quality Strategy Goal 7 to reduce and/or eliminate health care disparities for Medicaid members by December 31, 2027. Found at https://www.nevadamedicaid.nv.gov/siteassets/content/resources/adminsupport/reports/NV20252027_Quality_Strategy_F1_2.pdf.

- **Maintain the** NCQA Health Outcomes Accreditation

- **Incorporate State requirements** related to Behavioral Health pursuant to Nevada Revised Statutes (NRS) 422.2734. Found at www.leg.state.nv.us.

The CLAS Program is informed by demographic, geographic, disparity, and social needs insights to ensure cultural, linguistically appropriate service delivery and accessibility across member-facing services. While the CLAS Program uses these insights to guide planning, monitoring, and evaluation of service appropriateness and accessibility, responsibility for identifying, prioritizing, implementing, and evaluating workforce initiatives, disparity reduction strategies, and social risk interventions remain with their respective organizational programs (e.g., Quality Improvement, Health Equity, Workforce, Population Health). Outputs from these programs are used by the CLAS Program to inform planning, implementation, and evaluation, including the identification of opportunities to strengthen communication, access, and culturally responsive service delivery.

II. PROGRAM SCOPE

NRS Requirement 422.2734.2a

The CLAS Program applies to member-facing services, communications, and operational processes that influence service appropriateness and access to care and services for members. The scope of the CLAS Program is designed to ensure that members are able to meaningfully access information, services, and supports in a manner that is responsive to cultural, linguistic, and accessibility needs across applicable points of contact, and applies to all members served by health plan across applicable demographic groups, products, lines of business, benefit packages, and care settings, including medical, behavioral health, dental, and vision services, as applicable to the health plan's benefit design.

The CLAS Program applies to all member-facing services, communications, and operational processes that influence access to care and service appropriateness. The scope includes:

- **Language and Communication Services:** Interpreter services (telephonic, video, in-person), translation of vital documents, alternate formats (Braille, large print), and accessible accommodations for members with disabilities.

- **Digital and Physical Accessibility:** Accessible digital content (screen-reader friendly, plain language, large text options) and physical accommodations (height-adjustable exam tables, accessible diagnostic equipment).

- **Member-Facing Interactions:** Administrative, clinical, and service touchpoints where cultural, linguistic, or accessibility barriers may affect understanding, engagement, or experience.

- **Practitioner Network Responsiveness:** Activities to support culturally and linguistically appropriate care, including sharing member-level language and accommodation needs with practitioners and offering training on language services and disability accommodations.

- **Data and Analytics:** Collection and use of demographic and accessibility data (race, ethnicity, ancestry, national origin, immigration status, income level, familial status, language, sex, sexual orientation, disability status, accommodations, geography) to identify disparities, monitor progress, and inform improvement activities.

The CLAS Program leverages demographic, language, geographic, disability, social needs, and health outcomes insights to ensure accessible care, and the delivery of culturally and linguistically appropriate services. These insights inform organizational understanding of membership needs and barriers to optimal outcomes. Responsibility for identifying prioritizing, implementing, and evaluating workforce expertise, accessibility accommodations, and social risk interventions remains with the appropriate organizational programs, ensuring clear governance, accountability, and alignment. Outputs from these activities are used to inform planning, implementation, and evaluation, including the identification of opportunities to strengthen communication, access, and culturally responsive service delivery.

B. ORGANIZATIONAL FUNCTIONS IN SCOPE

1. ORGANIZATIONAL READINESS: TRAINING AND DEVELOPMENT (CLAS ENABLEMENT)

State Contract Requirement 6.3.1.D, 6.3.1.E, 6.3.2.E & 6.3.3.A

The organization is committed to building workforce-capacity to provide culturally responsive, linguistically appropriate, and accessible services to all members. Workforce-related insights, including aggregate information on experience, expertise, training, and employee feedback, are referenced by the CLAS Program as inputs to inform planning, implementation, and evaluation of culturally and linguistically appropriate service delivery activities. At least annually, we offer training to all employees on topics that improve the quality of care or service delivery and reduce health disparities. Training topics include culturally and linguistically appropriate practices, unique health or healthcare needs of relevant subgroups in our membership, practices to improve impartiality of care, practices to reduce ableism in care or services, inclusive and non-stigmatizing data collection practices, and trauma-informed care approaches. Training may be delivered through multiple formats including live webinars, recorded modules, and in-person sessions, and may be tailored to different staff roles while ensuring all employees have the opportunity to participate. The organization tracks training offerings and participation through our Learning Management System.

State Contract Requirement 6.3.2.D & 6.3.2.E

The Quality Improvement Project Manager is responsible for the completion and the management of the Cultural Competency Plan and noted within the position's job description. If there is a change in the individual staff member the state must be notified. The Quality Improvement Project Manager Job Description is available in Appendix A.

2. PRACTITIONER NETWORK AND CARE SITE RESPONSIVENESS (CLAS ENABLEMENT)

State Contract Requirement 6.3.2.H

The CLAS Program supports culturally responsive practitioner–member interactions by promoting communication, trust, and understanding across the care continuum. Recognizing that effective practitioner–patient relationships enhance care coordination and member experience, the organization seeks to ensure

that members have access to practitioners and care teams who are prepared to meet the cultural, linguistic, and accessibility needs of members.

Consistent with Health Outcomes Standards, practitioner language information and practice-level language services are made available to support informed member choice and access to culturally and linguistically appropriate care.

Information related to practitioner language capabilities, cultural expertise, and available language services is collected and maintained through established provider enrollment and credentialing processes. These data are used as inputs to inform culturally and linguistically appropriate service delivery, member communication strategies, and identification of opportunities to enhance access and choice for members.

Annually, practitioner network language capacity and cultural responsiveness are assessed through the CLAS Program Evaluation. The CLAS Program evaluation assesses whether practitioner network-related insights and analyses conducted under applicable Health Equity and network programs informed and enabled culturally and linguistically appropriate services during the measurement period.

Where gaps are identified, findings are escalated through established quality, provider network, and health equity governance structures and inform action planning, monitoring, and improvement activities implemented through applicable provider network, quality improvement, or health equity programs. The CLAS Program does not independently manage practitioner network operations but provides governance, evaluation, and integration to ensure identified needs are addressed. Publication of practitioner language, language services, and race/ethnicity information, including physician directory content and Member Services response processes, is governed through provider network and member experience operations and is informed by CLAS principles.

III. PROGRAM STRUCTURE AND ACCOUNTABILITY

C. GOVERNANCE AND ACCOUNTABILITY

The CLAS Program to Improve Service Appropriateness and Accessibility is organized through:

- **Governance & Oversight:** Board of Directors → Quality Improvement Committee → subcommittees/advisory committees as applicable.
- **Program Leadership & Planning:** Senior Manager, Performance & Quality Improvement leads annual program planning, including the work plan, evaluation inputs, and reporting cadence.
- **Operational Execution:** Member Services, Provider Services, Compliance, IT/Digital, Population Health/Clinical Ops, and Health Equity implement program activities within their functions.
- **Monitoring & Reporting:** Quality Analytics/Reporting produces routine dashboards and reports; findings are reviewed through governance forums and escalated as needed.

While multiple committees support the organization's Program to Improve Service Appropriateness and Accessibility, oversight is conducted through designated quality and health equity governance forums as part

of routine quality management processes. Committees listed below provide enterprise quality oversight; however, only committees with service appropriateness and accessibility and CLAS-related responsibilities review activities, progress, and evaluation findings as applicable to their scope. Documentation of review and actions is maintained in relevant committee records.

The CLAS Program is overseen through the health plan's established quality governance structure, which provides accountability, strategic direction, and review of program performance. Related activities, progress, and evaluation findings are reviewed through applicable quality and oversight committees as part of routine quality management processes.

Committees involved in oversight are responsible for reviewing program status, identifying barriers, approving improvement actions as appropriate, and escalating issues to senior leadership and the governing body. Governance bodies supporting service appropriateness and accessibility, and CLAS-related activities operate under approved charters and maintain accountability for their respective scopes of responsibility.
Service, accessibility, and CLAS related matters are integrated into existing governance forums rather than managed through standalone committees, ensuring alignment with broader quality, health equity, and operational priorities.

Quality and equity are integrated throughout the health plan and represent the strong commitment to delivering equitable, quality care and services to members. The Board of Directors is the governing body designated for oversight of the Quality Program and has delegated the authority and responsibility for the development and implementation of the CLAS 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 CLAS Program activities, findings, recommendations, actions, and results to the Board of Directors no less than annually. The health plan ensures ongoing member, provider, and community stakeholder input into the CLAS Program through a strong Quality Improvement Committee and subcommittee structure focused on member and provider experience. The SilverSummit Quality Improvement Committee structure is designed to continually promote information, reports, and improvement activity results, driven by the CLAS 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 CLAS Program.

D. FUNCTIONAL AREAS AND RESPONSIBILITIES

- **Quality Department (Program Administration):** Program oversight, work plan coordination, performance monitoring, evaluation coordination, reporting to governance. CLAS strategy input, demographic/disparity insights, culturally responsive interventions guidance, community partnership alignment.

- **Member Services / Customer Service:** Language assistance access, member communication supports, grievance intake trends, accessibility-related service support.

- **Provider Services / Network:** Provider communications about language services, provider cultural responsiveness enablement, provider data (languages) maintenance coordination.

- **Compliance & Regulatory Affairs:** Ensures communications/accessibility requirements meet federal/state requirements; monitors regulatory updates impacting accessibility and accommodations.

- **IT / Digital / Analytics:** Supports data capture (language, disability status, etc.), digital accessibility, reporting infrastructure, and trend dashboards.

- **Grievance & Appeals:** Tracks and reports language/accessibility-related grievances and appeals; routes quality-of-care issues; supports trend analysis.

The health plan committee structure is outlined below:

1. QUALITY DEPARTMENT STAFFING

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

2. CLAS PROGRAM RESOURCES: INFRASTRUCTURE AND DATA ANALYTICS

State Contract Requirement 6.3.2.G & NRS Requirement 422.2734.2a

The health plan has the technology infrastructure and data analytics capabilities to support goals for improving health outcomes, services to provide appropriate and accessible care to members, members, quality management and value. The health plan's health information systems collect, analyze, integrate, and report encounter data and other types of data to support quality analysis, demographic analysis, disparity outcomes and analysis, utilization (including but not limited to language services), complaints/grievances and appeals, care management/coordination, and all quality activities. The IT infrastructure makes data, including race, ethnicity, language, sexual orientation and gender identity, disability status, disability accommodations, geographic classification, and veteran status, available for effective monitoring, analysis, and evaluation

toward improving the delivery, quality, and appropriateness of health care furnished to all members, including those with special health care needs. The health plan IT systems and informatics tools support advanced assessment and improvement of quality, linguistic assistance and appropriate 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.

Direct Member Demographic Data Collection

Demographic data is requested from members, including race, ethnicity, language, sex, disability status, sexual orientation, gender identity and preferred pronouns. The health plan employs multiple direct data collection mechanisms to maximize response rates while respecting member autonomy. All data collection scripts, forms, and workflows include the ability to distinguish between members who decline to answer, members who have not yet been asked, and missing/unknown data. When members are unable to provide responses due to age or functional inability, information collected from caregivers is considered direct data collection. For sensitive data (sexual orientation, disability status), the organization employs non-stigmatizing practices including electronic self-administered surveys, clear explanations of how data will be used, staff training on respectful data collection, and privacy-protected environments for data disclosure.

Race, Ethnicity and Language Data

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. 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.

Sexual Orientation Data

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. 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.

Disability Status and Disability Identity Data

Implementation planning is underway to establish a standardized approach for collecting and assessing disability status and disability identity data by July 1, 2027. This includes:

- Data collection, validation and reporting

- Data governance processes
- Identifying system, workflow and training to support long-term adoption
- Strategies to incorporate disability related data into disparity analyses and quality improvement initiatives

Geographic Classification

Member residential ZIP code data is obtained from member enrollment files (834 files). ZIP codes are mapped to a primary Rural–Urban Commuting Area (RUCA) code following U.S. Department of Agriculture (USDA) guidelines. RUCA codes classify U.S. census tracts based on population density, urbanization, and daily commuting patterns. The organization applies the RUCA framework's ten primary codes for geographic designation.

For analytic and reporting purposes, RUCA codes are further grouped into three meaningful geographic classifications that align with the characteristics of the member population and support comparative analyses: urban / metropolitan, suburban / micropolitan and rural / small town.

Indirect Member Demographic Data Collection

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. If direct race/ethnicity data is not available for a minimum of 80% of the member population, the health plan utilizes indirect data sources that have been evaluated for reliability and validity for the population to which it will be applied (e.g., age group, geography, product line). Imputed data is used only for population-level analysis to identify healthcare disparities. Annually, the health plan uses a reporting and analytics platform to stratify the entire enrolled membership into meaningful subsets. The annual assessment drives the Population Health planning and strategy and uses the information to evaluate current programs and services for impact and the development new interventions and programs to meet needs of our members based on their clinical and sociodemographic factors. By assessing the characteristics and needs of the member population, we can better understand, appropriately segment, and address the needs of our member populations. This includes identifying disparities in member demographics such as race, ethnicity, language, and geography, prioritizing opportunities to advance equity at the neighborhood and health plan level and collaborating across the community to reduce inequities by targeting member, provider, and community interventions.

Indirect Race and Ethnicity Data

While direct collection of race and ethnicity is preferred, when directly collected member data are not sufficient, the health plan uses imputed data for population-level analysis to identify healthcare disparities and improve CLAS. Accuracy is monitored annually by comparing imputed values to self-reported data, and findings inform quality improvement and health equity strategies.

When direct collection is not available, demographic characteristics are estimated using member-level details (e.g., surname) combined with community-level data such as census block or ZIP code. The health plan applies predictive modeling, including analytics and artificial intelligence services to estimate race and 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 with estimates mapped according to U.S. Office of Management and Budget (OMB) guidelines.

Language Data

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. Additionally, the health plan evaluates state-level census

data annually to identify threshold languages spoken in its service area (languages spoken by 1% of the population or 200 individuals, whichever is less, up to 15 languages).

NRS 422.2734.5

SilverSummit Healthplan works closely with state and regulatory agencies to ensure compliance and access to demographic data and technical assistance necessary for program implementation. Additional data may be solicited from members and community organizations to enhance culturally responsive service delivery.

Systems for Member Data

Centelligence

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

The Centelligence platform receives, integrates, and continually analyzes large amounts of transactional data, such as medical, behavioral, and pharmacy claims; lab test results; health screenings and assessments; service authorizations; member information (e.g., current and historical eligibility and eligibility group; demographics including race, ethnicity, language, sexual orientation and gender identity, region, and primary care provider assignment; member outreach), and provider information (e.g., participation status; specialty; demographics that are provided on a voluntary basis, such as race, ethnicity, languages spoken).

The Centelligence analytic and reporting tools provide the health plan with 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 provide key quality personnel with 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, the health plan develops defined data collection and reporting plans to build custom measures and reports, as applicable. The health plan 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 the health plan'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 the health plan 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 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

The health plan'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 health plan 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 health plan staff to manage complaints, grievances, and appeals for all required reporting.

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

3. ORGANIZATIONAL READINESS (CLAS ENABLEMENT AND ALIGNMENT)

The health plan supports contracted practitioners in their efforts to provide competent language services and covered services to members. Contracted providers are advised on how to access language services in the provider operations manual, through routine provider updates, and via online newsletter articles. The services offered to contracted providers are intended to:

- Improve effective communication with members regardless of their language needs
- Support access to and coordination of language services (i.e., interpretation and translation)
- Offer tips for effective communication using interpreters.

State Contract Requirement 6.3.3.B

The plan operates an education program for the practitioners/providers and other subcontractors with direct member contact. The education program is designed to make practitioners/providers and other subcontractors aware of the importance of providing services in a culturally competent manner. The health plan provides sufficient opportunities to train practitioners/providers and other subcontractors in receiving training on how to provide culturally competent services.

NRS Requirement 422.2734.2d & 422.2734.6

SilverSummit Healthplan ensures that all behavioral health services are delivered in a trauma-informed manner by offering on going trauma informed training to our providers that emphasizes:

- Knowledge of and responsiveness to the effects of trauma.
- A focus on physical, psychological, and emotional safety for members.
- Strategies that empower members and restore control over their health and well-being.
- Stakeholder and Member Engagement

Providers are also encouraged to take the online cultural competency trainings offered by the Office of Minority Health on its website. These training modules encourage providers to focus on local population cultural needs and includes:

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

Providers are reminded annually of their responsibility to take cultural competency training through an annual provider newsletter or an annual provider update and in the provider manual. Providers may also call the health plan's toll-free Provider Relations number with any questions they may have about cultural or linguistic issues.

4. MEMBER LANGUAGE ACCESS

State Contract Requirement 6.3.1.G

Ensuring members are aware of available language assistance services is essential for meaningful access to healthcare services. The health plan informs members with limited English proficiency (LEP), as well as those who are deaf or hard of hearing, about language support at every point of contact, including member services, claims, utilization management, disease management, care management, and grievance and appeals processes.

Access and Availability: Spoken and Sign Language Services

State Contract Requirement 6.3.1.H

SilverSummit Healthplan upholds strict quality standards for interpreters, translations, and alternate formats, aligned with 45 CFR 92 (Section 1557 of the ACA). The health plan ensures that spoken language and sign language interpreters accurately and effectively facilitate communication for individuals who are Limited English Proficient (LEP), deaf, deaf-blind, hard of hearing, or hearing impaired. These standards are contractually defined with language service vendors to ensure compliance and service quality.

- Health plan staff may serve as interpreters only if they have undergone a language proficiency assessment and completed required training in effective communication.
- Bilingual employees engaging directly with LEP members are evaluated in target languages, and their language proficiency is documented in the organization's Human Resources system.
- Practitioners and provider offices offering bilingual services attest to proficiency during the credentialing process. This information is included in the provider directory to ensure accurate representation.
- Providers are educated on the availability and appropriate use of health plan language services, in alignment with federal CLAS standards and company policies.
- The availability and accessibility of translation services are not 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 are not encouraged to substitute a friend or relative for a translation service.

Access and Availability: Written Translation Services

State Contract Requirements 6.3.4.A

SilverSummit Healthplan is committed to ensuring that all member-facing materials are accessible, culturally relevant, and easy to understand. Member communications are written in plain language at or below the maximum reading grade level of 6th as defined by the State of Nevada. Readability is assessed using tools such as Flesch-Kincaid Grade Level and Readability Studio. Materials are also designed with consideration for literacy levels, disabilities, cultural differences, and age-specific learning needs. To further support clarity, training in plain language writing is available for all departments involved in producing member materials. Additionally, translation vendors must maintain the original English reading level in their translations to ensure consistency.

State Contract Requirements 6.3.4.A.1, 6.3.4.A.2 & 6.3.4.A.3

The health plan provides translated materials in threshold and prevalent languages as required by state and federal regulations. These materials are available in both mailed and electronic formats, ensuring members receive information in their preferred language. If a language is spoken by 3,000 members or 10% of the plan's LEP population (whichever is less), all materials must be translated into that language. For vital materials—such as notices related to the denial, reduction, suspension, or termination of services—translations are required when a language is spoken by 1,000 members or 5% of the LEP population (whichever is less). Additionally, if a contractor's caseload includes at least 1,000 members with LEP in a particular language, all notices informing members of their right to interpretation and translation services must be provided in that language.

To uphold quality standards, the health plan works exclusively with contracted translation vendors for all non-English written materials and alternate formats, including braille. These vendors are required to provide attestations of quality and adhere to strict accuracy and timeliness requirements outlined in their contracts. Certified bilingual staff may provide sight translation (oral translation of written materials) when available, ensuring members can access critical information in real time. All translation requests, including written and sight translations, are managed in accordance with Centene's CC.QI.CLAS.29 policy.

IV. COMMUNITY ENGAGEMENT AND INPUT

E. MEMBER ADVISORY BOARD

State Contract Requirement 6.3.2.F

The health plan maintains a structured advisory function through the Member Advisory Board (MAB) to obtain substantive input from individuals with direct experience, knowledge, or expertise relevant to the cultural, linguistic, accessibility-related, and other needs of the member population served. The advisory function includes a mix of participants, such as members or program participants and their advocates, community representatives, and practitioners or service providers, as applicable. Committee membership aims to reflect the geographic, cultural, and demographic diversity of the communities served.

Member Advisory Board (MAB) meets on a quarterly cadence, and are tasked with:

- Identifying barriers to service appropriateness and accessibility;
- Providing input on communication needs, language assistance, and accommodation-related experiences;

- Offering feedback on member experience, access to services, and opportunities for improvement; and
- Inform the prioritization, design, and refinement of improvement activities.

Feedback and recommendations from advisory groups are documented in meeting records, summarized by staff, and shared with plan leadership and relevant committees. The health plan uses a structured prioritization process to evaluate advisory group recommendations based on member impact, feasibility, and alignment with strategic objectives. Prioritized opportunities are incorporated into the Quality Improvement Work Plan and Performance Improvement Projects. Outcomes and actions taken are communicated back to advisory groups to ensure transparency and continuous engagement.

The committee Member Advisory Board (MAB) charter outlines the governance structure, roles, and responsibilities that support oversight of the CLAS Program and ensure alignment with organizational goals for service appropriateness, accessibility, and health equity (See Appendix B).

F. BEHAVIORAL HEALTH DISPARITY COMMITTEE

NRS Requirement 422.2734.3a

SilverSummit Healthplan is committed to ensuring that behavioral health services are delivered in a culturally and linguistically competent manner, in alignment with state and federal requirements. The Behavioral Health Disparity Committee is a subcommittee of the Health Equity Committee and aligns the requirements in the NV State Medicaid Contract as well as NRS 422.2734. The purpose of the Behavioral Health Disparity Committee is to ensure that behavioral health services for SilverSummit Healthplan members are provided in a culturally competent manner. The committee will assist with the development, ongoing review, and approval of the CLAS Workplan and development of culturally responsive strategies to identify, address, and reduce disparities in behavioral health access, utilization, and outcomes while promoting trauma-informed care and incorporating member and stakeholder engagement in all improvement efforts.

NRS Requirement 422.2734.3a & 422.2734.4

The Behavioral Health Disparity Committee is an open-invitation committee that reviews and guides the CLAS Workplan. This committee includes state and local government officials, behavioral health providers, consumer advocates, and experts in health equity to provide input. Meetings occur at least quarterly and are open to the public, fostering transparency and community involvement.

NRS Requirement 422.2734.2e

We actively solicit input from members, community partners, behavioral health providers, and other stakeholders to shape our culturally competent behavioral health initiatives. Feedback mechanisms, inclusive of the Behavioral Health Services Committee ensure ongoing collaboration and responsiveness to community needs.

NRS Requirement 422.2734.2b

The Behavioral Health Disparity Committee implements evidence-based strategies to address disparities, ensuring services are equitable and culturally responsive. Each strategy is developed with a clear rationale, measurable objectives, and a focus on sustainable impact. Key performance metrics track the effectiveness of our strategies and evaluate progress toward reducing disparities. Data is reviewed biennially to assess achievement of goals and to refine strategies as needed.

Strategies include analyzing HEDIS data and identifying disparities compared to the highest performing benchmark populations which serve as a standard against which we compare other populations. This helps the health plan understand what is achievable and set realistic goals for improvement. This data is then stratified by race, ethnicity, sex, age, spoken language, zip code. Highlighting where disparities exist allows for a clear view of which groups are not meeting the benchmark and coupled with SDOH/HRSN data to understand the why.

This insight is crucial for developing effective strategies to close these gaps. This data is utilized to determine the impact of gap closures on the overall HEDIS rate, showing how much performance in specific HEDIS measures can improve if disparities are eradicated. Regular monitoring helps identify persistent or emerging disparities in health outcomes among different population groups. This is essential for targeting interventions where they are most needed and for reducing disparities. Year over Year monitoring outcomes is an integral part of the strategy and the PDSA Cycle. It ensures that the health plan is continuously improving on interventions, making data-driven decisions, and staying accountable to the mission of providing equitable care. Through rigorous outcome monitoring, the health plan can effectively address disparities and promote a healthier community for our members.

V. GOAL AND OBJECTIVES

The health plan'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 CLAS Program aligns with the evidence-based priorities from CDC 6|18 Initiative, Healthy People 2020 and 2030, and the National Institutes of Health. The National CLAS Standards SMART goals drive performance improvement and operational excellence.

The health plan's 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 in treating the whole person with dignity, removing barriers to care and fostering local partnerships to enable meaningful, accessible healthcare.

Whenever possible, the health plan's CLAS 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 advancing health equity. The health plan ensures communications are culturally, appropriate, relevant, and meet federal and state requirements. The health plan also promotes the delivery of services grounded in cultural humility for all members, including individuals with limited English proficiency, members from varied cultural and ethnic backgrounds, and members with disabilities, 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 addressing 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.

To facilitate the systemic change in policies, practices, programs, resources, and power structures necessary to address inequity and advance equitable outcomes, the health plan utilizes a quality framework that

operationalizes the work into four pillars which are described below.

- **Capacity Building** – Cultivating human, cultural, financial, and social assets to enable the necessary collaborative for systemic change. This may include, but is not limited to, hiring additional staff, providing training to health plan staff, providers, and/or community members, or contributing financial or staff support to community partners.

- **Shared Accountability** – Convening a representative group of people within the health plan and in the defined communities it serves, to align on the who, what, where, when, and how the work gets done to dismantle inequitable systems.

- **Multifaceted Analysis** – Rigorously collecting, analyzing, sharing, and acting on data to identify priorities, conduct root cause analyses, and address the true drivers of inequity by designing, implementing, and evaluating the effectiveness of interventions.

- **Collaborative Improvement** – Through the activation of community partners and aligned efforts across departments, we jointly identify, design, improve, and evaluate interventions oriented to members, providers, and the wider community.

Overarching long-term goals that set the direction for the program include:

- Ensure meaningful access to culturally and linguistically appropriate services for members and caregivers by increasing/improving language assistance services, culturally responsive communication, and auxiliary aids across all applicable points of contact and reduce communication related grievances.
- Support informed and active participation in health and health care by ensuring that member and enrollee communications are clear, culturally appropriate, linguistically accessible, and responsive to individual needs and preferences.

Strengthen and sustain culturally and linguistically responsive practices by integrating CLAS principles into member-facing operations, provider communications, and service delivery processes. Strengthen culturally and linguistically responsive service delivery by ensuring staff and practitioners who interact with members are prepared to meet various cultural, linguistic, and access needs.

To realize these above-mentioned overarching goals, annually the health plan sets measurable goals also known as Specific, Measurable, Achievable, Relevant, and Timebound (SMART) objectives. The health plan establishes at least one SMART objective each for CLAS and disparity reduction within a clinical measure. Listed below are the annual SMART objectives the health plan has established for this current program year. It should be noted, however, that some SMART objectives will require more than 12 months to achieve. Regardless, progress toward the SMART objective will be evaluated every year.

Measurable Goal/SMART Objective to Improve Appropriateness of Accessibility of Care/Services:

- Reduce the “Unknown Race” designation in provider-reported demographic data from 87% to 83% (a 5% reduction) to improve the accuracy of provider data collection and support more appropriate and accessible care delivery by December 2028.

Measurable Goal/SMART Objective to Reduce Health Care Disparity:

- The health plan will increase Child and Adolescent Well-Care Visit (WCV) completion rates among Hispanic or Latino members (ages 3-21) in Nevada from the current baseline of 49.60% to at least 55.29% (4-Star threshold) by December 31, 2028.

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

NRS Requirement 422.2734.2c
The health plan specifically monitors HEDIS measures related to behavioral health:

- Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (FUM)
- Follow-Up After Emergency Department Visit for Substance Use – 7 Days (FUA)

Once disparate populations are identified, the goal is to reduce the disparities by 5% through prioritized outreach strategies. This is a collaborative effort with our Quality, Population Health, and Community Health Solutions teams.

VI. WORKPLAN

The health plan maintains an annual Work Plan for the CLAS Program and aligns with the goals, priorities, and requirements described in this Program Description.

CLAS Work Plan
The CLAS Work Plan outlines the goals, activities, timelines and responsible staff for improving culturally and linguistically appropriate services; enhancing language access; advancing network cultural responsiveness; and reducing identified health inequities. The CLAS Work Plan includes processes for monitoring CLAS performance, evaluating progress, and incorporating community feedback from the Member Advisory Committee (MAC). CLAS-related activities and measurable objectives in the Work Plan reflect member demographics, known cultural and linguistic needs, language services utilization patterns and opportunities for improvement identified through quality monitoring and community engagement.

The Work Plan is developed annually after completing the CLAS Program Evaluation for the previous year. The Work Plan incorporates evaluation findings, community and member input, and documented recommendations, and serves as the operational roadmap for improving culturally responsive, linguistically accessible, and appropriate service delivery during the upcoming measurement period. The Annual Work Plan reflects ongoing progress and includes, at minimum:

- **Program Scope** outlines the intent and focus of the program to ensure staff understand why the organization is investing in this work and how the program aligns with the organization's mission, vision, and quality priorities.

- **Objectives and planned activities** designed to improve the appropriateness and accessibility of services and reduce identified gaps in care and service delivery, including measurable goals aligned to member demographics, known or expected needs, and opportunities for improvement.

- **Defined timeframes** for completion of each activity and key milestone.

- **Assigned accountability**, including the department(s) and staff role(s) responsible for implementation and reporting.

- **Monitoring of previously identified issues**, including status of prior corrective actions, barrier remediation activities, and sustainability checks.

- **Monitoring and evaluation activities** related to service appropriateness and accessibility, including member communication and accessibility needs, language assistance services, disability-related accommodations, member experience trends, and practitioner network cultural responsiveness, as applicable.

- **Evaluation alignment**, documenting how work plan activities support annual program evaluation requirements and how results will be assessed and reported through governance

QI leadership, or designee, is responsible for review of data collected and/or reports used to monitor progress against goals, for all measures, throughout the year. The health plan annually reviews the existing CLAS Work Plan and confirms compliance with the health plan's current needs, accreditation requirements, and current state and/or federal requirements and deliverables related to the CLAS Program, as applicable. Progress toward CLAS goals is tracked using established performance measures, monitoring tools, and reporting processes.

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

At the discretion of the health plan, the CLAS Work Plan may include activities of all applicable departments (Member Services, Utilization Management, Care Management, Provider Services, etc.) within the health plan, or each department may maintain their own work plan independently. In either case, all work plans are formally approved or accepted by the Quality Improvement Committee at least annually.

VII. MONITORING, MEASUREMENT, AND OVERSIGHT

State Contract Requirement 6.3.5.A

For the CLAS Program, evaluation focuses on implementation, enablement, and alignment with culturally and linguistically appropriate service delivery; evaluation of clinical, disparity, and intervention outcomes is conducted through applicable quality and health equity programs. CLAS Program evaluation emphasizes process effectiveness, integration, and implementation contribution, rather than duplicating outcome evaluations conducted under other quality, workforce, or health equity programs. The CLAS Program Evaluation includes an annual summary of all quality activities, the impact the program has had on member care, an analysis of the achievement of stated goals and objectives, and the need for program revisions and modifications. The Program Evaluation outlines the completed and ongoing activities of the previous year for all departments within the health plan, including activities regarding provider services and network responsiveness, language and member services, utilization management, care management, complex case management, condition management, and safety of clinical care. Program Evaluation findings are

incorporated in the development of the annual CLAS Program Description and CLAS Work Plan for the subsequent year and reported to the State as directed.

G. MONITORING PLAN FOR PROGRAM GOALS

The health plan monitors progress toward CLAS Program goals using defined process and performance measures aligned with program objectives. Monitoring focuses on implementation status, service accessibility, communication effectiveness, and enablement of culturally and linguistically appropriate service delivery. Measures may include, but are not limited to, language services utilization, member experience feedback related to communication or access, grievance and appeal trends associated with cultural or linguistic barriers, workforce training completion summaries, and completion of CLAS Work Plan activities.

Monitoring occurs at least quarterly. Results are reviewed by the Quality Improvement Committee, with escalation to senior leadership and the governing body as appropriate. The Quality VP/Director is responsible for oversight, review, and sign-off of monitoring reports. Monitoring results are used to guide mid-year adjustments and inform the annual CLAS Program Evaluation and subsequent Work Plan

The Senior Manager, Performance Quality Improvement and Quality of Care 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.

H. PROGRAM EVALUATION APPROACH

For the CLAS Program, evaluation focuses on implementation, enablement, and alignment to identify outcomes and includes evaluation of the following:

- Analysis and evaluation of the overall effectiveness of the CLAS Program, including progress toward influencing network-wide culturally appropriate care, safe clinical practices, and:
- An evaluation of the adequacy of resources (e.g. staffing, analytic tools, and training) supporting implementation of the CLAS Program.
- Review of whether CLAS-related findings, monitoring results, and recommendations were reported through established quality and health equity governance bodies, as applicable.
- Review of health plan leadership and practitioner engagement related to CLAS implementation, monitoring, and improvement activities, as applicable; and
- A description of completed and ongoing CLAS-related activities addressing service appropriateness, accessibility, communication effectiveness, and cultural and linguistically appropriate services.
- Trending of CLAS-relevant measures collected over time to assess service appropriateness, accessibility, communication effectiveness, and reduction of identified barriers related to cultural, linguistic, or accessibility needs.
- CLAS-related interventions implemented to address identified barriers to culturally and linguistically appropriate service delivery.
- Measurement of CLAS program outcomes related to access, communication, and service appropriateness.
- Measurement of the effectiveness of CLAS-related interventions in addressing identified cultural, linguistic, or accessibility barriers.
- Analysis of whether CLAS-related activities contributed to improvements in service accessibility, communication, and member experience, as applicable.
- Identification of limitations and barriers to achieving program goals.
- Recommendations for the upcoming year’s CLAS Work Plan.

- Communication of CLAS-related findings and recommendations to applicable committees when issues or opportunities require cross-functional coordination.

State Contract Requirement 6.3.2.C

At the end of the CLAS Program cycle each year (calendar year, in alignment with the State Reporting Requirements Exhibit), the Quality Department facilitates and prepares the CLAS 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 CLAS Program. Recommended changes in program strategy or administration and commitment of resources that have been forwarded and considered by the Quality Improvement Committee should be included in the document.

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

The health plan provides general information about the CLAS Program to members and providers on the website or member/provider materials such as the member handbook or provider manual.

NRS Requirement 422.2734.3b, 422.2734.3c, & 422.2734.3d

The annual documents are submitted for state review and posted on a publicly available website for transparency. The updated plan is submitted to the state and made publicly accessible to demonstrate goal achievement and ongoing improvement efforts.

If required, communication includes how to request specific information about CLAS 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 CLAS Program Description and/or CLAS Program Evaluation, or summary documents.

I. GOVERNANCE OVERSIGHT AND REPORTING

The CLAS Program Description is reviewed and approved by the Quality Improvement Committee, which serves as the organization's designated oversight body for service appropriateness and accessibility. The QIC is accountable to the governing body through formal reporting and escalation processes, including submission of quarterly performance updates and annual program documents for review. Documentation of review and approval is maintained in official QIC meeting minutes and reflected in reports provided to the governing body. This process ensures organizational governance oversight and alignment with strategic priorities for improving cultural responsiveness, language access, and disability-related accommodations.

The CLAS Program Description and associated Work Plan are reviewed within the first quarter of the year on an annual basis in accordance with the organization's quality governance process. Documentation of review, discussion, and approval is maintained in the official meeting minutes of the Quality Improvement Committee.

VIII. APPENDIX

APPENDIX A: STAFFING TITLE AND ROLE

Chief Medical Director/Medical Director(s)	The health plan's Chief Medical Director and supporting Medical Directors (including a behavioral health Medical Director) have an active unencumbered license in accordance with the health plan's state laws and regulations to serve as Medical Director to oversee and be responsible for the proper provision of core benefits and services to members, the Quality Program, the Population Health and Clinical Operations (PHCO) Programs, and the Grievance System.
Quality VP/Director(s)	The VP/Director of Quality is a registered nurse or other qualified person with experience in health care, data analysis, barrier analysis, and project management as it relates to improving the clinical quality of care and quality of service provided to the members. The Quality VP/Director reports to identified executive leadership and is responsible for directing the activities of the quality staff in monitoring and auditing the health plan's health care delivery system and is responsible for oversight of service accessibility and disability-related accommodations, including physical, digital, communication, and auxiliary aid access. This role coordinates with Quality, Member Services, Provider Services, IT, and Health Equity to ensure accessibility needs are identified, monitored, and addressed across member-facing services including, but not limited to, internal processes and procedures, provider network(s), service quality, clinical quality, equitable hiring and recruitment practices, and related policies, promotion of diversity, equity, and inclusion at all levels that reflect the composition of the community served. The Quality VP/Director, or designee, leads annual program planning, including establishing the annual work plan, coordinating cross-functional inputs, ensuring monitoring and evaluation activities occur, and presenting program status and findings with the heads of all functional units to ensure that culturally and linguistically appropriate services are included and properly executed to support the membership. Leadership promotes this through policy, practices, and the allocation of human and financial resources to ensure integration and alignment of CLAS opportunities across the health plan and functional areas (e.g., medical management, customer service, provider services, quality, Information Technology, etc.). The Quality VP/Director assists the senior executive staff, both clinical and non-clinical, in overseeing the activities of the operations to meet the goal of providing health care services that improve the health status and health outcomes of its members. Additionally, the Quality VP/Director coordinates the Quality Improvement Committee proceedings in conjunction with the Chief Medical Director, supports corporate initiatives through participation on committees and projects as requested, reviews statistical analysis of clinical, service and utilization data, and recommends performance improvement initiatives while incorporating best practices as applicable.
Senior Manager, Performance & Quality Improvement	Responsible for implementing the health plan's Health Equity/Cultural Competency Program, including its Health Equity Plan focused on Culturally and Linguistically Appropriate Services (CLAS) and leading its health disparities efforts, including those focused on justice-involved individual members. This position provides collaboration with State, County, and local agencies to promote services that improve health outcomes, decrease health disparities and reduce the cost of care.
Quality Improvement Project Manager	Responsible for managing the Health Equity Program to reduce disparities through determining the root causes of inequities, developing targeted initiatives, implementing Culturally and Linguistically Appropriate Services (CLAS) programs, and collecting, measuring, and analyzing data to track progress in disparity reduction efforts. This position is responsible for maintaining the NCQA Health Outcomes Accreditation and the State required Cultural Competency Plan. This

	position provides collaboration with State, County, and local agencies to promote services that improve health outcomes, decrease health disparities, and reduce the cost of care.

APPENDIX B: MEMBER ADVISORY BOARD (MAB) CHARTER

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 of Operations or designee
Committee Composition	• Manager of Quality Improvement or designee • Manager of Justice Systems or designee • Manager of Population Health Management designee • Behavioral Health designee • Designee(s) from each applicable functional area: Operations, Quality, and Member Services • Members or/and representatives • Member family (Parents/foster parents/guardians/chosen) Members & Families may volunteer or be invited by staff.
Frequency	Quarterly, with additional meetings scheduled per health plan need
Attendance Required	A minimum of twelve (12) members. Committee membership aims to reflect the geographic, cultural, and demographic diversity of the communities served. 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	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.

APPENDIX C: HEALTH EQUITY IMPROVEMENT COMMITTEE (HEIC) CHARTER

Health Equity Improvement Committee (HEIC)	
Charter Statement	SilverSummit Healthplan's Health Equity Improvement Committee (HEIC) 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 Improvement Committee (HEIC) 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 HEIC 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.
Responsibilities	• 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.
Reports To	Quality Improvement Committee
Chairs	VP/Director of Quality Improvement or designee
Composition	• Chief Medical Officer/Director • VP/Director of Population Health • VP/Director of 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, with additional meetings scheduled per health plan need.
Attendance Required	All designee functional areas are required to attend or send a proxy.
Quorum	This is not a voting committee.
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 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 committee is not a voting committee and has no decision authority. Any recommendations are provided to the Quality Improvement Committee for further action. All committee members are responsible to raise any issue(s) during 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.

APPENDIX D: BEHAVIORAL HEALTH DISPARITY COMMITTEE CHARTER

Behavioral Health Disparity Committee	
Charter Statement	The Behavioral Health Disparity Committee 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 Behavioral Health Disparity Committee 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	Quality Improvement Committee
Committee Chair	Behavioral Health Director or Medical Director or designee
Committee Composition	• Chief Medical Officer/Director or designee • VP/Director of Behavioral Health or designee • VP/Director Network Management or designee • VP/Director of Member and Provider Services or designee • VP/Director of Quality or designee • Other SSHP staff from each applicable functional area: Operations, Quality Improvement, Population Health Management, and Network Management • 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	This is not a voting committee.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting are developed by the Committee Chair.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are 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	This committee is not a voting committee and has no decision authority. Any recommendations are provided to the Quality Improvement Committee for further action. All committee members are responsible to raise any issue(s) during 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.