POLICY AND PROCEDURE

DEPARTMENT: Quality	DOCUMENT NAME: Internal Quality Assurance Program (IQAP)
PAGE: 1 of 38	REPLACES DOCUMENT:
APPROVED DATE: March 2017	RETIRED:
EFFECTIVE DATE: July 2017	REVIEWED/REVISED: 6/18; 6/2019
PRODUCT TYPE: Medicaid & Marketplace	REFERENCE NUMBER: NV.QI.01

SCOPE:
SilverSummit Healthplan Quality Improvement and all other applicable health plan departments.

PURPOSE:
To describe the Quality Program and the documentation cycle for continuous quality improvement.

PROCEDURE:
See attached Quality Program Description.

REFERENCES:
Current NCQA Health Plan Standards and Guidelines
State and/or Federal Contract
SilverSummit Healthplan Request for Proposal (RFP)

ATTACHMENTS:
Quality Work Plan
Quality Program Evaluation

DEFINITIONS:
Quality Program: a written document that provides the purpose, scope, objectives, function and operation for a quality program in the health plan.
Quality Assurance: a formal set of activities to review and safeguard the quality of medical services provided. Includes quality assessment and implementation of corrective actions to address deficiencies identified in the quality of care and services provided to individuals or populations (NCQA definition).
Quality Improvement: 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 to improve/maintain health for our members.
Care/Case Management: a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes (Case Management Society of America definition).

REVISION LOG	DATE

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Developed IQAP for new Plan implementation.	**01/1/2017**
Update staffing structure	**1/2/18**
Updated for 2018	**6/11/18**
Updated for 2019 Reviewed against the 2019 standards & Changed name from QAPI to Quality Program Description.	5/30/19

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Centene's P&P management software, is considered equivalent to a physical signature.

2019
Quality
Program Description

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PURPOSE

SilverSummit Healthplan is committed to the provision of a well-designed and well-implemented Quality Program. The health plan's culture, systems, and processes are structured around its mission to improve the health of all enrolled members. The Quality Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of health care provided to all members, 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, population health management, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative, member, and network services.

SilverSummit Healthplan 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 setting. SilverSummit Healthplan provides for the delivery of quality care with the primary goal of improving the health status of the members. When a member's condition is not amenable to improvement, the health plan implements measures to prevent any further decline in condition or deterioration of health status or provides for comfort measures as appropriate and requested by the member. The Quality Program includes identification of members at risk of developing conditions, the implementation of appropriate interventions, and designation of adequate resources to support the interventions. Whenever possible, SilverSummit Healthplan's Quality Program supports processes and activities designed to achieve demonstrable and sustainable improvement in the health status of its members.

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

SCOPE

The scope of the Quality Program is comprehensive and addresses both the quality and safety of clinical care and quality of services provided to SilverSummit Healthplan members including medical, behavioral health, dental, and vision care as included in the health plan's benefits. SilverSummit Healthplan incorporates all demographic groups, lines of business, benefit packages, care settings, and services in its quality improvement activities, including preventive care, emergency care, primary care, specialty care, acute care, short-term care, long-term care (as applicable per the health plan's products), and ancillary services. SilverSummit Healthplan's Quality Program monitors the following:

- Acute, complex, and chronic care management
- Behavioral health care
- Compliance with member confidentiality laws and regulation
- Compliance with preventive health and clinical practice guidelines
- Continuity and coordination of care
- Delegated entity oversight
- Department performance and service
- Employee and provider cultural competency

- Marketing practices
- Member enrollment and disenrollment
- Member grievance and appeals system
- Member experience
- Member safety
- Primary care provider changes
- Pharmacy
- Primary care provider after-hours telephone accessibility
- Provider appointment availability
- Provider complaints
- Provider network adequacy and capacity
- Provider experience
- Selection and retention of providers (credentialing and recredentialing)
- Medical management
- Population health management
- Utilization management, including over- and under-utilization

GOALS

SilverSummit Healthplan's primary quality 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.

Quality Program **goals** include but are not limited to the following:

- A high level of health status and quality of life will be experienced by the members;
- Network quality of care and service will meet industry-accepted standards of performance;
- The health plan's services will meet industry-accepted standards of performance;
- Fragmentation and/or duplication of services will be minimized through integration of quality improvement activities across functional areas;
- Member satisfaction will meet SilverSummit Healthplan's established performance targets;
- Preventive health and clinical practice guideline compliance will meet established performance targets. This includes, but is not limited to, compliance with guidelines for immunizations, prenatal care, diabetes, asthma, etc.;
- Compliance with all applicable regulatory requirements and accreditation standards is maintained.

SilverSummit Healthplan's Quality Program **objectives** include, but are not limited to, the following:

- To establish and maintain a health system that promotes continuous quality improvement;
- To adopt evidence-based clinical indicators and practice guidelines as a means for identifying and addressing variations in medical practice;
- To select areas of study based on demonstration of need and relevance to the population served;
- To develop standardized performance measures that are clearly defined, objective, measurable, and allow tracking over time;

- To utilize management information systems in data collection, integration, tracking, analysis, and reporting of data that reflects performance on standardized measures of health outcomes;
- To allocate personnel and resources necessary to:
    - support the Quality Program, including data analysis and reporting;
    - meet the educational needs of members, providers, and staff relevant to quality improvement efforts;
    - meet all regulatory and accreditation requirements;
- To seek input and work with members, providers, and community resources to improve quality of care;
- To oversee peer review procedures that address deviations in medical management and health care practices and devise action plans to improve services;
- To establish a system to provide frequent, periodic quality improvement information to participating providers in order to support them in their efforts to provide high quality health care;
- To recommend and institute focused quality studies in clinical and non-clinical areas, where appropriate;
- To serve members with complex health needs;
- Conduct and report annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) (Qualified Health Plan [QHP] Enrollee Experience survey for the Marketplace product line, when applicable) and certified Healthcare Effectiveness Data and Information Set (HEDIS®) results for members *(CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ); HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)*;
- Achieve and maintain NCQA accreditation and/or other applicable accreditations for appropriate products;
- Monitor for compliance with regulatory and accreditation requirements.

CONFIDENTIALITY

Confidential information is defined as any data or information that can directly or indirectly identify a member or provider. The Quality Improvement Committee (QIC) and its subcommittees have the responsibility to review quality of care and resource utilization, as well as conduct peer review activities as appropriate. The QIC and related peer review committees conduct such proceedings in accordance with SilverSummit Healthplan's bylaws and applicable federal and state statutes and regulations.

The proceedings of the QIC, its subcommittees, work groups, and/or any ad hoc peer review committees are considered "Privileged and Confidential" and are treated as such. In this regard, all correspondence, worksheets, quality documents, minutes of meetings, findings, and recommendations for the programs are considered strictly confidential and therefore not legally discoverable.

Confidential quality findings are accessible only to the following individuals/groups:

- Board of Directors
- President and Chief Executive Officer (CEO)
- Chief Medical Director, Vice President of Medical Management (VPMM), Vice President of Quality, and designated Quality Department staff

- Peer Review Committee
- External regulatory agencies, as mandated by applicable state/federal laws
- SilverSummit Healthplan's legal executives
- Compliance leadership

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

SilverSummit Healthplan has adopted the following confidentiality standards to ensure quality proceedings remain privileged:

- All peer review and quality related correspondence documents are appropriately labeled "Privileged and Confidential, Peer Review" and maintained in locked files/secure electronic files;
- Confidentiality policies and procedures comply with applicable state statutes that address protection of peer review documents and information;
- Committee members and employees responsible for Quality, Medical Management, Credentialing, and Pharmacy program activities are educated about maintaining the confidentiality of peer review documents;
- The Quality Vice President (VP)/Director designates Quality Department staff responsible for taking minutes and maintaining confidentiality;
- For quality studies coordinated with, or provided to outside peer review committees, references to members are coded by identification number rather than a protected health information (PHI) identifier such as medical record number or ID number, with references to individual providers by provider code number;
- Records of review findings are maintained in secured files, which are made available only as required by law or specifically authorized in writing by the CEO, Chief Medical Director, Legal Counsel, VPMM, or the Board of Directors Chairman; and
- All participating providers and employees involved in peer review activities or who participate in quality activities or committees are required to sign confidentiality agreements.

CONFLICT OF INTEREST

SilverSummit Healthplan defines conflict of interest as participation in any review of cases when objectivity may not be maintained. No individual may participate in a quality of care or medical necessity decision regarding any case in which he or she has been professionally involved in the delivery of care. Peer reviewers may not participate in decisions on cases where the reviewer is the consulting practitioner or where the reviewer's partner, associate, or relative is involved in the care of the member, or cases in which the practitioner or other consultant has previously reviewed the case. When a practitioner member of any committee perceives a conflict of interest related to voting on any provider-related or peer review issue, the individual in question is required to abstain from voting on that issue.

CULTURAL COMPETENCY

SilverSummit Healthplan endeavors to meet the needs of all members with sensitivity to cultural needs and the impact of cultural differences on health services and outcomes. SilverSummit Healthplan is guided by requirements set by each respective state/federal contract and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) developed by the Office of Minority Health. Specifically, the Quality Program identifies and addresses clinical areas of health disparities. SilverSummit Healthplan assures communications are culturally sensitive, appropriate, and meet federal and state requirements. Population health management initiatives are reviewed to assure cultural issues and social determinants of health are identified, considered, and addressed. As part of the annual program evaluation, SilverSummit Healthplan also reviews member needs from a cultural competency standpoint, analyzes data for cultural, ethnic, race, and linguistic issues, and addresses identified barriers.

AUTHORITY

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

- Adopting the initial and annual Quality Program which requires regular reporting (at least annually) to the Board of Directors, and establishes mechanisms for monitoring and evaluating quality, utilization, and risk;
- Supporting QIC recommendations for proposed quality studies and other quality initiatives and actions taken;
- Providing the resources, support, and systems necessary for optimum performance of quality functions;
- Designating a senior staff member as the health plan's senior quality executive, defining the role of a physician in the Quality Program, and defining the role a behavioral health practitioner in the Quality Program; and
- Evaluating the Quality Program Description and Quality Work Plan annually to assess whether program objectives were met and recommending adjustments when necessary.

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

The Chief Medical Director, or as designated by the SilverSummit Healthplan President/CEO, serves as the senior quality executive and is responsible for:

- Compliance with state, federal, and accreditation requirements and regulations;
- Chairing the QIC, or designating an appropriate alternate chair, and participating as appropriate;
- Monitoring and directing quality activities among personnel and among the various subcommittees reporting to the QIC;

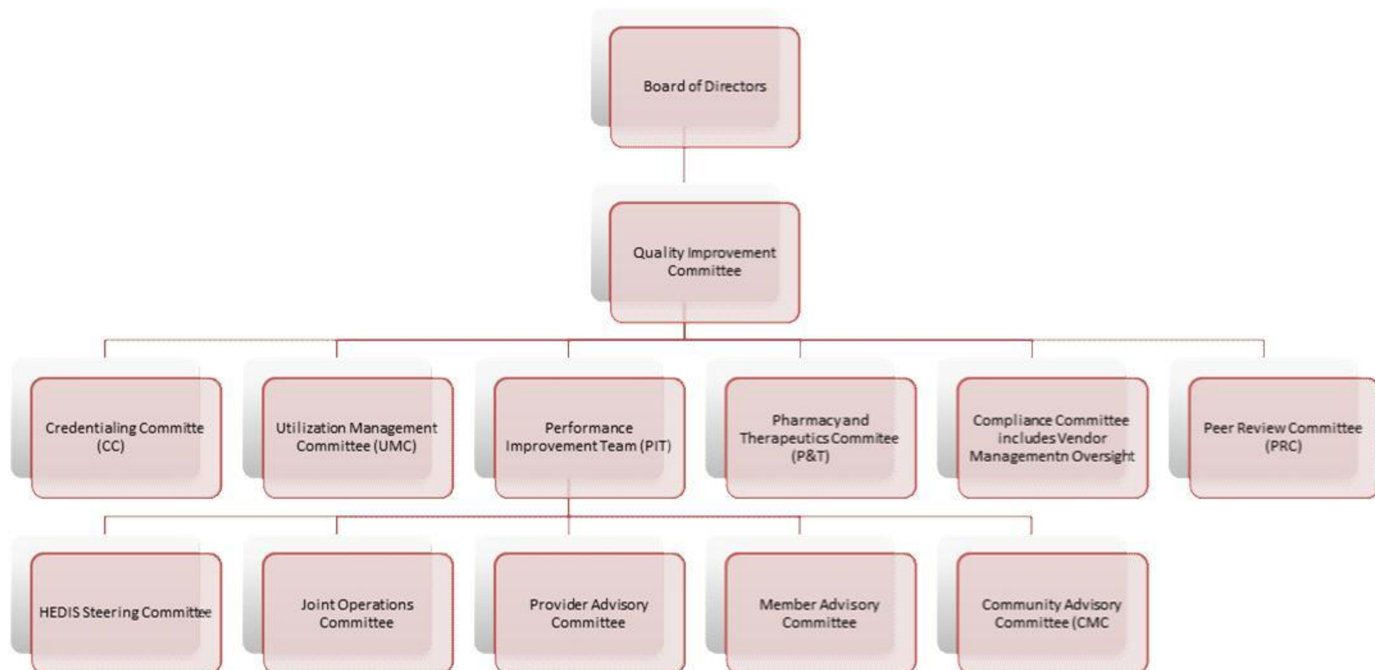
- Coordinating the resolution of outstanding issues with the appropriate leadership staff, pertaining to QIC recommendations, subcommittee recommendations, and/or other stakeholder recommendations;
- Being actively involved in the SilverSummit Healthplan's Quality Program including: recommending quality study methodology, formulating topics for quality studies as they relate to accreditation and regulatory requirements and state and federal law, promoting participating practitioner compliance with medical necessity criteria and clinical practice guidelines, assisting in on-going patient care monitoring as it relates to preventive health/sponsored wellness programs, pharmacy, diagnostic-specific case reviews, and other focused studies, and directing credentialing and recredentialing activities in accordance with SilverSummit Healthplan's policies and procedures;
- Reporting the Quality Program activities and outcomes to the Board of Directors at least annually.

QUALITY PROGRAM STRUCTURE

Quality is integrated throughout SilverSummit Healthplan, and represents the strong commitment to the quality of care and services for members. The Board of Directors is the governing body designated for oversight of the Quality Program and has delegated the authority and responsibility for the development and implementation of the Quality Program to the QIC.

The QIC is the senior management lead committee reporting to the Board of Directors. SilverSummit Healthplan has established subcommittees and work groups based on SilverSummit Healthplan needs as well as regulatory and accreditation requirements. Additional committees may also be included per health plan need, including regional level committees as needed based on distribution of membership. These committees assist with monitoring and supporting the Quality Program. The SilverSummit Healthplan committee structure is outlined below.

SilverSummit Healthplan Committee Structure



SilverSummit Healthplan Core Committee Charters

Quality Improvement Committee	
Charter Statement	The Quality Improvement Committee (QIC) is the senior leadership committee, accountable to the Board of Directors, that reviews and monitors all clinical quality and service functions of the health plan and provides oversight of all subcommittees.
Purpose	The purpose of the QIC is to provide oversight and direction in assessing the appropriateness of care and service delivered, and to continuously enhance and improve the quality of care and services provided to members. This is accomplished through a comprehensive, health plan-wide system of ongoing, objective, and systematic monitoring of activities and outcomes using the quality process.

Responsibilities	• Oversight of the quality activities of the health plan to ensure compliance with contractual requirements, federal and state statutes and regulations, and requirements of accrediting bodies such as the National Committee for Quality Assurance (NCQA); • Annual development of the Quality Program Description and Work Plan incorporating applicable supporting department goals as indicated; • Development of quality improvement studies and activities, and reporting of findings to the Board of Directors; • Annual review and approval or acceptance of the Credentialing, Pharmacy, Utilization Management, Case Management, and Population Health Management Program Descriptions and Work Plans as developed by the appointed subcommittees to facilitate alliance with strategic vision and goals; • Evaluation of the effectiveness of each departments' activities to include analysis and recommendations of policy decisions based on identified trends, follow-up, barrier analysis, and interventions required to improve the quality of care and/or service to members. Implements corrective actions as appropriate, and acts as a communication channel to the Board of Directors; • Prioritization of quality improvement efforts, facilitation of functional area collaboration, and assurance of appropriate resources to carry out quality activities; • Review and establishment of benchmarks and performance goals for each quality improvement initiative and service indicator; • Review and approval of due diligence information for any potential delegated entity and the annual oversight audit outcomes for delegated entities; • Adoption of preventive health and clinical practice guidelines to promote appropriate and standardized quality of care; • Monitoring of clinical quality indicators (such as HEDIS, adverse events, sentinel events, peer review outcomes, quality of care tracking, etc.) to identify deviation from standards of medical care, and supporting the formulation of corrective actions, as appropriate; • Ongoing evaluation of the appropriateness and effectiveness of practitioner profiling and pay-for-performance initiatives and support in designing and modifying the program as warranted.
Reports To	Board of Directors
Committee Chair	Chief Medical Director, may delegate individual meetings to an Associate Medical Director or Senior Quality Executive
Committee Composition	• Chief Executive/Operating Officer • Chief Medical Director • Behavioral Health Medical Director • VP/Director of Quality • VP/Director of Medical Management • VP/Director Network Development/Contracting • VP/Director of Member & Provider Services/Customer Service • VP/Director Compliance • Network practitioners, at least four (4) representing the range of practitioners within the network and across the regions in which the health plan operates, e.g. family practice, internal medicine, OB/GYN, behavioral health (i.e. physician or clinical PhD or PsyD), vision/dental care providers, and other high-volume specialists as appropriate • In addition, the committee may also have providers knowledgeable about members with disabilities; substance use, abuse of children, etc. • The provider representatives should have experience caring for the health plan membership , including a variety of ages and races/ethnicities, rural and urban populations, etc.
Frequency	Quarterly, with additional meetings scheduled per health plan need
Attendance Required	50% of scheduled meetings
Quorum	A minimum of four (4) committee members, including two health plan staff and two (2) external practitioners, must be present for a quorum. All permanent committee members are voting members; the Committee Chair is the determining vote in the case of a tie vote.

Agenda	Agenda items for the next meeting are developed by the Committee Chair in collaboration with the VP/Director of Quality. The committee receives regular reports from all subcommittees that are accountable to and/or advise the QIC.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable. Materials included in meeting packed are based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The QIC is authorized by the Board of Directors to make all decisions related to the Quality Program, with decisions made by consensus of the committee. Individuals are responsible to raise any issues at committee meetings.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information and/or situations when dissemination of information is to be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Peer Review Committee	
Charter Statement	The Peer Review Committee is an ad-hoc committee of the Quality Improvement Committee and responsible for reviewing alleged inappropriate or aberrant services by a practitioner/provider, including potential quality of care incidents, adverse events, and sentinel events where initial investigation indicates a significant potential or significant, severe adverse outcome has occurred or other cases as deemed appropriate by the Medical Director.
Purpose	The purpose of the Peer Review Committee is to review clinical cases and apply clinical judgment in assessing the appropriateness of clinical care and recommending a corrective action plan to best suit the particular situation.
Responsibilities	• To make determinations regarding appropriateness of care; • To make recommendations regarding corrective actions relating to provider quality of care; • To conduct the review by a practitioner of same or similar specialty as the practitioner and/or issue under review.
Reports To	Quality Improvement Committee
Committee Chair	Chief Medical Director
Committee Composition	• Chief Medical Director/Medical Director • VP/Director Quality • Peer practitioners; at least three (3) or more network practitioners who are peers of the practitioner being reviewed and who represent a range of specialties, including at least one practitioner with the same or similar specialty as the case under review, but whose presence does not indicate a conflict of interest • No Credentialing Committee members involved in the Peer Review Committee's recommendation will be included in the Credentialing Committee meeting when the Peer Review Committee's recommendation is discussed
Frequency	Ad hoc, date and time to be determined based on need. Network practitioners serving on the committee may or may not be the same external practitioners serving on the Quality Improvement Committee or Credentialing Committee. If the same practitioners are used, the Quality Improvement Committee or Credentialing Committee meeting is adjourned and the Peer Review meeting started as an independent meeting with an independent agenda and minutes.
Attendance Required	100% of scheduled meetings. Network provider members are not standing members of the committee and their attendance may change based on type of case being reviewed.
Quorum	At least two (2) network providers and one (1) Medical Director must be present for a quorum. All permanent committee members are voting members; the Committee Chair is the determining vote in the case of a tie vote.
Agenda	Meetings are agenda driven. The Committee Chair and/or Quality designee develop agenda items for the next meeting.
Recorder	Delegated committee designee

Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials. All names and identifying information is redacted and information is distributed in a secure manner.
Decision Authority	The Quality Improvement Committee authorizes the Peer Review Committee to make decisions and recommendations regarding practitioner quality of care.
Evaluation	The committee reviews the charter annually.
Confidentiality	Peer review laws governing confidentiality of its proceedings protect each committee member. Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information needs to be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Credentialing Committee	
Charter Statement	The Credentialing Committee is a standing subcommittee of the Quality Improvement Committee, and oversees and has operating authority of the Credentialing Program.
Purpose	The purpose of the Credentialing Committee is to provide oversight of the development and annual review/approval of credentialing policies. The Credentialing Committee has final authority for credentialing and recredentialing licensed medical and behavioral health practitioners, other licensed healthcare professionals, and organizational providers who have an independent relationship with the health plan. The Committee oversees the credentialing process to ensure compliance with regulatory and accreditation requirements and ensure network practitioners and organizational providers are qualified, properly credentialed, and available for access by health plan members.
Responsibilities	• Provide guidance to organization staff on the overall direction of the Credentialing Program; • Review and approve credentialing and recredentialing policies and procedures; • Review and recommend credentialing and recredentialing criteria; • Final authority to approve or disapprove applications by practitioners and organization providers for network participation status and recredentialing; • Provide clinical peer input to address standards of care for a particular type of practitioner; • Review oversight audits of delegates Credentialing Program performance; • Evaluate and report to management on the effectiveness of the Credentialing Program; • Review potential QOC events and adverse events, including any corrective action plans from peer review committee, for recredentialing decisions.
Reports To	Quality Improvement Committee
Committee Chair	Chief Medical Director; as committee member leadership develops, a committee network provider may chair at the discretion of the Credentialing Committee
Committee Composition	• Chief Medical Director/Medical Director(s) • Health plan Credentialing staff designee • Centene Corporate Credentialing Manager/Supervisor • Network practitioners from a range of specialties, e.g. family practice, internal medicine, OB/GYN, behavioral health, high-volume specialists, mid-level practitioners, etc. • Other executive leadership or health plan staff as determined • The committee actively involves participating network practitioners in credentialing review activities as available and to the extent that there is not a conflict of interest.
Frequency	At least ten (10) times per year to facilitate timely review of practitioners/providers and to expedite network development; additional meetings scheduled as needed.
Attendance Required	50% of scheduled meetings
Quorum	A minimum of four (4) voting members, including the Chair, must be present for a quorum. Three (3) voting members must be appropriately licensed healthcare practitioners. Only healthcare practitioners are voting members; the Chair is the determining vote in the case of a tie vote.
Agenda	Meetings are agenda driven and follow a standard format. Agenda items for the next meeting are developed by the Corporate Credentialing Manager in collaboration with the Committee Chair.
Recorder	Delegated committee designee

Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The Medical Director may approve clean files; the Quality Improvement Committee has delegated responsibility for credentialing/recredentialing practitioners, facilities, and other organizational providers not meeting clean file criteria to the committee. The decision making model is by consensus. Individuals are responsible and encouraged to raise any issues at committee meetings.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations of how dissemination of information is managed. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Medical Management Committee	
Charter Statement	The Medical Management Committee is a standing subcommittee of the Quality Improvement Committee with oversight and operating authority of medical management activities.
Purpose	The purpose of the Medical Management Committee is to review and monitor the appropriateness of care provided to health plan members. The Medical Management Committee is responsible for the review and appropriate approval of medical necessity criteria and protocols, and utilization management policies and procedures, including a list of procedures requiring prior authorization.
Responsibilities	• Annually review and approve program descriptions, work plans and annual evaluations for Population Health Management, Utilization Management, and Case Management; • Review and maintain applicable policies/procedures and guidelines; • Annually review and approve the criteria for determination of medical appropriateness; • Review the utilization management process, including referrals, second opinions, prior authorization/pre-certification, concurrent and retrospective review, discharge planning, etc. • Review practitioner/facility/geographic area specific reports for trends/patterns in utilization; • Formulate recommendations for specific practitioners/providers for further study; • Examine reports of the appropriateness of care for trends or patterns of under- or over-utilization and refer for performance improvement or corrective action if indicated; • Examine results of annual surveys of members and practitioners regarding satisfaction with UM processes and medical management programs • Create and implement a feedback mechanism for communicating findings and recommendations, as well as a plan for implementing corrective actions • Liaison with the Quality Improvement Committee for ongoing review of indicators of clinical quality.
Reports To	Quality Improvement Committee
Committee Chair	Medical Director, individual meetings may be chaired by an Associate Medical Director or network practitioner at the discretion of the Medical Director.
Committee Composition	• Executive Leadership • Chief Medical Director/Medical Director • Designated Medical Management staff • Designated Quality staff • Other operational staff as requested, e.g. Networking/Contracting, Member/Provider Services, Compliance/Regulatory, Pharmacy • Network practitioners representing the range within the network and across the service area may participate on the committee
Frequency	Quarterly, with additional meetings scheduled per health plan need
Attendance Required	50% of scheduled meetings.
Quorum	Minimum of 50% of committee members, including two (2) health plan staff and two (2) external practitioners (if included on the committee) must be present for a quorum. All permanent committee members are voting members; the Committee Chair is the determining vote in the case of a tie vote.

Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting are developed by the Committee Chair in collaboration with the VP/Director of Medical Management.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The Medical Management Committee is authorized by the Quality Improvement Committee to make all decisions related to the Medical Management Program, with decisions made by consensus of the committee. Individuals are responsible to raise issues at committee meetings.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when information is managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

Pharmacy and Therapeutics Committee	
Charter Statement	The Pharmacy & Therapeutics Committee is a standing subcommittee of the Quality Improvement Committee with oversight and operating authority of the Pharmacy Program.
Purpose	The Pharmacy & Therapeutics Committee is responsible for development and annual review of the pharmacy policies and procedures, review of pharmacy utilization data, decisions regarding inclusion of drugs on the Preferred Drug List (PDL), and recommendations for formulary management activities.
Responsibilities	• Develop and annually review the pharmacy policy and procedures; • Conduct practitioner and member profiling for appropriate drug utilization (DUR) and recommendations for DUR activities such as targeted prescriber and/or member education initiatives; • Evaluate and recommend drugs for inclusion in or removal from the PDL for appropriateness as a tool for providing high quality and cost-effective care; • Evaluation of drug costs by therapeutic class for pharmaceutical containment and projection of pharmaceutical costs; • Assure compliance with all contractual, regulatory, and accreditation pharmacy requirements; • Review of complaints/grievances regarding pharmacy issues; • Recommendations for formulary management activities such as prior authorization, step therapy, age restrictions, quantity limitations, mandatory generics, and other activities that promote access and patient safety • Review of requests from practitioners for additions or changes to formulary.
Reports To	Quality Improvement Committee
Committee Chair	Chief Medical Director, may delegate individual meetings to an Associate Medical Director or Senior Pharmacy Executive
Committee Composition	• Chief Medical Director/Medical Director • VP/Director of Pharmacy • Participating network pharmacists and internal clinical pharmacists • Other health plan executive and operational staff as requested
Frequency	Quarterly, with additional meetings scheduled per health plan need
Attendance Required	50% of scheduled meetings
Quorum	A minimum of four (4) voting members, including the Chair, must be present for a quorum. Three (3) voting members must be appropriately licensed healthcare practitioners (physicians or pharmacists). All permanent practitioner committee members are voting members; the Committee Chair is the determining vote in the case of a tie vote.
Agenda	Meetings are agenda driven. All agendas and minutes follow a standard format. Agenda items for the next meeting are developed by the Committee Chair in collaboration with the VP/Director of Pharmacy.

Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The committee is authorized by the Quality Improvement Committee to make all decisions related to the pharmacy benefit. Decisions made by consensus. Individuals are responsible and encouraged to raise issues at committee meetings.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/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.

Joint Operations Committee	
Charter Statement	The Joint Operations Committee provides guidance to and oversight of operations affecting the scope of functions of delegated vendors, subcontractors, and Centene specialty companies that provide services to the health plan membership.
Purpose	The purpose of the Joint Operations Committee is to provide oversight and assess the appropriateness and quality of services provided on behalf of the health plan to members. The Joint Operations Committee monitors delegate/vendor compliance with the delegation service agreement and regulatory requirements, identifies issues and opportunities for improvement, and develops mitigation plans as appropriate.
Responsibilities	• Oversee operations of the delegate/vendor to ensure compliance with contractual requirements, federal and state statutes and regulations, and requirements of accrediting bodies; • Annually review the applicable delegate/vendor program descriptions, policies, & procedures; • Examine activity and performance reports to identify undesirable trends and/or patterns; • Provide a feedback mechanism for communicating findings, recommendations, and a plan for implementing corrective action (when necessary) related to the scope of delegated functions; • Monitor financial incentives to ensure quality of care/service is not compromised; • Develop utilization and quality reporting, summary analysis of data, and specialized reports designed exclusively to describe the findings of delegate/vendor activities; • Report recommended actions to address any identified opportunities for improvement to the Performance Improvement Team; • Provide a forum for discussion and collaboration for toward mutual goal attainment; • Review findings of annual delegation audits with the Quality Improvement Committee; • Recommend continuation or termination of the delegation arrangement to the Quality Improvement Committee
Reports To	Quality Improvement Committee
Committee Chair	Delegated Department VP/Director/Manager
Committee Composition	• Chief Medical Director/Medical Director(s) • VP/Director of Compliance • Delegated Vendor Oversight/Compliance staff • VP/Director Quality • VP/Director of Medical Management and/or VP/Director of Pharmacy as applicable • VP/Director of Network Management and Contracting, Member Services, Provider Services • Grievance and Appeals Coordinator • Delegated vendor staff
Frequency	Quarterly, with additional meetings scheduled per health plan need
Attendance Required	50% of scheduled meetings.
Quorum	A minimum of four (4) voting members, including the Committee Chair, must be present for a quorum. All permanent committee members are voting members; the Committee Chair is the determining vote in the case of a tie vote.

Agenda	Meetings are agenda driven. Agenda items for the next meeting are developed by the Committee Chair in collaboration with the applicable department leads.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The committee is authorized by the Quality Improvement Committee to make all decisions related to delegated vendor oversight. Decisions made by consensus. Individuals are responsible and encouraged to raise issues at committee meetings.
Evaluation	The committee will review the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information will be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.
Performance Improvement Team	
Charter Statement	The Performance Improvement Team is an internal, cross-functional quality improvement team that facilitates the integration of a culture of quality improvement throughout the organization. Results from performance improvement efforts and activities planned/taken to improve outcomes compared with expected results and findings are evaluated by the Performance Improvement Team, using an industry-recognized methodology for analyzing data.
Purpose	The purpose of the Performance Improvement Team is to be responsible for gathering and analyzing performance measures, performing barrier and root cause analysis for indicators falling below desired performance, and making recommendations regarding corrective actions/interventions for improvement. The Performance Improvement Team is also responsible for overseeing the implementation of recommended corrective actions or interventions from the Quality Improvement Committee and/or its supporting subcommittees, monitoring the outcomes of those improvement efforts, and reporting results to the designated committee.
Responsibilities	• Review and evaluate key clinical quality and service performance indicators; • Prompt initiation of ad hoc performance improvement initiatives (including corrective action plans) to address any negative or static trends; • Review, categorize, track, and trend grievances, administrative reviews, and requests for external reviews. Determines appropriate disposition and follow-up; • Monitor resource allocation to ensure appropriate support for the Quality Program; • Track progress of tasks in the annual Quality Work Plan, make recommendations to improve quality activities noted in the Work Plan as needed, in response to issues raised by the Quality Improvement Committee; • Provide ongoing reports to the Quality Improvement Committee, as appropriate, on the progress of clinical and performance improvement initiatives; • Review operational policies and procedures at least annually and recommend modifications as necessary.
Reports To	Quality Improvement Committee
Committee Chair	VP/Director of Quality
Committee Composition	• Chief Medical Officer / Medical Director • VP/Director of Quality • Designee (Director/Manager) from each applicable functional area, i.e. Medical Management, Network Development & Contracting, Provider Relations/Services, Member Services, Grievance and Appeals, Compliance & Regulatory Affairs, Pharmacy • Behavioral Health Provider/Representative • Additional staff may participate as requested by the Chair
Frequency	At a minimum ten (10) times per year
Attendance Required	50% of scheduled meetings
Quorum	50% of members. All permanent committee members are voting members; the Committee Chair is the determining vote in the case of a tie vote.

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

SilverSummit Healthplan

Additional Committee Charters

Quality Measures Steering Committee (previously HEDIS Steering Committee)	
Charter Statement	The Quality Measures Steering Committee is the health plan's committee responsible for monitoring and improving quality scores (e.g. HEDIS, CAHPS, Medicare STARS, Marketplace QRS measures, state critical measures, etc.)
Purpose	The purpose of the Quality Measures Steering Committee is to oversee the quality performance process at the health plan level. The committee reviews monthly rate trending, identifies data concerns, and communicates corporate initiatives to senior leadership. The Quality Measures Steering Committee directs member and provider initiatives to improve quality scores. Goals include obtaining and maintaining "Best in Class" status in the state, continued improvement in scores over time to ensure NCQA Commendable Accreditation, and maximize quality bonuses and/or auto-assignment, and to ensure no penalties are received.
Responsibilities	• Review monthly and final quality scores; • Analyze scores to determine areas in need of improvement; • Review, approve, and implement corporate-led initiatives; • Develop initiatives to improve selected measures and oversee the implementation, progression and outcomes monitoring of initiatives • Recommend resources necessary to support the on-going improvement of quality scores; • Review/establish benchmarks or performance goals; • Oversee delegated vendor roles in improving quality scores
Reports To	Performance Improvement Team
Committee Chair	VP/Director of Quality
Committee Composition	• VP/Director of Quality • Manager of Quality • Manager/Supervisor of HEDIS • HEDIS Coordinator • Designee (Manager/Supervisor) from each applicable functional area, i.e. Medical Management, Network Development & Contracting, Provider Relations/Services, Member Services, Grievance and Appeals, Pharmacy
Frequency	Quarterly, additional meetings scheduled per health plan need
Attendance Required	50% of scheduled meetings
Quorum	A minimum of four (4) voting members, including the Chair, must be present for a quorum. All permanent committee members are voting members; the Committee Chair is the determining vote in the case of a tie vote.
Agenda	Meetings are agenda driven. Agenda items for the next meeting are developed by the Committee Chair in collaboration with the applicable department leads.
Recorder	Delegated committee designee

Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The committee is authorized by the Quality Improvement Committee to make all decisions related to quality measure performance. Decisions made by consensus. Individuals are responsible and encouraged to raise any concerns/issues at the committee meetings.
Evaluation	The committee will review the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information will be managed in a specific manner.
Grievance and Appeals Committee	
Charter Statement	The Grievance and Appeals Committee is a subcommittee of the Quality Improvement Committee and is responsible for maintaining compliance with contractual, federal and state, and accrediting body requirements.
Purpose	The purpose of the Grievance and Appeals Committee is to maintain compliance with contractual, federal and state, and accrediting body requirements as relating to the processing of grievance and appeals, and when appropriate, critical incidents. The scope of the Grievance and Appeals Committee includes tracking and analysis of member grievances and appeals, including type and timeliness of resolution, performing barrier and root cause analysis, and making recommendations regarding corrective actions as indicated. The committee, as required by the health plan contract, is also responsible for review, discussion, and determination of member grievances and clinical appeals and facilitating requests for administrative review filed by members (and providers who file on behalf of members regarding administrative reviews), including, as applicable, determinations by a delegated entity.
Responsibilities	• Review, categorize, track, and trend member grievances and appeals; • Perform barrier and root cause analysis and make recommendations regarding corrective action as appropriate; • Provide ongoing reports to the Quality Improvement Committee and Credentialing Committee, as appropriate; • Review operational policies and procedures at least annually and recommend modifications as necessary.
Reports To	Performance Improvement Team
Committee Chair	VP/Director of Quality or Director of Compliance & Regulatory Affairs
Committee Composition	• VP/Director of Quality Improvement • G&A Coordinator • Director of Compliance & Regulatory Affairs • Additional committee members, including clinical staff and/or a community advocate, may be appointed by the Chair as appropriate, depending on the nature of the grievance/appeal or matter under review. The Grievance and Appeals Committee is composed primarily of health plan staff
Frequency	Quarterly or per health plan need
Attendance Required	50% of scheduled meetings.
Quorum	50% of members. All permanent committee members are voting members; the Committee Chair is the determining vote in the case of a tie vote.
Agenda	Meetings are agenda driven. Agenda items for the next meeting are developed by the Committee Chair in collaboration with the applicable department leads.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The Quality Improvement Committee authorizes the Grievance and Appeals Committee to make decisions regarding grievance and appeal resolution, as applicable, and recommendations regarding performance improvement processes related to grievances and appeals. Decisions made by

	consensus. Individuals are responsible and encouraged to raise any concerns/issues at the committee meetings.
Evaluation	The committee will review the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information will be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.
Provider Advisory Committee	
Charter Statement	The Provider Advisory Committee is a committee utilized to communicate the health plan's programs and processes to its provider network allowing for collaboration and feedback through discussion with the providers.
Purpose	The purpose of the Provider Advisory Committee is to provide input on the health plan provider profiling and incentive programs, and other administrative practices, and supports development of the provider scorecard indicators, useful analyses of the data, and effective means of helping providers improve their performance.
Responsibilities	• To provide the health plan with feedback regarding programs and processes from a community provider-based perspective; • To allow providers to make recommendations related to the programs and processes; • Assist the health plan to identify key issues related to programs that may affect community providers.
Reports To	Performance Improvement Team
Committee Chair	Chief Medical Director or designee
Committee Composition	• Chief Medical Director • The Chair appoints members for committee representation from the provider network (serving one year terms) • Facilities representatives • Ancillary provider representatives • Director of Contracting and Network Management • Provider Relations staff as appropriate
Frequency	Quarterly or per health plan need
Attendance Required	There is no minimum meeting attendance requirement.
Quorum	This is not a voting committee.
Agenda	Meetings are agenda driven. Agenda items for the next meeting are developed by the Committee Chair in collaboration with the applicable department leads.
Recorder	Delegated committee designee
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The Provider Advisory Committee is a non-voting committee, intended to solicit direct feedback from the local provider network.
Evaluation	The committee will review the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information will be managed in a specific manner.
Member Advisory Committee	
Charter Statement	The Member Advisory Committee is a group of members, parents, guardians, member advocacy groups, and health plan staff as appropriate, that reviews and reports on a variety of quality and service issues. The health plan understands that the ability to effectively engage stakeholders, including members/family members/caregivers, advocates, and community organizations in the quality program is a crucial component of our collaborative efforts to enhance a patient-centered service delivery system, to optimize clinical outcomes, and to positively affect program operations.
Purpose	The purpose of the Member Advisory Committee is to solicit member input into the approach and effectiveness of the health plan programs, policies, and services, and to promote a collaborative effort to enhance the service delivery system in local communities. The Member Advisory Committee represents the geographic, cultural and racial diversity of our membership across the

	state. The committee provides input for quality improvement activities, program monitoring and evaluation, and member, family, and provider education, and/or other topics as defined by the Performance Improvement Team or Quality Improvement Committee.
Responsibilities	The Member Advisory Committee solicits member input into the quality programs. Based on the health plan size and distribution, the Member Advisory Committee may include regional level committees. • Members are randomly selected in accordance with the Managed Care Reform and Patient Rights Act; • Members may be informed about the committee through such materials as the member handbook, member newsletters, contacts at community events, and the health plan website; • The health plan will provide an orientation and ongoing training for Member Advisory Committee members so they have sufficient information and understanding of the managed care program to fulfill their responsibilities; • The Member Advisory Committee meets in-person to promote two-way communication where members can provide input and ask questions and the health plan can and obtain direct feedback from members; • The Member Advisory Committee recommends program enhancements, review satisfaction survey results, and provide feedback on the health plan performance levels.
Reports To	Performance Improvement Team
Committee Chair	Director of Member Services
Committee Composition	• Director of Member Services • Members - may volunteer or be suggested by staff • Parents/foster parents/guardians of child members - may volunteer or be suggested by staff • Health plan staff as indicated • Quality Department designee • Members and families/significant others of members
Frequency	Determined by health plan; at least annually
Attendance Required	No minimum attendance required.
Quorum	This is not a voting committee.
Agenda	Meetings are agenda driven. Agenda items for the next meeting are developed by the Committee Chair in collaboration with relevant member input.
Recorder	Delegated committee designee.
Minutes/Meeting Packets	Draft minutes are completed no later than within 30 days of the meeting, or as needed for regulatory reporting. Minutes are stored in a secure area. Meeting packets are distributed by secure means to committee members prior to the scheduled meeting date with sufficient time to provide review of meeting materials, as applicable based on need for prior review and privacy/sensitivity of materials.
Decision Authority	The Member Advisory Committee is a non-voting committee to solicit feedback from local hospital representatives.
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.
Community Advisory Committee	
Charter Statement	The Community Advisory Committee is a community-wide advisory committee responsible for providing the health plan with feedback and to make recommendations regarding health plan performance from a community-based perspective.
Purpose	The purpose of the Community Advisory Committee is to assist the health plan in identifying key issues related to programs that may affect specific community groups and provide community input on potential service improvements. In addition, the Community Advisory Committee offers effective approaches from reaching or communicating with members or other issues related to the member population. Based on the health plan size and distribution, the Community Advisory Committee may include regional level committees.
Responsibilities	• To provide the health plan with feedback regarding its performance from a community-based perspective;

	• Make recommendations related to program enhancements based on the needs of the local community; • Assist health plan to identify key issues related to State programs that may directly impact specific community groups; • Provide community input on potential health plan service improvements and offer effective approaches for reaching or communicating with members or other issues related to member population.
Reports To	Performance Improvement Team
Committee Chair	VP/Director of Compliance & Regulatory Affairs
Committee Composition	Representation from key community stakeholders such as: • Church leaders • Local business leaders • Hospital representatives • Representatives from advocacy groups • Other community based organizations
Frequency	Determined by health plan
Attendance Required	No minimum attendance required.
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 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 Community Advisory Committee is a non-voting committee intended to solicit feedback from community stakeholders.
Evaluation	The committee reviews the charter annually.
Confidentiality	Each committee member is accountable to identify confidential information or situations when/if the dissemination of the information will be managed in a specific manner. Each committee member must agree to and sign a committee confidentiality statement on an annual basis.

QUALITY DEPARTMENT STAFFING

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

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Staffing

Chief Medical Director/Medical Director(s)	The health plan's Chief Medical Director and supporting Medical Directors (including a behavioral health Medical Director) have an active unencumbered license in accordance with the health plan's state laws and regulations to serve as Medical Director to oversee and be responsible for the proper provision of core benefits and services to members, the Quality Program, the Medical Management Programs, and the Grievance System.

Quality VP/Director	The VP/Director of Quality is a registered nurse or other qualified person with experience in health care, data analysis, barrier analysis, and project management as it relates to improving the clinical quality of care and quality of service provided to the members. The Quality VP/Director reports to identified executive leadership and is responsible for directing the activities of the quality staff in monitoring and auditing the health plan's

	health care delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality, and clinical quality. The Quality VP/Director assists the senior executive staff, both clinical and non-clinical, in overseeing the activities of the operations to meet the goal of providing health care services that improve the health status and health outcomes of its members. Additionally, the Quality VP/Director coordinates the Quality Improvement Committee proceedings in conjunction with the Chief Medical Director, supports corporate initiatives through participation on committees and projects as requested, reviews statistical analysis of clinical, service and utilization data, and recommends performance improvement initiatives while incorporating best practices as applicable.
Quality Coordinator/Specialist	Quality Coordinators/Specialists are highly trained clinical and non-clinical staff with significant experience in a health care setting; experience with data analysis and/or project management. At least one of the health plan's Quality Coordinators/Specialists is a registered nurse. Quality Coordinators/Specialists scope of work may include medical record audits, data collection for various quality improvement studies and activities, data analysis and implementation of improvement activities, and complaint response with follow up review of risk management and sentinel/adverse event issues. A Quality Coordinator/Specialist may specialize in one area of the quality process or may be cross-trained across several areas. The Quality Coordinator/Specialist collaborates with other departments as needed to implement corrective action or improvement initiatives as identified through health plan's quality improvement activities and quality of care reviews
HEDIS Coordinator	The HEDIS coordinator is a highly trained individual with significant experience in managed health care, data analysis, and project management. The HEDIS Coordinator is responsible for coordinating the documentation, collection and reporting of HEDIS measures to both NCQA and the State as required.
Accreditation Specialist	The Accreditation Specialist reports to and supports the Accreditation Manager in the achievement of as well as the ongoing maintenance of health plan NCQA Accreditation and HEDIS reporting processes and requirements. The Accreditation Specialist supports the document prep and submission of documents for the accreditation survey. He or she supports the development of health plan performance improvement activities. In addition, the Accreditation Specialist may coordinate delegation vendor oversight.
Grievance & Appeals Manager	The Grievance & Appeals Manager is responsible for the appropriate processing of member grievances and appeals as well as requests for State Fair Hearings and external reviews. The Grievance & Appeals Manager is required to attend and represent grievances and appeals in multiple internal health plan committees as needed. This position manages grievance and appeal data and reports and the day to day responsibilities of the Grievance & Appeals Coordinator. The Grievance & Appeals Manager reports to the Quality VP/Director.
Grievance & Appeals Coordinator	The Grievance & Appeal Coordinator logs member grievances and appeals, and refers those pertaining to potential quality of care issues to a Quality Coordinator (or Medical Director as appropriate) for investigation and resolution. The Grievance & Appeal Coordinator evaluates complaints and grievances by type, location, and region to identify trends indicating potential areas in need of further analysis and intervention. The Grievance & Appeal Coordinator also tracks and resolves all administrative member grievances and provider complaints. The Grievance & Appeals Coordinator reports to the Grievance & Appeals Manager.

INTER/INTRADEPARTMENTAL QUALITY PROGRAM RESOURCES

The Quality Department maintains strong inter/intradepartmental working relationships, with support integrated throughout the health plan to address the goals and objectives of the Quality Program and assess effectiveness of the program. Collaborative activities include development of department objectives and plans, coordination of activities to achieve department goals, and participation on quality committees as needed to support the Quality Program. Partnerships include, but are not limited to, the health plan departments/functional areas identified below:

- Medical Management Operations

- Pharmacy
- Provider Engagement/Provider Relations
- Network/Contracting
- Member Services
- Compliance

ADDITIONAL PROGRAM RESOURCES

The management information systems supporting the Quality Program allow key personnel the necessary access and ability to manage the data required to support the reporting and measurement aspects of quality improvement activities.

- **Centelligence**TM **-** A comprehensive family of integrated decision support and health care informatics solutions. The Centelligence platform integrates data from internal and external sources, producing actionable information: care gap and wellness alerts, key performance indicator (KPI) dashboards, provider clinical profiling analyses, population level health risk stratifications, HEDIS and hybrid HEDIS reporting, and unique operational and state compliance reports. The web-based reporting platform provides advanced capabilities for provider practice pattern and utilization reporting, supporting both quality staff and providers with summary and detailed views of clinical quality and cost profiling information. Centelligence includes a predictive modeling application with care gap and health risk identification applications to identify and report potentially significant health risks at multiple population, provider, and member levels. The Enterprise Data Warehouse (EDW) receives, integrates, and continually analyzes transactional data, such as medical, behavioral, and pharmacy claims, lab test results, health screenings/assessments, service authorizations, and member and provider information as required for the Quality Program.

- **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 coordination, and case, behavioral health, condition, and utilization management. Integrated with Centelligence for access to supporting clinical data, TruCare allows Medical Management and Quality department staff to capture utilization, care, and population health management data, to proactively identify, stratify, and monitor high-risk enrollees, to consistently determine appropriate levels of care through integration with InterQual 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.

- **Quality Spectrum Insight - XL (QSI-XL) and INDICES -** an Inovalon software system used to monitor, profile, and report on the treatment of specific episodes, care quality, and care delivery patterns. QSI-XL produces NCQA-certified HEDIS measures and is an NCQA-certified software, its primary use is for the purpose of building and tabulating HEDIS and other state required performance measures. QSI-XL 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 the health plan with 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. QSI-XL and INDICES are updated at least monthly by using an interface that extracts claims, member, provider, and financial data. Data are mapped into QSI-XL and summarized. Staff is given access to view standard data summaries and drill down into the data or request ad-hoc queries.

SilverSummit Healthplan obtains data and analytical support through the Information and Management Systems Department, Corporate Quality, Health Economics, and other support resources as deemed necessary, which may include corporate and health plan resources.

DOCUMENTATION CYCLE

The Quality Program incorporates an ongoing documentation cycle that applies a systematic process of quality assessment, identification of opportunities, action implementation as indicated, and evaluation. Several key quality instruments demonstrate SilverSummit Healthplan's continuous quality improvement cycle using a pre-determined documentation flow such as the:

- Quality Program Description
- Quality Work Plan
- Quality Program Evaluation

Quality Program Description: The Quality Program Description is a written document that outlines SilverSummit Healthplan's structure and process to monitor and improve the quality and safety of clinical care and the quality of services. The Quality Program Description includes at least the following: specific roles, structure, and function of the QIC and subcommittees/work groups, including meeting frequency and accountability to the governing body, a description of dedicated Quality Program staff and resources, and behavioral health care involvement. No less than annually, ideally during the first quarter of each calendar year, the designated quality staff prepares, reviews, and revises as needed the Quality Program Description. The Quality Program Description is reviewed and approved by the QIC and Board of Directors on an annual basis. Changes or amendments are noted in the "Revision Log. SilverSummit Healthplan submits any substantial changes to its Quality Program Description to the QIC and appropriate state agency for review and approval as required by state contract, if applicable.

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

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

The Work Plan is developed annually after completing the Quality Program Evaluation for the previous year, and includes all recommendations for improvements from the annual Program Evaluation. The Work Plan reflects the ongoing progress of the quality activities, including:

- Yearly planned quality activities and objectives for improving quality of clinical care, safety of clinical care, quality of services and member experience;
- Timeframe for each activity's completion;
- Staff members responsible for each activity;
- Monitoring of previously identified issues; and
- Evaluation of Quality Program.

SilverSummit Healthplan utilizes the existing Work Plan and confirms compliance with the health plan's current needs, the most recent updates from NCQA, and assures the Work Plan reflects all current state and/or federal requirements. Work Plan status reports are reviewed by the QIC on a regular basis (e.g. quarterly or semiannually). The Work Plan is a fluid document; designated quality staff make frequent updates to document progress of the Quality Program throughout the year.

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

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

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

- Analysis and evaluation of the overall effectiveness of the Quality Program, including progress toward influencing network-wide safe clinical practices;
- A description of completed and ongoing quality activities that address quality and safety of clinical care and quality of service;

- Trending of measures collected over time to assess performance in quality of clinical care and quality of service;
- Interventions implemented to address the issues chosen for performance improvement projects and focused studies;
- Measurement of outcomes;
- Measurement of the effectiveness of interventions;
- An analysis of whether there have been demonstrated improvements in the quality of clinical care and/or quality of services;
- Identification of limitations and barriers to achieving program goals;
- Recommendations for the upcoming year's Quality Work Plan;
- An evaluation of the scope and content of the Quality Program Description to ensure it covers all types of services in all settings and reflects demographic and health characteristics of the member population;
- An evaluation of the adequacy of resources and training related to the Quality Program; and
- The communication of necessary information to other committees when problems or opportunities to improve member care involved more than one committee's intervention.

At the end of the Quality Program cycle each year (calendar year, unless otherwise specified by state contract), the Quality Department facilitate/prepare the Quality Program Evaluation. The evaluation assesses both progress in implementing the quality improvement strategy and the extent to which the strategy is in fact promoting the development of an effective Quality Program. Recommended changes in program strategy or administration and commitment of resources that have been forwarded and considered by the QIC should be included in the document.

In addition to providing information to the QIC, the annual Program Evaluation, or an executive summary as appropriate, can be used to provide information to a larger audience such as, accrediting agencies, regulators, stockholders, new employees, and the Board of Directors.

CLINICAL PERFORMANCE MEASURES

As reported by NCQA, HEDIS is one of the most widely used sets of health care performance measures in the United States. HEDIS includes measures across 5 domains of care including: Effectiveness of Care, Access and Availability, Satisfaction with the Experience of Care, Use of Services, Cost of Care, Health Plan Descriptive Information, Health Plan Stability, and Informed Health Care Choices.

HEDIS rates and state performance metrics are used by SilverSummit Healthplan as one of the primary sources to monitor, assess, and promote patient safety and quality of care. HEDIS is a collaborative process between the health plan, Corporate Quality, and several external vendors. Ultimate ownership and accountability of the HEDIS project, HEDIS and CAHPS/QHP survey metrics, as well as state and CMS performance metrics are the responsibility of the health plan. SilverSummit Healthplan reports and monitors population appropriate metrics as defined by NCQA and/or state and federal contracts.

SilverSummit Healthplan calculates and analyzes HEDIS rates at least annually utilizing Inovalon's NCQA-certified QSI-XL software. HEDIS rates, analysis, and progress of the HEDIS

work plan are reported to the QIC and appropriate subcommittees at least annually. HEDIS rates are audited by an NCQA-certified auditor and submitted to NCQA, the Centers for Medicare and Medicaid Services (CMS), and the State as required by state and federal contracts. In order to facilitate External Quality Review Organization (EQRO) analytical review to assess the quality of care and service provided to members, and to identify opportunities for improvement, the health plan supplies claims and encounter data to the appropriate EQRO and works collaboratively with the state agency and the EQRO to assess and implement interventions for improvement.

PROMOTING MEMBER SAFETY AND QUALITY OF CARE

The Quality Program is a multidisciplinary program that utilizes an integrated approach to monitor, assess, and promote patient safety and quality of care SilverSummit Healthplan has mechanisms to assess the quality and appropriateness of care furnished to all members including those with special health care needs, as defined by the State. These activities are both clinical and non-clinical in nature and address physical health, behavioral health, and social health services, and include but are not limited to, the following:

Member safety is a key focus of the SilverSummit Healthplan Quality Program. Monitoring and promoting member safety is integrated throughout many activities across the health plan, including through identification of potential and/or actual quality of care events and critical incidents, as applicable. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of member care, is not compliant with evidence-based standard practices of care, or signals a potential sentinel event, up to and including death of a member. Employees (including medical management staff, member services staff, provider services staff, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, state partners, Medical Directors, or the Board of Directors may inform the Quality Department of potential quality of care issues and/or critical incidents. Potential quality of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action, up to and including review by the Peer Review Committee as indicated. Potential quality of care issues and critical incidents received in the Quality Department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

In addition, the health plan monitors for quality of care and/or adverse events through claims-based reporting mechanisms. An adverse event is an event over which health care personnel could have exercised control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred. Although occurrence of an adverse event in and of itself is not necessarily a preventable quality of care issue, SilverSummit Healthplan monitors and tracks these occurrences for trends in type, location, etc., to monitor member safety and investigates further and/or requests a corrective action plan any time a quality of care issue is definitively substantiated.

The Quality Program also supports member safety initiatives in the education of practitioners, providers, and members about safe practice protocols and procedures. These initiatives include utilizing provider and member newsletter articles and mailings to communicate information regarding member safety. SilverSummit Healthplan may incorporate the review of practitioner and provider initiatives to improve member safety.

Access and Availability - SilverSummit Healthplan's QIC provides oversight to the provider network in order to ensure adequate numbers and geographic distribution of primary care, specialists, and behavioral health practitioners, while taking into consideration the special and cultural needs of members.

Practitioner availability is analyzed at least annually by the Network/Contracting or Provider Relations Department. Results are reviewed and recommendations are made to the QIC to address any deficiencies in the number and distribution of primary care, specialty, and behavioral health practitioners. Availability of hospitals, ancillary, and other provider types is also assessed per applicable state or federal contract requirements. The QIC sets standards for the number and geographic distribution of the above listed practitioners/providers in accordance with state or federal requirements, with consideration of clinical safety and appropriate standards for the applicable service area.

The Quality Department analyzes practitioner appointment accessibility (primary, specialty, and behavioral health care practitioners) and Member Services telephone accessibility at least annually. Results are reviewed by the QIC and included in the annual Quality Program Evaluation to ensure compliance with contractual, regulatory, and accreditation requirements and to maintain appropriate appointment access and availability.

Member and Provider Experience - SilverSummit Healthplan supports continuous ongoing measurement of clinical and non-clinical effectiveness and member and provider experience by monitoring member and provider complaints and appeals, member and provider satisfaction surveys, and member and provider call center performance. The health plan collects and analyzes data at least annually to measure its performance against established benchmarks or standards and identifies and prioritizes improvement opportunities. Specific interventions are developed and implemented to improve performance and the effectiveness of each intervention is measured at specific intervals, applicable to the intervention.

SilverSummit Healthplan solicits feedback from members, medical consenters, and caregivers to assess satisfaction using a range of approaches, such as the CAHPS member satisfaction survey, monitoring member complaints/grievances, and direct feedback from member focus groups and/or the Member Advisory Committee. The Quality Department is responsible for coordinating the CAHPS/QHP surveys, aggregating and analyzing the findings and reporting the results. Survey results are reviewed by the QIC, with specific recommendations for performance improvement interventions or actions. The Member Advisory Committee or other member focus group may also review survey results.

Provider satisfaction is assessed annually using valid survey methodology and a standardized comprehensive survey tool. The survey tool is designed to assess provider satisfaction with the network, claims, quality, utilization management, and other administrative services. The Provider Communications/Network Development departments are responsible for coordinating the provider satisfaction survey, aggregating and analyzing the findings, and reporting the results to appropriate committees. Survey results are reviewed by the QIC, with specific recommendations for performance improvement interventions or actions.

Member Grievances and Provider Complaints - The Quality Department investigates and resolves member quality of care concerns/grievances. Member grievances related to quality of

care and service are tracked, classified according to severity, reviewed by the Medical Directors, categorized by the Quality Department, and analyzed and reported on a routine basis to the QIC. The QIC recommends specific practitioner/provider improvement activities as needed.

All member grievances are tracked and resolution is facilitated by the Grievance and Appeal Coordinator. Data are analyzed and reported to the QIC on a regular basis to identify trends and to recommend performance improvement activities as appropriate. Grievance reports are submitted to the QIC, along with recommendations for quality improvement activities based on results.

All provider complaints are tracked and resolution is facilitated by the Provider Services Department. Data are reported to and analyzed by the QIC on a regular basis to identify trends and to recommend performance improvement activities as appropriate. Provider complaint reports are submitted to the QIC, along with recommendations for quality improvement activities based on results.

Practice Guidelines - Preventive health and clinical practice guidelines assist practitioners, providers, members, medical consenters, and caregivers in making decisions regarding health care in specific clinical situations. Guidelines are adopted in consultation with network practitioners/providers (including behavioral health as indicated) and based on the health needs and opportunities for improvement identified as part of the Quality Program, valid and reliable clinical evidence or a consensus of health care professionals in the particular field, and needs of the members. SilverSummit Healthplan adopts clinical practice guidelines for at least two (2) non-preventive acute or chronic medical conditions and at least two (2) behavioral health conditions (preventive or non-preventive) relevant to the target population. At least two (2) of the adopted clinical practice guidelines directly correspond with disease management programs offered by the health plan. SilverSummit Healthplan also adopts preventive health guidelines for perinatal care, care for children, and care for adults. Clinical and preventive health guidelines are updated upon significant new scientific evidence or change in national standards or at least every two (2) years. Guidelines are distributed to providers via the Provider Manual, website, and/or provider newsletters.

Practitioner adherence to health plan's adopted preventive and clinical practice guidelines may be encouraged in the following ways: new provider orientations include the practice guidelines section of the Provider Manual with discussion of health plan expectations; measures of compliance are shared in provider newsletter articles available on the provider web site; targeted mail outs that include guidelines relevant to specific provider types underscore the importance of compliance; and the Provider Profiling program, as discussed later in this document, also work to promote compliance with practice guidelines.

SilverSummit Healthplan uses applicable HEDIS measures to monitor practitioner compliance with adopted guidelines. If performance measurement rates fall below the health plan/state/accreditation goals, SilverSummit Healthplan implements interventions for improvement as applicable. Monitoring outcomes and analysis is presented to the QIC at least annually.

Continuity and Coordination of Care – the health plan monitors and takes action as needed to improve continuity and coordination of care across the health care network. This includes

continuity and coordination of medical care through collection of data on member movement between practitioners *and* data on member movement across settings. Annually, this data is collected and analyzed to identify opportunities for improvement, opportunities for improvement are selected, and actions to improve coordination of medical care are implemented. The effectiveness of improvement actions are also measured annually and re-measurement results analyzed.

Continuity and coordination between medical care and behavioral healthcare is also monitored on an annual basis. Data is collected in the following areas to identify opportunities for collaboration: exchange of information; appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care; appropriate use of psychotropic medications; management of treatment access and follow-up for members with coexisting medical and behavioral disorders; primary or secondary preventive behavioral healthcare program implementation; and special needs of members with severe and persistent mental illness. The health plan collaborates with behavioral healthcare practitioners to complete analysis of the data collected in the areas noted above, and identify opportunities for improvement. Opportunities for improvement are then selected and actions taken to improve continuity and coordination between medical care and behavioral healthcare, with the effectiveness of improvement actions measured and re-measurement results analyzed annually.

Continuity and coordination of medical care and between medical care and behavioral healthcare may be assessed via several different measures or activities. These include but are not limited to, HEDIS measures, CAHPS or other member experience survey results, provider satisfaction surveys, etc.

Medical Record Documentation Standards - As required by state and federal regulations, SilverSummit Healthplan monitors network practitioners for maintenance of medical records in a current, detailed, and organized manner which permits effective and confidential patient care and quality review. The minimum standards for practitioner medical record keeping practices, which include medical record content, medical record organization, ease of retrieving medical records, and maintaining confidentiality of member information, are outlined in the Provider Manual. Additionally, the health plan may conduct medical record reviews for purposes including, but not limited to, utilization review, quality management, medical claim review, or member complaint/appeal investigation. Providers must meet specific requirements for medical record keeping; elements scoring below a determined benchmark are considered deficient and in need of improvement. The health plan works with providers who score below benchmark to develop an action plan for improvement. Medical record review results are filed in the Quality Department and shared with the Credentialing Department for consideration at the time of recredentialing.

Monitoring Utilization Patterns - To ensure appropriate care and service to members, the Medical Management Committee performs at least an annual assessment of utilization data to identify potential over- and under-utilization issues or practices. Data analysis is conducted using various data sources such as medical, behavioral health, pharmacy, dental, and vision encounter data reporting to identify patterns of potential or actual inappropriate utilization of services. The Medical Management Department works closely with the Quality Department, Chief Medical Director, VP Medical Management, and Medical Directors to identify problem areas and provide

improvement recommendations to the QIC for approval. Once approved, the Quality and Medical Management departments implement approved actions to improve appropriate utilization of services.

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

- General and supportive member and provider education such as articles in member and provider newsletters, face-to-face interactions, and written educational materials provided to members at health fairs, diaper distribution events, etc.
- Targeted telephonic and/or written outreach to members/parents/guardians to remind of applicable preventive health screenings and services due or overdue and assistance with scheduling appointments and transportation to the appointments as needed.
- Targeted written and/or face-to-face education and communication to providers identifying assigned members due or overdue for preventive health screenings such as annual well visits, immunizations, lead testing, cervical cancer screening, breast cancer screening, etc.

Chronic Care and Complex Care Management - provides care and condition management for members identified at risk, intervenes with specific programs of care, and measures clinical and other health-related outcomes. Decision support encourages informed health care decisions by providing members with education about their conditions and treatment options, and by supporting members to make informed treatment decisions in collaboration with their providers. SilverSummit Healthplan’s condition management and population health management programs help members understand their diagnoses, learn self-care skills, and adhere to treatment plans. All clinical management programs include the use of general awareness and targeted outreach and educational interventions, including but not limited to, newsletter articles, advertising regarding available programs, direct educational/informational mailings, and care management. Programs also include written communication to primary care providers informing of members on their panel with chronic conditions such as diabetes and/or hypertension and reminders on appropriate screening and monitoring tests as recommended by evidenced-based practice guidelines. Clinical care management programs include asthma, behavioral health, diabetes, lead poisoning, and high risk OB management. The Care Management Program Description further outlines the health plan’s approach to addressing the needs of members with complex health issues, which may include: physical disabilities, developmental disabilities, chronic conditions, and severe and persistent mental illness.

Practitioner/Provider Profiling - as part of its network performance strategy, the health plan systematically profiles the quality of care delivered by high-volume PCPs or other network practitioners to improve provider compliance with preventive health and clinical practice guidelines and clinical performance indicators. By providing quantitative feedback on clinical measures, the health plan promotes the success of providers and the health of members. The profiling system is developed with input from SilverSummit Healthplan network providers to

ensure the process has value to practitioners, providers, members, and may include a financial component as noted below.

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

Profiles include a multidimensional assessment of a PCP or other practitioner's performance using clinical and administrative indicators of care that are accurate, measurable, and relevant to the target population. To support providers in their delivery of robust preventive and interventive care, SilverSummit Healthplan provides quantitative and actionable analyses of the providers' member panel via analytic tools.

The health plan offers a population health management tool designed to support providers in the delivery of timely, efficient and evidence-based care to members. Claims data is used to create a detailed profile of each member with the ability to organize members by quality measures and disease conditions. This provider analytics tool includes:

- Disease registries
- Care gap reporting at member and population levels
- Claims-based patient histories
- Exportable patient data to support member outreach

Additional assessment, at SilverSummit Healthplan's discretion, may include such elements as availability of extended office hours, member complaint rates, and compliance with medical record standards.

The health plan implements a provider profiling program that transitions to an incentive program after adequate time has elapsed for testing the measures and incorporating provider feedback as indicated. To support providers in their incentive programs, SilverSummit Healthplan provides quantitative and actionable analyses of the provider's performance via portal-based tools.

SilverSummit Healthplan offers a cost and utilization tool designed to support providers who participate in a value-based program in order to identify provider performance opportunities and assist with population health management initiatives. Provider analytics prioritizes measures based on providers' performance to help identify where to focus clinical efforts in order to optimize pay-for-performance (P4P) payouts, which may include:

- Key performance indicators
- Cost and utilization data
- Emergency room cost, utilization, and trending data
- Pharmacy comparisons of brand vs. generic
- Value-Based Contracting performance summaries

Through these supporting platforms, the health plan works to keep providers engaged in the delivery of value-based care by promoting wellness and incentivizing the prudent maintenance of

chronic conditions. This engagement helps providers identify performance insights as well as identify opportunities for improvement. Practitioners who meet or exceed established performance goals and who demonstrate continued excellence or significant improvement over time may be recognized by SilverSummit Healthplan in publications such as newsletters, bulletins, press releases, and recognition in the provider directories.

Interventions are discussed with the practitioner to address practitioners' performance that is out of range (outliers) from their peers, and such interventions may include, but are not limited to, provider education, sharing of best practices and/or documentation tools, assistance with barrier analysis, development of corrective action plans, ongoing medical record reviews, and potential termination of network status when recommended improvements are not implemented. Providers identified as significantly outside the norm are re-measured at six (6) month intervals.

PERFORMANCE IMPROVEMENT ACTIVITIES

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

The health plan utilizes traditional quality/risk/utilization management approaches to identify activities relevant to the health plan programs or a specific member population and that describe an observable, measurable, and manageable issue. Initiatives are identified through analysis of key indicators of care and service based on reliable data which indicate the need for improvement in a particular clinical or non-clinical area. Baseline data may come from: performance profiling of contracted providers, mid-level providers, ancillary providers and organizational providers; provider office site evaluations; focus studies; utilization information (over-and under-utilization performance indicators); sentinel event monitoring; trends in member complaints, grievances and/or appeals; issues identified during care coordination; and/or referrals from any source indicating potential problems, including those identified by affiliated hospitals and contracted providers. Other initiatives may be selected to test an innovative strategy or as required by state or federal contract. Projects and focus studies reflect the population served with consideration of social determinants of health, age groups, disease categories, and special risk status.

The QIC assists in prioritizing initiatives focusing on those with the greatest need or expected impact on health outcomes and member experience. Performance improvement projects, focused studies, and other quality initiatives are designed to achieve and sustain, through ongoing measurements and interventions, significant improvement over time in clinical and non-clinical care areas in accordance with principles of sound research design and appropriate statistical analysis. The QIC helps to define the study question and the quantifiable indicators, criteria, and goals to ensure the project is measureable and able to show sustained improvement. Evidence-based guidelines, industry standards, and contractual requirements are used as the foundation for developing performance indicators, setting benchmarks and/or performance targets, and designing projects and programs that assist providers and members in managing the health of members. If data collection is conducted for a random sample of the population, baseline and

follow-up sampling is conducted using the same methodology and statistical significance and a 90% or more confidence level is determined.

The QIC or subcommittee/work group may also assist in barrier analysis and development of interventions for improvement. Data are re-measured at predefined intervals to monitor progress and make changes to interventions as indicated. Once a best practice is identified, control monitoring reports are implemented to monitor for changes in the process and need for additional intervention. Improvement that is maintained for one (1) year is considered valid and may include, but is not limited to, the following:

- The achievement of a pre-defined goal and/or benchmark level of performance;
- The achievement of a reduction of at least 10% in the number of members who do not achieve the outcome defined by the indicator (or, the number of instances in which the desired outcome is not achieved); and
- The improvement is reasonably attributable to interventions undertaken by the health plan.

COMMUNICATING TO MEMBERS AND PROVIDERS

At least annually, SilverSummit Healthplan provides information, including a description of the Quality Program and a report on the health plan’s progress in meeting Quality Program goals, to members and providers. At a minimum, the communication addresses how to request information about Quality Program goals, processes, and outcomes as they relate to member care and service which includes health plan specific data results such as HEDIS, CAHPS/QHP surveys, and results of performance improvement projects. Information about how to obtain a hard copy description of the program and/or program outcomes is included on the website and/or in the Member Handbook and Provider Manual. Information available to members and providers may include full copies of the Quality Program Description and/or Quality Program Evaluation (when requested), or summary documents. Member materials are written at an appropriate reading level or as mandated by state or federal contract and monitored for compliance. Members requiring/requesting receipt of information in an alternative format are identified by SilverSummit Healthplan, either through a direct request or through normal member service and/or medical management functions, taking into consideration the member’s special needs, including those who are visually impaired, have limited reading proficiency or cultural differences SilverSummit Healthplan communicates this need to the Corporate Communications Department who works with external vendors to create the alternative format on an as needed basis.

REGULATORY COMPLIANCE AND REPORTING

SilverSummit Healthplan departments perform required quality of service, clinical performance, and utilization studies throughout the year based on contractual requirements, requirements of other state and regulatory agencies and those of applicable accrediting bodies such as NCQA. All functional areas utilize standards/guidelines from these sources and those promulgated by national and state medical societies or associations, the Centers for Disease Control, and the federal government. The Quality Department maintains a schedule of relevant quality reporting requirements for all applicable state and federal regulations and accreditation requirements, and submits reports in accordance with these requirements. This includes any federal/state requirements that apply to joint contracts (e.g., dual eligible Special Needs Plans, Financial Alignment Demonstrations, etc.). Additionally, the Quality Program and all health plan

departments fully support every aspect of the federal privacy and security standards, Business Ethics and Integrity Program, Compliance Plan, and Waste, Fraud and Abuse Plan.

DELEGATED SERVICES

The QIC may authorize participating provider entities such as independent practice associations or hospitals, or organizations such as disease management companies to perform activities (such as utilization management, care management, credentialing, or quality) on the health plan's behalf. SilverSummit Healthplan evaluates each delegated entity's capacity to perform the proposed delegated activities prior to the execution of a delegation agreement. A mutually agreed upon delegation agreement, signed by both parties, includes, but is not limited to, the following elements:

- Responsibilities of the health plan and the delegate
- Specific activities being delegated
- Frequency and type of reporting (i.e. minimum of semiannual reporting)
- The process by which the health plan evaluates the delegate's performance
- Explicit statement of consequences and corrective action process if the delegate fails to meet the terms of the agreement, up to and including revocation of the delegation agreement
- The process for providing member experience and clinical performance data to the delegate when requested

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

SilverSummit Healthplan retains accountability for all functions and services delegated, and as such monitors the performance of the delegated entity through annual approval of the delegate's programs (Credentialing, Utilization Management, Care Management, Quality, etc.), routine reporting of key performance metrics, and annual or more frequent evaluation to determine whether the delegated activities are being carried out according to health plan and regulatory requirements and accreditation standards. SilverSummit Healthplan Medical Management, Quality and/or Compliance designees, in conjunction with Centene Corporate Compliance designees, conduct an annual evaluation and documentation review that includes the delegate's program, applicable policies and procedures, applicable file reviews, and review of meetings minutes for compliance with health plan, state and federal requirements and accreditation standards. The health plan retains the right to reclaim the responsibility for performance of delegated functions, at any time, if the delegate is not performing adequately.

Delegated services may include dental care, vision services, pharmacy management services, transportation, nurse hotline, and disease management services. See individual delegation agreements for specifics on delegated activities.

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

ENDORSEMENT OF THE Quality Program Description

The Quality Program Description has been reviewed and endorsed by the quality senior leadership effective this day of 1st day month of July 2019.

Roxane Coulter, RN, BSN
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Vice President/Director Quality

Joel Silberberg, MD (Medical Director)
____
Chief Medical Director

ENDORSEMENT OF THE Quality Program Description
The Quality Program Description has been reviewed and endorsed by the Board of Directors effective this day of 9th day, month of August, 2019.

Eric Schmacker
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Board of Directors Chairman