2018
Quality Assessment Performance Improvement Medicaid Program Evaluation

Report Period: January 1, 2018-December 31, 2018

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INTRODUCTION

SilverSummit Healthplan's 2018 Quality Assessment and Performance Improvement (QAPI) Program Evaluation provides an overview and analysis of the quality improvement activities completed in 2018. SilverSummit Healthplan, herein referred to as "SSHP" is committed to providing a well-designed and well implemented QAPI Program that evaluates the quality of care and services available to our members. The program evaluation presented reflects the combined efforts of the various departments contributing to the SilverSummit Healthplan's Quality Improvement Program.

SSHP's QAPI 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, including those with special healthcare needs. This systematic approach to Quality Improvement provides a continuous cycle for assessing the quality of care and service among SSHP's initiatives including preventive health, acute and chronic care, overutilization and underutilization, continuity and coordination of care, patient safety and administrative and network services. SilverSummit Healthplan is committed to the provision of a well-designed and well implemented Internal Quality Assurance Program (IQAP).

SSHP's culture, systems and processes are structured around its mission to improve the health of all Medicaid product line enrolled members. The IQAP 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, including those with special needs. This systematic approach to quality improvement provides a continuous cycle for assessing the quality of care and services in such areas as preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services.

PURPOSE

SSHP's purpose is to integrate its mission to improve the health of all enrolled members by planning, implementing and monitoring ongoing efforts that demonstrate improvements in member safety, health and satisfaction. The program evaluation documents the results of an on-going and continuous evaluation process with a focus on improving both clinical and non-clinical services, and enhancing these services through quality initiatives.

To achieve this purpose, the program encompasses all levels of disciplines within the company. SSHP's recognizes its legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, SSHP will provide for the delivery of quality care with the primary goal of improving the health status of our members.

Membership Demographics

SSHP covers two counties across the state of Nevada, Clark and Washoe. As of December 31, 2018, SSHP's population was composed of a total of 48,016 members. SSHP's TANF population had a total of 22,297 members, Medicaid Expansion had a total of 23,920 members and CHIP a total of 1,799 members. See below table.

Medicaid Product Line	2018 Enrollment
TANF	22,297
CHIP	1,799
Medicaid Expansion	23,920
Total Membership	48,016

The tables below breaks down membership by age, sex, eligibility category and Region

Region	Product	Age Group	Sex	Members
Northern Region	CHIP	0-12 Months	F	1
		1-5	F	34
			M	34
		15-20	F	26
			M	39
		6-14	F	87
			M	85
	Medicaid Expansion	15-20	F	108
			M	70
		21-34	F	617
			M	567
		35-44	F	219
			M	304
		45+	F	476
			M	591
		6-14	F	38
			M	35
	TANF	0-12 Months	F	103
			M	126
		1-5	F	382
			M	414
		15-20	F	192
			M	150
		21-34	F	300
			M	57
		35-44	F	111
			M	32
		45+	F	41
			M	24
		6-14	F	378
			M	403

Region	Product	Age Group	Sex	Members
Southern Region	CHIP	0-12 Months	F	6
			M	11
		1-5	F	136
			M	134
		15-20	F	167
			M	161
		6-14	F	436
			M	442
	Medicaid Expansion	15-20	F	598
			M	538
		21-34	F	3,885
			M	4,598
		35-44	F	1,833
			M	2,247
		45+	F	3,266
			M	3,490
		6-14	F	217
			M	223
	TANF	0-12 Months	F	603
			M	655
		1-5	F	2,493
			M	2,598
		15-20	F	1,343
			M	1,249
		21-34	F	2,153
			M	371
		35-44	F	912
			M	288
		45+	F	319
			M	178
		6-14	F	3,147
			M	3,276

SSHP provided services to members of all cultures, races, and ethnic backgrounds in a manner that recognized individual values and respected the worth of the individual members. SSHP has a Cultural Competency Plan in place, based on the Cultural and Linguistically Appropriate Services (CLAS) standard guidelines. SSHP offers language assistance services to members who require translation services. Services are available for both telephonic and on-site interactions and are arranged by Case Management staff for member conversations with both SSHP's staff and network providers. The table below represents the in person language request for which members have requested translation services.

American Sign Language	17
Tigrinya	5
Spanish	4
Vietnamese	2

Additionally, the table below displays the race/ethnicity of the total population. SSHP uses state provided eligibility data for the most accurate and specific data available specifically related to the total population.

RACE/ETHNICITY	Member Count	% of Total Population
Not Provided	38,367	79%
American Indian or Alaskan Native and Black/African American	127	<1%
Hispanic	1	<1%
Other	5,531	11%
Asian or Pacific Islander	381	<1%
Black	158	<1%
Asian Pacific American	164	<1%
Pacific Islander	353	<1%
White (Non-Hispanic)	2,908	7%
Subcontinent Asian American	40	<1%
Grand Total	48,016	100%

Communication and Language Assistance

SSHP can provide complimentary in-person interpretation to our members if it is scheduled in advance of their appointment, or a free telephonic interpretation service that can be used on-demand. In 2018, twenty-eight request for in-person interpretation was received. SSHP has two separate language vendors, in case one vendor is temporarily out of service. We also monitor these services to assure that members are getting access to the language interpretation they need. In addition to spoken interpretation services, we also provide members with written material translated into any language upon request, including large print and braille. During 2018, one translation request was received for Chinese, during a Member Advisory Committee Meeting. This request was completed and member provider with Member Handbook in Chinese.

Though we have had quality interpretation and translation services at no cost to members or providers since our inception, we strive to make continual improvements to make it even easier for members and providers to access these services.

Analysis

Based upon the analysis of the available data, SSHP's members' prominent language is English, with the most prominent secondary language being undetermined. Race/ethnicity data from SSHP's Membership and Eligibility reports indicate the largest percentage of the population is in the other category (11%), followed by 7% White, Non-Hispanic. This data was obtained through

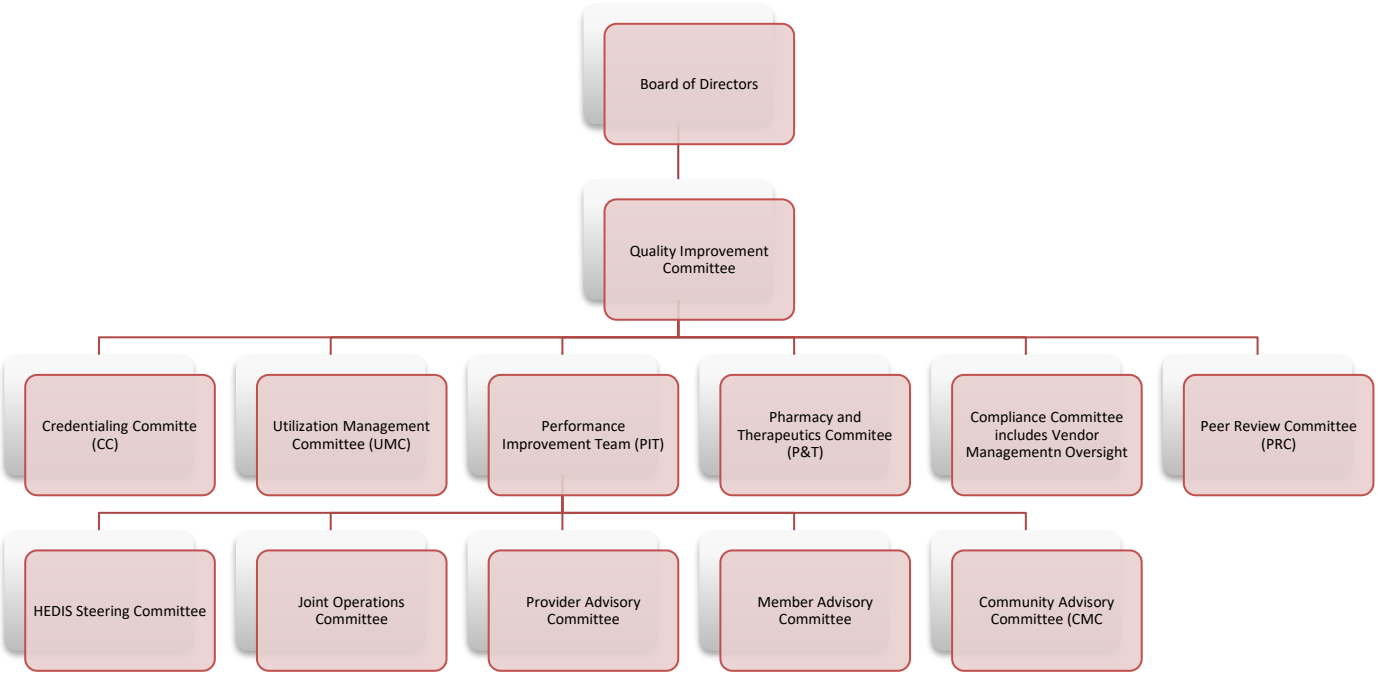
Division of Health Care Financing and Policy (DHCFP) 834 file gathered by SSHP's Analytics in May, 2019.

SSHP investigates member grievances/complaints related to the culturally and linguistically appropriate services (CLAS). For 2018, no grievances were received related to cultural and/or linguistic issues. SilverSummit Healthplan's grievance goal is less than two grievances per member for CLAS grievances/complaints, which was meet for 2018. For quality assurance purposes, SSHP will continue to track and trend grievances and zero (0) is the baseline data evaluation result for CLAS related grievances. All grievances are identified at the time of intake by trained Grievance and Appeals staff. All grievances are investigated thoroughly by the Quality Improvement (QI) Department and reviewed to ensure all systemic issues are identified and addressed.

Program Overview

Committee Structure

The Quality Improvement Committee (QIC) is SilverSummit Healthplan's senior level committee accountable directly to the Board of Directors (BOD). SilverSummit Healthplan's BOD oversees the development, implementation and evaluation of the QAPI Program. The BOD has the ultimate authority and oversight of the quality of care and services provided to members. However, the BOD delegates daily oversight and operational authority to QIC. All quality activities from all quality committees, both service and clinical, are reviewed by the QIC. The SilverSummit Healthplan's Committee structure for 2018 is in the diagram below.



The QIC was chaired by the Chief Medical Director in 2018. The Annual QI Work Plan was updated to reflect completion of all 2018 quality activities. The QIC met four (4) times in 2018.

The below table displays all applicable committees that supported QIC efforts, along with the completed number of meetings held during the calendar year of 2018.

Committee Name	Number of Completed Meetings
Performance Improvement Team (PIT)	10
Credentialing Committee (CC)	12
Utilization Management Committee (UMC)	4
Joint Operations Committee (JOC) with each vendor	4
Pharmacy and Therapeutics Committee (P&T)	4
Compliance Committee * includes Vendor Oversight	4
HEDIS Steering Committee	10
Provider Advisory Committee	2
Member Advisory Committee	4
Community Advisory Committee	2

SSHP's Committee structure was adequate and met all charter requirements/objectives and supported the quality program successfully during 2018. As a result, no changes have been proposed or planned to the committee structure for 2019. There was adequate practitioner participation, quorums and engagement on the QIC, P&T Committee, Utilization Management Committee and the Credentialing Committee.

QI Department Structure & Resources

The Quality Improvement Department Resources met the needs of the program for the year of 2018. The staff included:

- Chief Executive Officer (1)
- Chief Medical Director (1)
- Vice President of Quality (1)
- Quality Improvement Coordinator (2)
- HEDIS Coordinator (2)
- EPSDT Coordinator (1)
- Grievance and Appeals Manager and (1) Grievance and Appeals Coordinator
- NCQA Coordinator (1)

In addition, Quality activities where supported by external practitioners including family practice, internal medicine, pediatrician and a psychiatrist.

Scope of the Quality Improvement Program

The QAPI program is a comprehensive program that utilizes many systems to monitor and trend quality indicators that affect the population it serves. The program addresses both the quality and safety of clinical care and services provided to SSHPs members. The program incorporates all aspects of member demographics, care settings and services in its QI activities. SSHP's QAPI Program monitors the following areas:

- Preventive Care
- Emergency Care
- Primary Care
- Specialty Care
- Acute and chronic Case Management
- Behavioral Health Care (BH)
- Care furnished to enrollees with special health care needs
- Coordination with behavioral health care
- Compliance with member confidentiality laws and regulation
- Compliance with preventive health guidelines and practice guidelines for medical and BH populations
- Continuity and Coordination of Care
- Delegated entity oversight
- Department performance and service
- Employee and provider cultural competency
- Marketing practices
- Member enrollment and disenrollment
- Member and Provider Grievance system and Member and Provider Appeals
- Member satisfaction
- Patient safety
- PCP changes
- Pharmacy drug utilization
- After-hours telephone accessibility
- Provider appointment availability
- Provider complaint system
- Provider Network adequacy and capacity
- Provider Satisfaction
- Selection and retention of providers (credentialing and re-credentialing)
- Utilization Management, including underutilization and overutilization
- HEDIS scores and initiatives

Quality Improvement (QI) Work Plan

The Quality Improvement Work Plan defines the activities, the person(s) responsible for the activity, the date of expected task completion and the monitoring techniques that will be used to ensure completion within the established timeframe. The QI work plan also includes the details of monitoring previously identified issues. The QI Work Plan was presented to the Quality Improvement Committee (QIC) during the 1st quarter, 2018 QIC meeting and was approved and work plan updates were presented during QIC meeting during 2nd and 4th quarter 2018.

National Committee for Quality Assurance (NCQA) Preparation

SSHP is committed to providing best in class health care delivery to its members. SSHP became Interim Survey Accredited in May, 2018 and is scheduled for First Year Survey in December, 2019. Our Quality department is evaluating for performance improvement projects and audits for compliance with NCQA standards and action plans, review of policy and procedures, website information, provider and member handbooks in preparation for the First Year Survey.

2018 Quality Improvement Program Effectiveness

In 2018, activities were conducted to achieve effective and positive outcomes for our members including initiating a pay for performance program for key providers to incentivize for member engagement for preventative visits and screenings, conducting provider and staff cultural competency training to aid in member receiving quality healthcare, implemented an ED Diversion program to ensure members get the right care at the right time at the right place and to help members obtain a PCP for ongoing healthcare, implemented provider access and availability surveys to ensure access to PCP and specialists, tracking and trending of member grievances to address any clinical or safety issues with our members and focus on HEDIS and member satisfaction to ensure members are receiving quality healthcare.

All of SSHP's departments are continuously collaborating toward achieving effective and positive outcomes with its quality initiatives and health care delivery for our members. SSHP facilitates organizational improvements through education, assessments, communication and continued process evaluation that lead to timely identification of barriers and resolutions.

The Quality Improvement was effective with adequate program resources to assess quality of care and safety of clinical care provided by our providers, committees to address program activities and recommend activities for improvement and to ensure safe and quality clinical care for our members, external network providers specializing in family practice, internal medicine, pediatrics and psychiatry along with our Chief Executive Officer and Chief Medical Director to ensure adequate staff, resources and participation to ensure an effective program.

2018 Strengths and Accomplishments

- Membership increase from approximately 34,900 to 48,013
- Conducted a Pay for Performance Program (P4P) for an identified thirteen (13) key providers with incentivizing our providers $2 PMPM for care coordinator of the members assigned to their panel of their panel. A bonus payment of $2 PMPM for four (4) key measures were evaluated for these thirteen (13) providers was completed with a payout of bonus payments of greater than $300,000.00
- Interim Survey Accreditation received
- Conducted Behavioral Health member experience survey with a response rate for adult of 8.3% and Child of 6.8% with an overall satisfied with services of 84.6% for adults and 90.6% for children. The goal for response rate of 15% was not met. The goal of overall satisfaction of 65% was met for both adult and children.
- Conducted a New Member Understanding IVR study with the following results:
  - 199 members completed the survey with a goal of 300 members completing which was not met
  - 63% of new members received their new member packet. The goal of 50% was met
  - 86% satisfied with their coverage. The goal of 65% was met
  - Greater than 80% found information in welcome packet easy to understand. The goal of 55% was met.
  - 50% satisfied with their plan. The goal of 75% was not met.
  - Areas of improvement included boarder network of providers, increase prescription coverage

- Implemented Provider Access and Availability surveys
- Conducted annual provider and SSHP Cultural Competency Training
- Tracked and trended grievance and appeals data for areas of improvement
- Implemented a ED Diversion program

2019 Opportunities for Improvement

- Continue ED Diversion and connecting members with needed resources and a primary care provider, as needed
- Ensure appropriate length of stay (LOS) for members to reduce risk of adverse events in an acute setting
- Decrease inappropriate readmissions to improve member's quality of life and health outcomes
- Achieve First Year Survey NCQA Accreditation
- Implement interventions identified from the areas of New Member Understanding Survey and Behavioral Health Survey for improvement opportunities
- Initiate Corporate P4P program with key providers including new Provider Analytical 2.0 tool for providers to utilize to identify care gaps and measures that need to be addressed
- Focus on the Pay for Performance Program identified in the contract with a goal to meet 100% of all targets
- Continue to conduct HEDIS training for providers and provide pocket-size HEDIS guides for providers
- Continue to track and trend grievance and appeals data for areas of improvement
- Partnership with Nevada Behavioral Health provider to conduct mobile assessments, schedule appointments within 7 days of discharge from ER or hospital and provide wrap around services according to members need

Compliance Program

The Compliance Department is responsible for SSHPs Compliance Program which includes working in collaboration with the Special Investigations Unit of Centene Corporation to monitor and investigate potential fraud, waste and abuse by providers, members and employees. The Compliance Department consists of the Vice President of Compliance, a Compliance Specialists, and Reporting Specialists, a Compliance Analyst and a Compliance Coordinator. Each member of the team works to ensure that the Compliance Program is executed, that Protected Health Information is secured and that instances of potential fraud, waste and abuse are detected and reported to the proper authorities within Centene Corporation, the Division of Health Care Financing and Policy (DHCFP), and the Nevada Attorney General's Office. The Compliance Department also works to ensure that Centene/SilverSummit Health Plan's Business Ethics and Conduct Policy is upheld and that employees are fully aware of company policies and procedures and state and federal laws and regulations that govern SSHP's business activities.

The Compliance Department works in conjunction with SSHP Vice Presidents and Directors and their staff and the Corporate Compliance Reporting team to compile data for state performance reporting requirements. The Compliance Department ensures that DHCFP's templates are implemented and maintains a schedule of reports that are due weekly, monthly, quarterly and annually. The Compliance Department acts as SSHPs liaison to DHCFP for contractual

reporting requirements and investigations. SSHP submitted all required reports to DHCFP within required timeframes during 2018.

The Compliance Department functions as lead for the Compliance Committee. The Compliance Committee membership includes a cross-section of SSHP employees. The Compliance Committee meets quarterly and includes oversight of all vendors. During calendar year 2018, the Compliance Committee met four times.

During 2018 thirty-four cases were referred by our Special Investigative Unit (SIU) to SSHP for action. Twelve were referred to the Medicaid Fraud Control Unit, one to the State Licensing Department. At the end of 2018, twenty-two cases are still open.

Cultural Competency

No gaps in services were identified during calendar year 2018, all members requiring translation/interpretive services received services as requested and none of the member grievances or appeals received were validated for lack of linguistically or culturally appropriate services. During calendar year 2018, the CLAS Program Description, Provider Network Assessment and interventions to improve the cultural competency of the providers serving members were approved by the QIC. In 2019, SSHP will continue its review of services provided by the SSHP to identify any service gaps that require resolution. SSHP will continue to examine data regarding the racial composition of the membership and the health plan and network providers' ability to meet members' cultural and linguistic needs. Currently, the member eligibility file received from the state includes member demographic information and SSHP provider credentialing application records data regarding provider race and the languages spoken by the provider other than English. The Quality Department will continue working with SSHP marketing staff and corporate communications staff to ensure that member education material is translated in prevalent languages and that large font documents are available, if requested.

SilverSummit Healthplan is committed to establishing multicultural principles and practices throughout its organizational systems of service and programs as it works towards the critical goal of developing a culturally competent service system. It is the goal of SSHP to reduce healthcare disparities and increase access to care by providing quality, culturally competent healthcare through strong doctor-patient relationships. SSHP believes all members deserve quality healthcare regardless of their background, and we are committed to ensuring that members receive needed services in a manner that recognizes, values, affirms, and respects the worth of each individual by adhering to the National Standards on Cultural and Linguistically Appropriate Services (CLAS standards). SSHP works to minimize all barriers to care and to preserve the dignity of our members by utilizing the fifteen CLAS standards, developed by the U.S. Department of Health and Human Services' Office of Minority Health.

These standards fall in three areas:

- Governance, Leadership and Workforce
- Communication and Language Assistance
- Engagement, Continuous Improvement, and Accountability

Implementing CLAS standards provides SSHP with clear direction to ensure that we will provide culturally competent services to its members.

Further, SSHP defines cultural competency as the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population. It is the use of a systems perspective which values differences and is responsive to diversity at all levels of an organization, i.e., policy, governance, administrative, workforce, provider, and consumer/client. Cultural Competence is developmental, community focused, and family oriented. In particular, it is the promotion of quality services to underserved, racial/ethnic groups through the valuing of differences and integration of cultural attitudes, beliefs, and practices into diagnostic and treatment methods, and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions, and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

Governance, Leadership and Workforce

In the area of Governance, Leadership, and Workforce in 2018, SSHP conducted the operation of the Cultural Competency Program under the direction of the Vice President of Quality. This Cultural Competency program includes management staff from all areas to ensure buy in from all areas of the organization. In 2018, the Cultural Competency Policies and Procedures were reviewed with no changes made and were presented to the QIC in second quarter 2018 meeting and they were approved.

Education is also conducted annually so all SSHP staff are knowledgeable in cultural awareness and legal requirements. In addition, in 2018, during new orientation workshops held with our providers, cultural competency training is conducted and is done annually thereafter. Also, during contracting and credentialing, all providers must take cultural competency training and attest they have taken and understand cultural competency.

In 2018, during the Member Advisory Committee meetings held quarterly in Reno and Las Vegas, cultural competency training was provided to members to guide them to understanding of the cultural competency program and how it affects them. Members were very receptive to this training and in one instance we received a request to translate the member handbook.

SSHP also strives to recruit, hire and retain a diverse staff. Activities completed in 2018 included establishing a culturally diverse recruitment procedure for new employees, develop a culturally diverse leadership and staffing model for all employees, and develop a culturally diverse retention program for employees. In 2018, all employees were required to take a cultural competency refresher training.

Engagement, Continuous Improvement and Accountability

SSHP makes efforts to recruit and develop a diverse provider network. In 2018, we continued to make efforts to recruit providers in communities that accurately reflect the cultural population (members) who are seeking services in that community. SSHP also assisted providers with the

tools and resources necessary to provide and coordinate care for members with linguistic and disability-related needs, assisted providers with materials needed to maintain cultural competency level of excellence, and included cultural competency information in provider newsletters.

SSHP also strives to partner with our community agencies to assess community cultural needs. This was done through partnerships with community agencies, such as Salvation Army, to assess existing needs, working with our faith and community-based organizations to promote cultural competency.

Care Delivery Performance Measures and Outcomes

Healthcare Effectiveness Data Information Set (HEDIS) Indicators

SilverSummit Healthplan has been proactively capturing necessary data to obtain a baseline for HEDIS rates. In 2018, a HEDIS Steering Committee was implemented and is delegated to oversee initiatives and implementation of interventions related to HEDIS benchmarks. DHCFP has included in the contract a Pay for Performance (P4P) System to provide financial incentives for achieving specific levels of performance in the programs priority areas. DHCFP has reserved the right to implement the P4P Program at any time.

Although DHCFP has not implemented this program, SSHP is aware of this program and is tracking rates for these measures. The following is the Administrative Rates for 2018 and SSHP's baseline rates as this is first year of HEDIS rates for these measures:

	2018 Final Medicaid Rates
NV Core HEDIS Measure	**SSHP**
Children's Access to Primary Care Practitioner (CAP) *12-24 Months*	88.56%
CAP *25 months - 6 years*	72.28%
CAP *12-19 years*	N/A
Childhood Immunization Status (CIS) (*Combo 10*	13.13%
Comprehensive Diabetes Care (CDC) *HbA1c Testing*	79.08%
Prenatal and Postpartum Care (PPC) *Timeliness of Prenatal Care*	66.91%

	2018 Final CHIP Rates
NV Core HEDIS Measure	**SSHP**
CAP *12-24 Months*	94.21%
CAP *25 months - 6 years*	83.54%
CAP *12-19 years*	N/A
CIS *Combo 10*	28.57%

CDC *HbA1c Testing*	N/A
PPC *Timeliness of Prenatal Care*	100%

* Member most have continuous enrollment for prior year and measurement year. Since first year no one meet criteria in 2018

Improving Early, Periodic Screening, Diagnosis and Treatment (EPSDT) Visits

A major goal of SilverSummit Healthplan is to improve the completion of EPSDT visits by members. SSHP informed members about the importance of EPSDT screenings (Well-Child Check-Ups) through the member handbook, at health fairs, and through member brochures.

The CMS-416 report used to track EPSDT compliance calculated a participant ratio of 52% in administrative data in 2018.

EPSDT Participation Ratio

	Totals	Age Group <1	Age Group 1-2	Age Group 3-5	Age Group 6-9	Age Group 10-14	Age Group 15-18	Age Group 19-20
2018 Annual Report	52%	88%	62%	63%	42%	43%	34%	16%

Quality Improvement Activities

State Mandated Performance Improvement Projects

SSHP is committed to the continuous monitoring of its performance related to standards of care and service for enrollees. Through this monitoring process, areas for potential improvement are identified and individual departmental projects are initiated to focus on improving the overall care, service and healthcare outcomes of its members. In 2017, the State issued two performance improvement projects (PIPs):

- Well-Child Visits ages 3, 4, 5 & 6 year olds
- Follow-up within 7 days following emergency room visit for mental health

During 2018, Modules 1-3 were completed and submitted to the State and approved. In 2019, testing phases of modules will be implemented and PIPs finalized by July, 2019.

Two internal PIPs were established in 2018 and completed. These PIPs were:

- Increase usage of CentAccount Rewards Program
- ED Diversion Program

Overall, both PIPs meet their aim statement and were completed in 2018. For 2019, two internal PIPs will be chosen. The PIPs are chosen and oversight is provided through the Performance Improvement Committee which meets at a minimum of ten times a year.

Member Experience and Engagement

2018 Member Grievance Results:

- Access - Total =8
- Billing and Financial Issues - Total =8
- Quality of Care - Total =10
- Attitude and Service - Total =18
- Quality of Practitioner Office Site-=1

For 2018, SSHP had a goal of less than .50 per 1,000 member grievance rate. In 2018, SSHP had a total of 45 grievances which represents a .22 per 1,000 member grievance rate, therefore the goal was meet for 2018. For these grievances, 14 were substantiated and 31 were unsubstantiated. SSHP will continue to track and trend grievances for opportunities for improvement. An analysis of the grievances received to identify any trends was conducted with no trends noted in 2018. SSHP will continue to analysis for any trends and address as identified.

2018 Member Appeal Results:

- Access- total 125

Member appeals for the year 2018 were sub-categorized as follows:

- Pharmacy Denial Appeals =8
- Behavioral Health Appeals =40
  - Inpatient admission -=1
  - Inpatient concurrent review = 1
  - Outpatient =1
  - Other behavioral health services =21
  - Community Based Services =l 2
  - Inpatient continued hospital stay -=14
- Physical Health Appeals=16
  - Consultation- Ophthalmology= 1
  - Consultation- Rheumatology= 1
  - Injections-Epidural= 1
  - Special Services-Pain Management= 6
  - Inpatient-Continued Hospital Stay= 2
  - Outpatient-procedure= 3
  - Physical Therapy= l 13
  - Speech Therapy= 1
  - ME-Other= 2
- Advanced Imaging Appeals - Total =61
  - Radiology- Total =36
  - MRI- Total= 8
  - CT Scan-Total= 3

- Billing and Financial Issues = 0
- Quality of Care = 0
- Attitude and Service = 0
- Quality of Practitioner Office Site=0

For 2018, SSHP had a goal of less than .50 per 1000 member appeals. In 2018, SSHP received 125 appeals, which represented a .26 per 1000 member appeals, therefore the goal was meet. SSHP analysis noted a lower than anticipated appeal rate and upon review it was determined that providers were submitting appeals however, they were not on behalf of the member and SSHP was unable to get an authorization of release form signed by the member indicting that the provider was appealing on their behalf. Further analysis was conducted to identify any trends with appeals. During this review, it was determined that a vendor contracted with SSHP to conduct post-service reviews for Physical, Speech and Occupational Therapy had a high denial rate thus resulting in the largest appeal category. SSHP conducted meetings with the vendor, the vendor and SSHP conducted provider training on expected documentation to indicate the medical necessity for the therapy. During this process, the therapy providers stop accepting SSHP patients for therapy, thus the leadership team made the decision to stop all post-service reviews and in 2019 will initiate prior authorization for therapy services after the first 25 visits. In 2019, SSHP will track the number of appeals received related to therapy as well as the member's access to therapy services with the removal of the post-service reviews and the initiation of prior authorization process.

In addition, an assessment of overturned appeals was conducted that revealed that a large portion of appeals were due to a lack of clinical documentation during the initial UM review causing the original denial. Challenges noted with providers include the knowledge deficit related to guidelines as it relates to turnaround times for submission of correct and complete clinical documentation. With each appeal, providers were educated on time frames for submission of the appropriate clinical documentation and the various turnaround times. Additionally, the Grievance and Appeal (G & A) team worked collaboratively with the Medical Affairs Department on the implementation of proactive interventions and educational support to address lack of clinical information during the initial denial process.

The following interventions were conducted in 2018:

- Audits were conducted on a quarterly basis to determine the efficiency of the UM/Appeals processing and consistency of application.
- Enhancement of the current analysis process for turn-around times

Based on these interventions, the following was conducted to increase efficiency in UM/Appeals processes:

- Staff/Provider education regarding documentation requirements for medical necessity and the importance of timeliness of request for any additional documentation
- Evaluation of staffing resources to ensure timeliness of reviews and obtaining documentation needed to determine medical necessity
- Development of a team of multidisciplinary staff for continuous process improvement as it related to UM review, Peer to Peer discussions, and Appeal processes

In addition, SSHP will continue to track and trend appeals for any areas of opportunity.

All grievance and appeals turnaround times were within required times for a 100% compliance. In addition, in 2018, two requests for a State Fair Hearing were received and they were resolved prior to going to a hearing in favor of the provider and appeal was overturned.

Member Enrollment and Disenrollment

SSHP reviews the net change in membership month over month to understand reasons members may opt out of SSHP or lost due to no longer eligible for Medicaid in order to identify improvement opportunities. Members in Nevada may elect to change MCO within 90 days of enrollment without cause. Following that period, members must show cause to select an alternate MCO.

From January 1, 2018 to December 31, 2018, data shows a total of 5,269 members transferred from SSHP to another MCO during the 90 day grace period. In addition, beginning in September, 2018, SSHP noticed that more than 3,000 members a month due to loss of Medicaid eligibility. This was SSHP's first year in the market so this data will serve as a baseline for evaluation in the upcoming years.

Analysis of these two areas was conducted and the following was identified:

- Providers were encouraging members to change MCOs as they were not familiar with SSHP as we were new to the market
- Increase of jobs available in Nevada resulted in loss of Medicaid eligibility

From this analysis, SSHP increased the number of provider relations representatives to conduct outreach to provider offices, established joint operating committees with our largest Federal Qualified Health Centers, hospital and other key providers, and members of the executive team made outreach calls to key providers. SSHP will continue to monitor monthly enrollment for any trends and to track the number of volunteer transfers per month and the Nevada Medicaid membership.

Provider Experience and Engagement

Provider Complaints

- The team is led by the Director of Provider Relations, who reports directly to the VP of Network.
- Within the team, Provider Relations Specialists track, monitor, and report provider complaints from intake through resolution, and draft and mail complaint acknowledgment, status and resolution letters.
- The Provider Relations specialists comprises staff members with diverse and complementary backgrounds in claims coding, research and resolution, contracting, credentialing, and provider data management. The team's diversity enables them to successfully research and resolve all types of complaints.
- All staff members are cross-trained and able to fill in different roles as needed to adjust to volume and trends.
- Provider complaints and resolutions are tracked and trended. Based on the data, workflows and processes were established in 2017.
- Due to significant turn over and changes in Provider Relations during 2018, provider complaints were not sufficiently tracked.

Areas of Opportunity for 2019:

- Track and trend all provider complaints

- Provider Relations specialist to make provider visits on a set schedule with the provider and to educate on provider analytic tool, HEDIS, and closing care gaps and risk gaps
- Conduct annual training on cultural competency, medical record documentation, advance directives, HEDIS and other topics as identified
- New provider orientations within 30 days of enrollment

PCP Changes

SSHP allows members freedom of choice when selecting an in-network PCP, and members have the option to change their preferred PCP at any time, with or without cause. New members either choose a PCP at the time they select SSHP or are auto-assigned a PCP based on an algorithm that accounts for geographical proximity to the member's home. Member-requested PCP changes are effective on the next calendar day following the request.

SSHP maintains a record of the reasons why members actively select PCPs in order to monitor the network and ensure quality PCPs are available to members. Overwhelmingly, members select a PCP based on their personal preference when they initially join SSHP. Reasons members may change PCPs include geographical proximity, provider retiring or leaving the network, and to see the same provider as family members. Trends in PCP changes, particularly moving away from particular practitioners or groups, can lead to quality investigations to determine if the PCPs are unfit to remain in SSHP's network. This may further lead to provider education and/or termination from the network.

SSHP analyzed PCP change requests in 2018 with no one cause for requesting a change noted. Due to this SSHP will continue to track in 2019 to identify any areas of opportunity.

Patient Safety and Quality of Care Events

Quality Investigations

SSHP's Quality Investigation process addresses both quality concerns and adverse occurrences. Quality investigations can be requested from any department within the health plan, from a member, members authorized representative, or provider. Potential, quality of care and service issues are classified according to a defined risk severity level that is outlined in the QI policy.

Data included in the assessment of patient safety, and quality of care issues identified by any department, are reported to the Quality department for investigation. Member safety is monitored by tracking and trending adverse occurrence reviews that are identified during the daily Utilization Management processes. Adverse occurrence screening is the mechanism utilized to monitor all medical management activity for consistency and compliance with medically accepted standards of practice. Tracking and trending of these occurrences additionally identifies provider issues that are related to potential quality performance. A quality risk assessment is assigned to each occurrence investigated. Information was compiled on a quarterly basis and reported through the QIC.

POTENTIAL QUALITY OF CARE SUMMARY LOG 2018

Type Summary	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	YTD
Adverse Medical	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Adverse Surgical	0	0	0	0	0	0	0	0	0	0	0	0	
Allergic Reaction	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Death	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Dissatisfied w/ Care	1	3	0	0	1	0	0	0	0	2	2	0	**9**
Access and attitude	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Miscellaneous (lost medical records, wrong file, safety issues)	0	0	0	0	0	0	1	0	0	0	0	0	**1**
Totals	**1**	**3**	**0**	**0**	**1**	**0**	**1**	**0**	**0**	**2**	**2**	**0**	**10**

Severity Levels are as follows:

Severity Level	Definition
Level 0 - None	Investigation indicates acceptable Quality of Care has been rendered.
Level 1 - Low	Investigation indicates that a particular case was *without significant potential* for serious adverse effects, but could become a problem if a pattern developed.
Level II - Medium	Investigation indicates that a particular case demonstrated a *moderate potential* for serious adverse effects.
Level III -High	Investigation indicates that a particular case has demonstrated a *significant potential* for serious adverse effects.
Level IV - Critical	Investigation indicates that a particular case demonstrated a *serious, significant adverse outcome*.

Severity Summary	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	YTD
Severity Level 0	1	3	0	0	1	0	1	0	0	2	2	0	10
Severity Level 1	0	0	0	0	0	0	0	0	0	0	0	0	
Severity Level 2	0	0	0	0	0	0	0	0	0	0	0	0	
Severity Level 3	0	0	0	0	0	0	0	0	0	0	0	0	
Severity Level 4	0	0	0	0	0	0	0	0	0	0	0	0	
Pending Severity	0	0	0	0	0	0	0	0	0	0	0	0	
Totals	**1**	**3**	**0**	**0**	**1**	**0**	**1**	**0**	**0**	**2**	**2**	**0**	**10**

In 2018, the quality investigation cases included various cases with the majority falling in the misc. category, such as delay in getting prescription prior authorization and refill and dissatisfaction with provider services rendered, including the wrong treatment.

For 2018, SSHP had a goal of less than 50 Quality of Care Issues per year. In 2018, this goal was meet. Due to low volume of Quality of Care issues received, SSHP will continue to monitor, track and trend in 2018 for possible areas of provider education, improvement opportunities.

Serious Occurrence Reports
DHCFP provides SSHP with reports received from Personal Care Attendant (PCA) Providers when a patient that is receiving PCA services has an event that requires the member to be sent to the emergency room or admitted to inpatient hospital services. SSHP's responsibility is to track and trend the information from these reports to determine potential quality of care issues.

During 2018, SSHP received 27 Serious Occurrence reports and of this total seven were two providers.

Of the 7, the first provider had the following were identified:

- Unplanned Hospital Visit/ED- 7 Total: Mild heart attack, fall, doctor appointment and physician sent member to hospital, and difficulty breathing.

The second provider had the following identified

- Unplanned Hospital Visit/ED- 7 Total: Shortness of breath, chest pain, stomach pain, and fever.

Although one provider was identified with 9 serious occurrences last year, there was no pattern of unplanned visit secondary to fall or injury. SSHP will continue to track and trend these reports in 2019.

Network Access & Availability

The Network department is responsible for the development and maintenance of SSHPs' system of providers. Consisting of Network and Provider Contract (PC), the department works closely with providers to ensure members have access to providers as mandated by DHCFP. Contracting is responsible for the initial build of the provider network and maintenance of existing providers once networks are established. Provider Contract representatives assist with any issues of contracted providers. PC and Network work closely to achieve good working relationships with practitioners and facilities for the betterment of members.

SSHP is required to have one (1) full time equivalent (FTE) primary care provider for every one-thousand five hundred (1,500) members per service area. However, if the PCP practices in conjunction with a health care professional the ratio is increased to one (1) FTE PCP for every one thousand eight hundred (1,000) members per service area. SSHP geographic and member to practitioner ratio Network Adequacy for 2018 for PCPs and Specialists Results

	Child	Adult
Clark County -		
Primary Care Providers-to-enrollee ratio		
# of PCP providers =	199	219
# of enrollees =	19,121	26,973
# of providers per 1,500 enrollees =	15.6	12.2
Washoe County -		
Primary Care Providers-to-enrollee ratio		
# of PCP providers =	50	62
# of enrollees =	2,944	4,076
# of providers per 1,500 enrollees =	25.5	22.9
Statewide		
# of PCP providers =	249	281
# of enrollees =	22,065	31,049
# of providers per 1,500 enrollees =	16.92	13.58
	Child	Adult
Clark County -		
Physician Specialists-to-enrollee ratio		
# of Physician Specialists =	333	1271
# of enrollees =	19,121	26,973
# of providers per 1,500 enrollees =	26.1	71
Washoe County -		
Physician Specialists-to-enrollee ratio		
# of Physician Specialists =	120	418
# of enrollees =	2,944	4,076
# of providers per 1,500 enrollees =	61	154.2
Statewide		
# of Physician Specialists =	4523	1,689
# of enrollees =	22,065	31,049
# of providers per 1,500 enrollees =	307	81.63

Provider Type	Number
PCP	**1,195**
Hospitals	**45**
Specialist	**640**
Behavioral Health	**2,129**

Accessibility of Services

SSHP monitors primary care physician (PCP), Behavioral Health and specialists' routine and urgent care appointment accessibility and after-hours access to ensure members have access to care 24 hours a day, 7 days a week. This monitoring is done through provider site visits by the provider relations representatives conducting inquiries during visits.

In addition, in 2018, "secret shopper" surveys were conducted to assess compliance with required appointment accessibility and after-hours access. SSHP also will be monitoring PCP, Behavioral Health and Specialists' accessibility through the review of CAHPS results when they are available and through member complaints and appeals data. .Until CAHPS surveys are available, SSHP is monitoring access to services through member grievances and appeals data. Evaluation of grievance and appeals related to access to services indicated the following:

- One grievance received for availability of an appointment with a PCP for a routine visit
- One grievance received for availability of an appointment for a specialists for urgent care
- No appeals received related to access and availability for appointments were received

SSHP will continue to monitor the grievance and appeals in addition to CAHPS survey results.

In 2018, secret shopper calls were made to 75 distinct providers quarterly for a total of 300 providers with only 2 instances of standards not being met for after hour's accessibility. The 2 providers received education on the requirements from our Provider Relations team.

Medical Record Review (MRR) Evaluation

SSHP assesses high-volume Primary Care Physicians with 25 or more linked members including individual offices and large group facilities every quarter. SSHP has written policies and procedures for ensuring provider compliance and annually will provide DHFCP with a written summary of results of medical record audits.

Physicians/practitioners sampled must meet 80% of the requirements for medical record keeping or be subject to corrective action plan (CAP). The SSHP's auditing process details are as follows:

- Conducts medical record audits quarterly
- The audit tool used encompasses all criteria as required by DHFCP
- Medical record audits are conducted on site and/or by records received by fax, mail or email
- Report developed inclusive of selected Primary Care Physicians (PCP) based upon claims filed in the previous quarter
- Providers achieving less than 80% are contacted after results are reviewed to discuss

- Each PCP is sent a letter informing them of the upcoming audit with documentation guidelines and a list of patients whose records have been chosen for review
- The data is reviewed quarterly for analysis and trending
- All provider results are trended for education and quality improvement opportunities
- Re-audits are conducted according to the individual practice scores within 180 days of the original MRR for providers not meeting the 80% rate

Medical record review results are trended by the Quality Improvement department to determine plan-wide areas in need of improvement. Issues may be addressed network-wide and/or by provider-specific education to improve elements of medical record documentation

During 2018, SSHP Quality Department conducted medical record reviews in each quarter. For 2018, 69 reviews were conducted with the following scores:

- 100%-7 providers
- 99-90%-40 providers
- 89%-80%-21providers
- Under 80%-1

For the one provider that scored below 80%, an educational session where provided in writing to address the areas they had deficits. Deficits included missing immunization records, lack of advance directives discussion/forms, illegible records. In 2019, medical record reviews will continue quarterly and will expand to include providers with greater than 100 claims per quarter.

Member Rights and Responsibilities

SSHP is committed to providing appropriate information to members and treating members in a manner that respects their rights. A list of member's rights and responsibilities are given to the members upon enrollment with SSHP as part of the Member Handbook. It is the policy of SSHP to advise their members of their rights and responsibilities and how they will be protected in accordance with the Centers for Medicare & Medicaid Services (CMS) regulations, Nevada regulations and NCQA guidelines.

Call Statistics – Member and Provider Services

Call volumes for the Member Call Center was consistently high in 2018 with a large percentage of members utilizing the call center to learn more about their benefits, seeking assistance in finding a provider, getting a member card and asking for assistance in using the website. Service level goal of 85% was not met in Jan, Feb, April, July, and September 2018 due to high utilization by members and staff turnover.

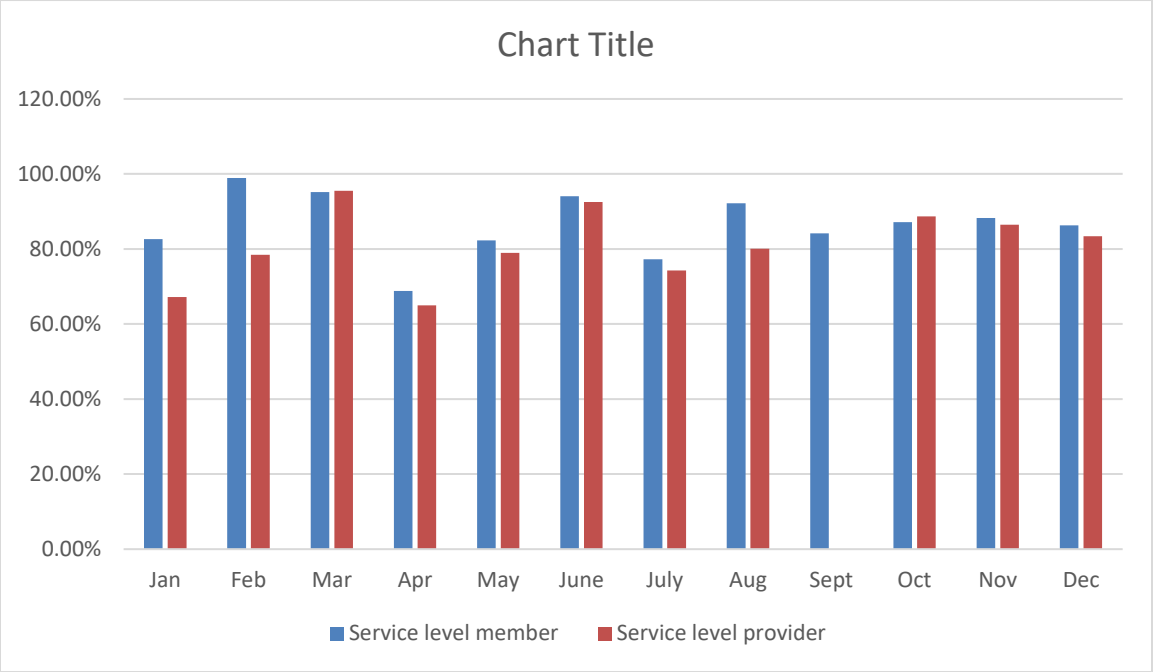
Barriers identified to meeting the service level goals was related to lack of staff to meet the call volume in addition to staff turnover the first 4 months of the year.

Analysis of the call volume for the months not meeting the goal indicated the following:

- The increase of membership beginning in November, 2017 through June, 2018 contributed to call volume
- New members who picked or were auto assigned to SSHP after open enrollment occurred in July, 2018

- No indication for reason for increase in calls identified in September, 2018

Provider Call Center has had a consistent call volumes throughout 2018 with largest volume related to inquiries regarding claims. Provider Call Center service levels did not exceed the goal of 85% for the months of Jan, February, April, May, July and September. The abandonment rate for provider calls ended in 2018 at 4.5% with a goal of less than 5% which was met.



Barriers identified to meeting the service level goals were related to lack of staff to meet the call volume in addition to staff turnover throughout the year.

Analysis of call center metrics indicated barriers to meeting the goal was a result of the amount of time per call to research and answer providers' questions related to claims resulted in delays in answering calls, the number of calls abandoned and hold times.

Opportunities and Actions for improvement in 2019

- Hire additional staff for member and provider call center
- Direct members to the member portal to obtain information, complete PCP change forms, make a copy of member ID card, view the member handbook and utilize "find the provider" tool
- Direct providers to the provider portal to obtain information, verify eligibility, view provider manual, check status of claim(s), submit claims, verify member benefits
- Deploy member chat capability in which the member may communicate through chat option as opposed to a phone call

Credentialing and Re-Credentialing

Structure and Resources

The credentialing process is managed collaboratively between Centene Corporate and the SSHP. The committee chair is the Chief Medical Director. The committee members include SSHPs Medical Director, SSHP Credentialing designee, and Centene physicians including family practitioners, OB/GYN, psychiatry, and internist.

The following represents the number credentialed providers brought before the Credentialing Committee 2018 and the total number of practitioners and providers who were credentialed by SSHP in 2018. No goals were established for SSHP for 2018 as this was a baseline year. SSHP will continue to monitor and establish a goal for re-credentialing in 2020, the year most providers will undergo re-credentialing.

SilverSummit Health Plan January –December 2018	
Number of PCPs	111
Number of Specialists	704
Initial Credentialing	
Number of practitioners credentialed	815
Re-credentialing	
Number of practitioners re-credentialed	11
Terminated/Rejected/Suspended/Denied	
Number with cause	0
Number denied	1

Delegated Vendors and Sister Companies Oversight

SSHP delegates to contracted vendor and sister companies' for service as noted below.

2018 SilverSummit Healthplan Vendor Delegation			
Vendor/ Sister Company		**Vendor Description**	**Annual Audit Responsibilities**
Envolve PeopleCare - Sister Company	Legacy Cenpatico Behavioral Health	Manages specialty behavioral health services, including disease management, utilization management	Corporate Compliance
	Legacy NurseWise	Provides 24-hour Nurse Advice line services	Corporate Compliance
	Legacy Nurtur	Provides Disease Management services. Conditions include Asthma, COPD, Diabetes, Heart Failure, and Web portal wellness assessment	Corporate Compliance
National Imaging Associates (NIA)		Radiology benefit manager and Post Service Review PT/OT/ST services (these services were discontinued in May, 2018)	Corporate Compliance
Envolve Vision- Sister Company	Legacy OptiCare	Vision benefit manager	Corporate Compliance
Envolve Pharmacy Solutions- Sister Company	Legacy US Script	Pharmacy benefit manager.	Corporate Compliance

SSHP exercises proper oversight of sister companies, contractors, consultants, and vendors performing delegated functions or services for or on behalf of SSHP. Individuals and entities performing delegated functions are required to comply with all relevant requirements. All delegated vendors participate, at a minimum, in quarterly joint operational committee (JOC) meetings in which the vendor shares critical compliance information such as call center statistics, utilization management metrics, and other performance indicators. We also discuss member and provider experiences with these vendors by monitoring and discussing member grievances and provider complaints. Representatives from all involved departments convene for cross-departmental and cross-organizational communication.

SSHP evaluates vendors/ sister companies on a quarterly basis, based on criteria including compliance with state metrics, quality of services provided, report submission, and administrative services. Scores are reported internally through the Vendor Oversight Committee. It is in this manner we can fairly and uniformly assess the performance of our vendors despite their widely differing functions and provide a snapshot of each vendor's performance.

For 2018, JOCs where held with each of our vendors in all four quarters. During 2018, the following vendors were outside the standard metrics established for the vendor:

- EPC-Pharmacy
    - YTD ASA <5 – Result .56%
    - YTD PA threshold 100% within 24 hours – Results: non-specialty drugs 99.1% and specialty drugs 97.71%
    - YTD expedited PA 100% within 24 hours – Result 98.72%
    - YTD standard PA within 24 hours 100%- Result 98.99%
- National Imaging Associates (NIA)
    - YTD ASA <5 sec- Result .76%

Corrective action plans were provided by each vendor to address metrics outside SLA's.

Recommendations for 2019:

- Continued oversight of the vendor's performance, including accuracy of reporting, metrics, member and provider grievances and/or appeals trends.
- Review corporate annual audit results and address any corrective action plans for any vendors in PIT committee and in QIC.

Overall Effectiveness of the Quality Improvement Program

SSHP annual evaluation determined that the resources allocated to the QI program are appropriate, as validated through staffing models established for the QI departments. The committee structure provides for adequate support to successfully improve processes. SSHP's executive and senior level management team are actively engaged in the Quality Improvement Committees and demonstrate a commitment to improve quality and service to the membership. There are adequate network practitioners participating on the quality committees to provide oversight and input for quality initiatives. SSHP completed the 2018 QI Work Plan, monitored and evaluated the clinical quality and services provided to the members. In closing, goals for 2019 have been set for the QI Program related to quality and safety of clinical care and quality of service. It should be noted that resources and staffing will meet needs.

Review and Approval

The QI activity was reported to the following QI Committees:

Committee Name	Meeting Date	Committee Actions or Recommendations
QIC		

Approval

The Quality and Utilization Assessment and Performance Improvement Program Evaluation for 2017 has been reviewed and approved as follows:

_____ _____

Roxanne Coulter, RN, Vice President, Quality Date

_____

Jeff Grahling, Interim CEO & Plan President _____

Date

Presented to Board of Directors Date of Meeting