SilverSummit Healthplan PHM Strategy

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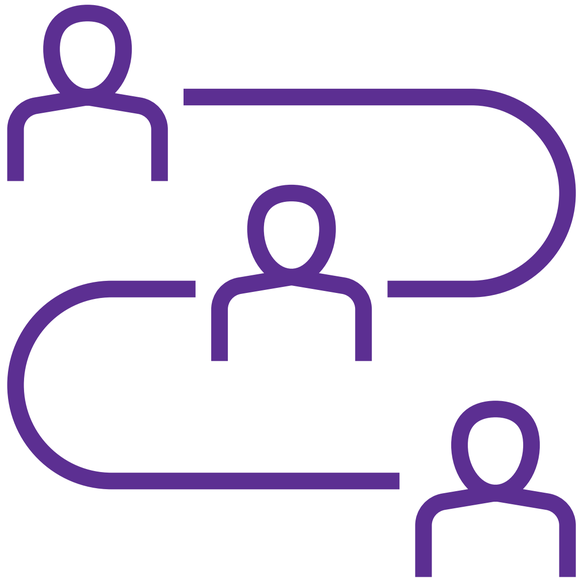
Medicaid 2022

Population Health Management Program Overview

PHM Framework



- Evidence Based
- Addressed Members needs across the continuum
- Members are ALWAYS at the center
- PHM is utilized to guide, organize, align and collaborate across the health ecosystem
- Leverages population health data science and analytics to improve overall population health

Population Health Management Pillars

The three pillars differentiates our PHM Framework. The Three pillars are:

Whole Health

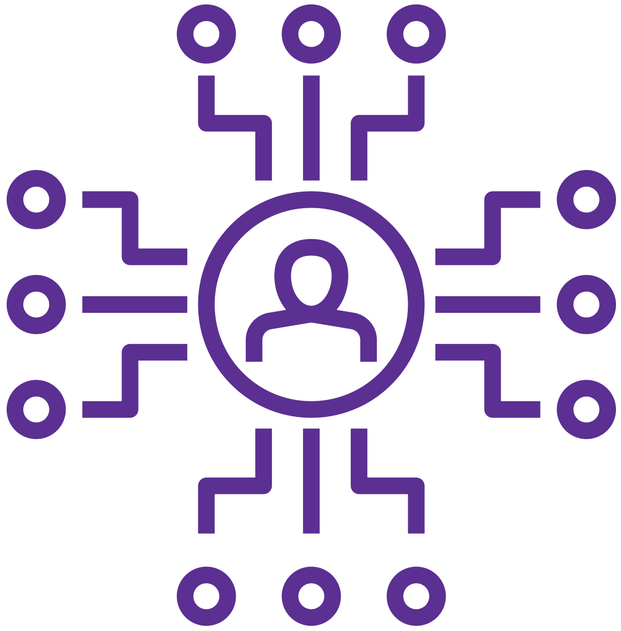
Focus on Individuals

Active local Involvement

PHM strategy aims to reduce and prevent health risks, manages existing conditions across the population and applying relevant programs to service our members needs.

Clinical Domains

Identified and established clinical domains to categorize the PHM programs, services, and activities. Each domain has multiple programs. The domains are as follows:



- **Behavioral Health**
- **Maternal-Child Health**
- **Medical Conditions**
- **Independent Living (includes LTSS)**
- **High Acuity & Transition**
- **Advanced Illness**

Annual Population Health Assessment

Annually, SSHP conducts a Population Health Assessment and updates our PHM strategy to reflect changes in the population, develop programs and services and goals to meet the needs of the targeted population. There are four areas of focus:

Keeping Members Healthy

Managing Multiple Chronic Illnesses

Managing Members with Emerging Risk

Patient Safety or Outcomes Across Settings

Every single SSHP member falls into one of these four categories and are aligned to the Population Health Categories. Members can fall into more than one focus area and/or transition within focus areas as conditions and health status changes

Informing Members about Programs and Services

Informing & Engaging with SSHP Members

Silver Summit Healthplan uses a multichannel approach including online, print, digital and person-to-person communication to engage our members and provided information/education

- **New Member Welcome Packets Mail** (sent via US Postal)
- **Telephonic Outreach** (unsolicited)
  (members identified during risk stratification)
- **Telephonic Outreach** (members who agree to be enrolled)
- **Customer Service** (Member inquiry or Request for Assistance)
- **Email**
- **Automated Text/SMS (opt-in)**
- **Website**
- **Annual Newsletter**
- **Face to face visits**
- **Member Handbook**
- **Member Portal**
- **Automated Calls**
- **Community Events**

Data and Information Sharing

- **Providers receive claims information on their assigned members**
- **Providers have access to SSHP provider portal for additional resources, authorization detail, claim status, eligibility inquiry.**
- **Program specific reporting from various tools including WebIZ, and the HIE**

Silver Summit Healthplan is a web based, PHI secured platform

Performance Analytics Platform: Suite of tools designed to contribute to both the health of our members and the success of our providers.

Tools consist of three applications:

- **Patient (Member) Analytics**
- **Intrepreta**
- **Provider Analytics**

Provider Practice Transformation

Pay for Performance (P4P) Program

Silver Summit Healthplan provides support to primary care practices in the delivery of safe, effective, and efficient care to improve integration, optimize the patient/member experience, and move towards value-based care.

Provides financial incentives for engaging members and closing care gaps based on NCQA and HEDIS quality performance standards.

- Member Engagement Ratio
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Breast Cancer Screening
- Proportion of Days Covered (Statins)
- Proportion of Days Covered (ACE/ARB)
- Proportion of Days Covered (Diabetes) Medication
- Management Asthma
- Antidepressant Medication - Acute Phase
- Antidepressant Medication - Continuation Phase
- Comprehensive Diabetes Care – eye exam
- Comprehensive Diabetes Care – HbA1c Control
- Comprehensive Diabetes Care – Nephropathy
- Controlling Blood Pressure

Value Based Care

- **Key component to PHM framework**
- **Providers have access to our proprietary Quality Risk Model suite of reporting.**
- **Enables providers to prioritize care and align to the QRM risk contracts.**
- **Incentivizes providers to improve the quality of care of our members by directly tying the provider's performance to member outcomes**

Provider Education

- SSHP provides clinical practice and preventive health guidelines to network provider via the provider website
- Provides access to Choosing Wisely through our provider website

  - Choosing Wisely is an initiative of the ABIM Foundation that seeds ot advance a national dialogue of avoiding unnecessary medical tests, treatments, and procedures.

Program and Service Coordination

PHM Framework is a foundational component to our approach to Care Coordination, and central to our Care Coordination model which is to improve the health of the SSHP population, one member at a time

Holistic and Integrated Care Coordination

SSHP care team is organized around the member to provide simple and coordinated services through the following structure

1. One primary contact at the Healthplan to ensure streamlined communication and the coordination of programs and services

2. One Care Management/Service Plan

3. One Care Management Team (varies in size and composition based on member needs)

4. A team that is trained in Person Centered Thinking/Person Centered Planning

Care Coordination Continued

Proactive Information Coordination

- Copies of all care plans and/or interventional programs and other member updates to the members practitioner

Member Information Orchestration and Engagement

- Understanding who are customers/member are and how they engage is the focus of member orchestration

- SSHP uses a variety of tools to drive member engagement. This includes Omni, and Prime

Multi-disciplinary, Interdisciplinary, Cross-Functional Rounds, Teams and/or work groups

- Assists to develop and maintain strategies for effective and efficient PHM program coordination. Most notable cross-functional teams and work groups for SSHP are as follows:

Quality Improvement Committee (QIC), Population Health Management Committee (PHMC), Performance Improvement Team (PIT), Member Experience Satisfaction Committee (CAHPS, QHP EES, ECHO Behavioral Health), Community Advisory Committee (CAC), Member Advisory Committee (MAC), Health Equity Committee (HEC), Vendor Management Oversight Committee (VMOC) (Summit Behavioral Health (SBH), National Imaging Associates Inc. (NIA), TurningPoint HealthCare LLC (TPH), and Vida Health)

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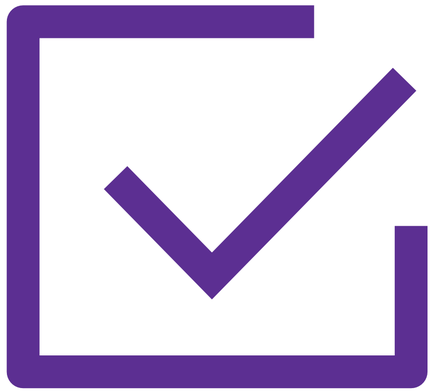
- Imaging Associates Inc. (NIA), TurningPoint HealthCare LLC (TPH), and Vida Health)

Population Identification

Data Integration

Proprietary platform combines data from multiple sources and systems to segment and stratify the population to determine their care needs by using a combination of proprietary algorithms and advance predictive analytics. Some of the data points include the following:



- **Medical Claims Data**
- **Behavioral Health Claims Data**
- **Pharmacy Claims Data**
- **Laboratory Claims Data, including Lab Results when Available**
- **Health Appraisal/Health Screening/Health Risk Assessment Data**
- **Electronic Health Records, when Available**
- **Utilization Management and Care Management Program Data**
- **Nevada Immunization Registry and Health Information Exchanges**
- **Member Demographics**
- **Member Information (e.g., eligibility, PCP assignment, etc.)**
- **Provider Information (e.g., participation status, specialty, etc.)**

Population Assessment

SSHP conducts a comprehensive Population Health Assessment to identify the needs of our members. The following categories are assessed for member needs.

- **Demographic Characteristics and Needs, Social Determinants of Health (SDoH)**
- **Child and Adolescent Members**
- **Members with Disabilities**
- **Member with Serious and Persistent Mental Illness**
- **Racial or Ethnic Groups**
- **Members with limited English Proficiency**
- **Identifying and Assessing at Least Two Relevant Member Subpopulations**

Annually, SSHP stratifies the entire enrolled membership into meaningful subsets.

- **The annual assessment drives the PHM planning and strategy for the following year.**
- **Following analysis, changes are made to programs and activities as areas of opportunity are found.**

Commitment to Health Equity

SSHP has a specific health equity approach that identifies disparities in member demographics. Collaborates across the community on identified disparities to reduce these disparities by targeting members, provider and community interventions.

The core component of SSHP health equity approach includes:

- **Enhance and sustain organizational structure for promoting health equity including training and advocacy on cultural sensitivity, promoting diversity in recruiting and hiring, enhancing the demographic data collection, internal and external governance structure, and incorporation of our health equity improvement model across the organization**
- **Empowering members and their caregivers in their health care choices through plain language and language services innovation**
- **Deliberately addressing health inequities through a data-driven 4 step approach including analysis of inequities, identification of health equity opportunities in HEDIS, obtaining stakeholder (member driven) feedback and partnership and implementing strategies across member, provider, and community systems**
- **Improving understanding and sensitivity to cultural diversity among staff and network providers**
- **Improving health outcomes by instilling cultural sensitivity into all parts of the organization, such as member services, network development, population health, utilization and care management, and quality improvement.**

Risk Stratification

The entire membership for SSHP is processed through our proprietary platform (Centelligence) on a regular basis to identify, enroll, track and coordinate eligible members for engagement in appropriate PHM programs

Members are risk stratified, and then segmentation is performed placing the entire population into mutually exclusive categories representing the members health status

Population Health Category	f	%
Level 01: Healthy, Stable	56,845	41.43%
Level 02: Acute Episodic	19,663	14.33%
Level 03: Healthy, At Risk	19,292	14.06%
Level 04a: Chronic Condition Big 5: Stable	7,195	05.24%
Level 04b: Chronic Condition: Other Conditions: Stable	2,347	01.71%
Level 04c: Behavioral Health Primary: Stable	6,061	04.4%
Level 05a: Health Coaching	9,150	06.67%
Level 05b: Physical Health Care Management	13,858	10.10%
Level 05c: Behavioral Health Care Management	2,014	01.47%
Level 06: Rare High-Cost Conditions	287	00.21%
Level 07a: Catastrophic: Dialysis	113	00.08%
Level 07b: Catastrophic: Active Cancer	178	00.13%
Level 07c: Catastrophic: Transplant	5	00.00%
Level 08a: Dementia	60	00.04%
Level 08b: Institutional (Custodial Care)	2	00.00%
Level 10a: End of Life	133	00.10%
Total	137,203	100%

Segmentation

2022 Segmentation ReportTotal Membership: 137,203

1 Appendix A & F2 Appendix B3 464 SSFB Executive Dashboard4 Clinical Initiatives Dashboard5 Gaps in Care report6 Claims Data-Glu Leading Indicators Executive Dashboard7 NCQA Dashboard

Clinical Domain [1]	Target Intervention [2]	Population Segment [12]	f	%
High Acuity & Transitions, Advanced Illness, Medical Conditions, Behavioral Health	Care Management Program	Members identified through predictive modeling in applicable Population Health Categories 5b-10	80,358	58.57
Medical Conditions	Chronic Conditions Suite Program	Members identified through predictive modeling in applicable Population Health Categories 5a	9,150	6.67%
Prevention & Wellness; Maternal-Child Health	Start Smart for Baby (SSFB) Program	Pregnant members in applicable Population Health Category 1-5c1	3,754	2.74%
High Acuity & Transitions, Medical Conditions, Behavioral Health	Readmission Reduction Program	Members with over utilization or potential over utilization of the Emergency Room and/or in Population Health Category 5a-5c	7,565	5.51%
High Acuity & Transition	ED Diversion Program	Members with a readmission risk score of 50 or greater, and/or high risk for readmission and/or in Population Health Category 5a-10[2]	25,022	18.24%
Prevention and Wellness; Maternal-Child Health	Childhood & AdolescentPreventive ServicesImmunizations	Child & Adolescent members with preventive health needs in applicable Population Health Category 1-5c	3,521	2.57%
Prevention and Wellness; Maternal-Child Health	Fluvention Program	Members eligible for flu vaccination per CDC definition[1]	133,700	97.45%
High Acuity & Transitions, Advanced Illness, Medical Conditions, Behavioral Health	Adult Preventative ServicesWellness visits & cancer screenings	Adult members with preventive health needs in applicable Population Health Category 1-5c[5]	106,445	77.58%
Prevention and Wellness	Healthy MembersRoutine member newsletters, call campaigns (i.e., wellness surveys, healthy activity promotions)	No chronic conditions or condition is stable, no acute concernsPopulation Health Category 1-5a	94,827	69.11%
Prevention and Wellness	Limited or No utilizationRoutine member newsletters, call campaigns (i.e.: wellness surveys, healthy activity promotions)	No claims/utilization in past 12 months[7]	51,731	37.70%

Population Health Management Impact

Annually SSHP evaluates the impact of the PHM strategy through the measurement of relevant clinical, utilization, and experience measures.

- **Annual assessment drives the PHM planning and strategy for program activity and resource modifications.**
- **Clinical measures selected to assess the impact of the PHM strategy are based on process and outcomes measures.**
- **Interpretation of these results gives the Healthplan insight into its' PHM programs and services and the overall effectiveness and impact on the areas of focus.**

PHM Focus Areas and Segmentation

Focus Areas

NCQA Focus Area(s):	Keeping Members Healthy
Clinical Domain(s):	Prevention and Wellness; Maternal-Child Health
Population Health Categories:	Level 01: Healthy Level 02: Acute Episodic Level 03: Healthy, At Risk Level 04a: Chronic Condition Big 5: Stable Level 04b: Chronic Condition: Other Conditions: Stable Level 04c: Behavioral Health Primary: Stable Level 05a: Health Coaching

NCQA Focus Area(s):	Managing Members with Emerging Risk
Clinical Domain(s):	Prevention & Wellness; Medical Conditions; Maternal-Child Health; Behavioral Health
Population Health Categories:	Level 05a: Health Coaching Level 05b: Physical Health Care Management Level 05c: Behavioral Health Care Management

Focus Areas

NCQA Focus Area(s):	Patient Safety or Outcomes Across Settings
Clinical Domain(s):	Prevention and Wellness; Behavioral Health; Maternal-Child Health; Medical Conditions; Advanced Illness; High Acuity & Transition; Independent Living
Population Health Categories:	All categories

NCQA Focus Area(s):	Managing Multiple Chronic Illnesses
Clinical Domain(s):	Medical Conditions; Maternal-Child Health; High Acuity & Transition; Advanced Illness
Population Health Categories:	Level 05b: Physical Health Care Management Level 05c: Behavioral Health Care Management Level 06: Rare High Cost Conditions Level 07a: Catastrophic: Dialysis Level 07b: Catastrophic: Active Cancer Level 07c: Catastrophic: Transplant Level 08a: Dementia Level 08b: Institutional (Custodial Care) Level 9a: LTSS Service Coordination Level 9b: LTSS High-Needs Care Management Level 10a: End of Life

PHM Programs and Service Descriptions

Child & Adolescent Immunizations

Priority Area: Child & Adolescent Preventive Services - Immunizations	
NCQA Focus Area(s):	Keeping Members Healthy
Clinical Domain(s)	Prevention and Wellness Maternal-Child Health
Goal:	To ensure that children and adolescents receive appropriate immunizations as recommended. Increase the rate of *Child Immunization Status* (CIS) *Combo-3* in the target population to 72.75% in MY-2022. Increase the rate of *Immunizations for Adolescents* (IMA) *Combo-2* in the target population to 43.55% in MY-2022.
Target Population(s):	All members; age 0 to 2 years (CIS) All members; 13 years of age (IMA)

FluVention Program

Priority Area: Annual Flu Vaccination (Fluvention® Program)	
NCQA Focus Area(s):	Keeping Members Healthy Managing Members with Emerging Risk
Clinical Domain(s)	Prevention and Wellness Maternal-Child Health
Goal:	▪ Increase the rate of vaccination in the target population to 19.1% in MY. Increase rate of members responding yes on Adult CAHPS® survey question “Have you had a flu shot since July 1 (of the prior year)?” to 40% in MY-2022.
Target Population(s):	Any member who is eligible to receive a flu vaccination per Centers for Disease Control and Prevention (CDC) definition. High-risk, vulnerable populations (e.g., pregnant women, children, older adults, and members with chronic conditions)

Adult Preventative Services

Priority Area/Program: Adult Preventive Services	
NCQA Focus Area(s):	Keeping Members Healthy
Clinical Domain(s)	Prevention and Wellness
Goal:	▪ Increase the rate of *Breast Cancer Screening (BCS)* in the target population to 58.7% in MY-2022. Increase the rate of *Cervical Cancer Screening (CCS)* in the target population to 63.66% in MY-2022. Increase the rate of *Chlamydia Screening (CHL)* in the target population to 61.75% in MY-2022.
Target Population(s):	All members; age 50 to 74 years (BCS) All members; age 21 to 64 years (CCS) All members; age 16 to 24 years (CHL)

Diabetes & Hypertension

Priority Area/Program: Chronic Condition Management – Diabetes & Hypertension	
NCQA Focus Area(s):	Managing Members with Emerging Risk Managing Multiple Chronic Illness
Clinical Domain(s)	Medical Conditions
Goal:	• Improve the rate Hemoglobin A1c (HbA1c) Control (<8.0%) (HBD) in the target population to 51.34% in MY-2022. • Improve the rate Controlled High Blood Pressure (CBP) in the target population to 62.53% in MY-2022.
Target Population(s):	All members; age 18 to 75 years (HBD) with diabetes (type 1 and type 2) All members; age 18 to 85 years (CBP) with a diagnosis of hypertension

Start Smart for Baby (SSFB

Priority Area/Program: Start Smart for Baby (SSFB)	
NCQA Focus Area(s):	Managing Members with Emerging Risk Keeping Members Healthy
Clinical Domain(s)	Maternal-Child Health
Goal:	To reduce rates of pregnancy complications, premature deliveries, low birth weight deliveries, and infant disease. Increase the rate of *Timeliness of Prenatal Care (PPC)* in the target population to 89.29% in MY-2022. Increase the rate of *Postpartum Care Visit (PPC)* in the target population to 79.56% in MY-2022.
Target Population(s):	Members who are pregnant

Emergency Department Diversion

Priority Area/Program: Emergency Department Diversion Program	
NCQA Focus Area(s):	Patient Safety or Outcomes Across Settings
Clinical Domain(s)	High Acuity & Transitions
Goal:	▪ Decrease ED utilization in the target population by 10%.
Target Population(s):	Members with four or more ED visits in the last 12 months and one ED visit in the last 30 days.

Readmission Reduction Program

Priority Area/Program: Readmission Reduction Program

NCQA Focus Area(s): **Patients Safety or Outcomes Across Settings**

Clinical Domains(s): **High Acuity & Transitions, Medical Conditions, Behavioral Health**

Goals:

Annual Medical goals – days are measured in calendar days for all PHO goals

- PHO 10-day goal rate in MY: 87.8%
- PHO 3-day goal rate in MY: 87.8%
  - Numerator: Count of members with a TOC assessment opened in specified timeframe
  - Denominator: Count of members with a medical authorization type flagged as “YES”
- PHO Success 10-day goal rate in MY: 32.9%
  - Numerator: Count of members with a successful TOC assessment submitted within 10 days post-discharge
  - Denominator: Count of members with a medical authorization type flagged as “YES”

Annual Behavioral goals – days are measured in calendar days for all PHO goals

- PHO 10-day goal rate in MY: 88.5%
- PHO 3-day goal rate in MY: 88.5%
  - Numerator: Count of members with a TOC assessment opened in specified timeframe
  - Denominator: Count of members with a behavioral authorization type flagged as “YES”
- PHO Success 10-day goal rate in MY: 29.7%
  - Numerator: Count of members with a successful TOC assessment submitted within 10 days post-discharge
  - Denominator: Count of members with a behavioral authorization type flagged as “YES”

Decrease the O/E ratio of Plan All-Cause Readmissions (PCR) in the target population to 91.9 in MY-2022.

- Assesses the rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge

Target Population(s): **All Eligible Members with a readmission risk score of 50 or greater, and /or high risk forreadmission by clinical judgment, with active CM flag.**

Readmission Reduction Program

Priority Area/Program: Integrated Complex Care Management Program	
NCQA Focus Area(s):	Managing Multiple Chronic Conditions Patient Safety or Outcomes Across Settings Members with Emerging Risk
Clinical Domain(s)	High Acuity & Transitions Advanced Illness Medical Conditions Behavioral Health
Goal:	▪ Decrease rate of inactive or overdue case (engagement) status in the target population to <10% in MY. Increase Medicaid member engagement, as identified by increasing average active CM caseload, from 70 to 73 in MY. Achieve member overall satisfaction with the program scores of 85% or higher as measured by the annual Case Management Satisfaction Survey
Target Population(s):	Members identified through predictive modeling in applicable population health categories (Table 1: categories 5b – 10a, as applicable). Members with at higher risk/with complex health needs conditions and/or who self-report their health as poor Members may also self-refer and be referred to the program by other internal and external sources, including practitioners.