2026
Quality Improvement Program



SecurityHealth Plan℠

Promises kept, plain and simple.

Table of contents

Section	
1	Introduction
2	Program purpose
3	Program goals and objectives
4	QI program scope
5	Program oversight • Authority • Peer review
6	Program structure and resources • Quality Improvement program committee structure • Consultative/assistive work groups and committees • Program resources • Data resources • Program oversight staff structure • Quality and Population Health Department areas of responsibility
7	Quality of clinical care • Performance metrics • Additional areas of focus
8	Quality of service • Performance metrics
9	Safety of clinical care • Quality of care and service concerns • Medication therapy management • Member safety
10	Member experience with clinical care • Appeals, grievances, and complaints • CAHPS, EES • Behavioral health member experience • Complaint review
11	Informing members about quality
12	Quality compliance and oversight • Quality program documents • Regulatory submissions • Quality ratings and requirements
13	Medicare quality initiatives
14	Medicaid quality initiatives
15	Population assessments
16	Value-based contracting
17	Continuity and coordination of care
18	Diversity and inclusion
19	Serving members with complex health needs

20	Behavioral health care management
21	Delegation
22	Credentialing and contracting
23	Collaborative activities
24	Communicating results
25	Annual evaluation of the QI program
26	Annual work plan
27	Functional areas, responsibilities, and reporting

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1. Introduction

Security Health Plan of Wisconsin, Inc. and Security Health Plan of Michigan LLC in Michigan are not-for-profit managed care organizations. Security Health Plan (Security) was incorporated in 1986 with a sole corporate member which is Marshfield Clinic Health System (MCHS). Effective January 1, 2025, Sanford, a North Dakota nonprofit corporation, became the sole corporate member of MCHS and therefore controls MCHS. Following the transaction, MCHS remains the sole corporate member of Security, and Sanford, as the sole corporate member of MCHS, indirectly controls Security. In other words, Sanford is now the ultimate parent company of MCHS and Security.

We offer a variety of health insurance options for employer groups and individuals and families of all ages and income levels. Our broad provider network includes doctors, other health care professionals, hospitals and pharmacies members know and trust. Security is currently serving over 205,350 members; our plans and service area consist of:

- Commercial HMO, POS, EPO
- Marketplace EPO, HMO, POS
- Medicare Advantage with Prescription Drug Plans
- Medicare Medical Savings Account (MSA)
- Medicare Dual-Eligible Special Needs Plan (DSNP)
- BadgerCare (BC) Plus Managed Care Program
- Medicaid SSI Program

In general, members have access to all affiliated providers without a referral from a primary care provider, except for certain specialty services. We strongly encourage members to establish a relationship with a primary care provider to assist with coordination of care and ensure that members receive appropriate preventive and other recommended care and services. We do not require precertification for emergency or urgent care services. Additionally, members have open access to any affiliated Behavioral Health (BH) or AODA provider.

2. Program purpose

Security Health Plan is committed to the ongoing evaluation and improvement of the quality and safety of care and services provided to its members. This is done, in part, through the Quality Management and Improvement (QI) program. The QI program is the framework for our processes and continuous performance monitoring using objective, measurable standards.

Mission, Vision, Values

Mission – To care, comfort, and cure.

Vision – To be the premier rural health system in the United States.

Values
SERVICE – Caring for our people, patients and communities through compassion, acceptance and sincerity.

STEWARDSHIP – Safeguarding the resources that have been entrusted to us to advance the mission.

HUMILITY – Practicing respect of self and others and approaching our communities and colleagues with modesty.

COURAGE – Having strength to persevere, innovate, use our voices and take action.

FAMILY – Celebrating the connection and commitment we have to each other through it all.

3. Program goals and objectives

Security Health Plan's goals are to:

- Achieve a 4.5-star rating from the Centers for Medicare and Medicaid Services (CMS) for our Medicare Advantage Prescription Drug Plans
- Earn a 5 out of 5 rating for our Commercial, Medicare Advantage Plan and Medicaid plans as reported by the National Committee for Quality Assurance (NCQA) and published in WebMD.
- Remain NCQA accredited for our Commercial, Medicare, Medicaid, and Marketplace plans.
- Earn a Qualified Health Plan rating of 5 stars for our Marketplace EPO and HMO plans.
- Earn 80% of the Wisconsin Department of Health Services (DHS) withhold (2.5%) by achieving the goal for BadgerCare Plus and SSI Pay for Performance measures.
- Achieve Employee Trust Funds (ETF) Quality Credit of 0.5% or greater.
- Meet all the quality regulatory requirements for DHS, NCQA, OCI and CMS for all product lines with zero deficiencies.
- Ensure the care and treatment provided to members are based on accepted evidence-based medical principles, standards, and practices.
- Be accountable and responsive to member concerns and grievances.
- Utilize technology and other resources efficiently and effectively for member welfare.
- Ensure that appropriate care and treatment are accessible to members and provided in a timely manner.
- Ensure quality initiatives are directly relevant to the membership.

- Ensure cultural and linguistic sensitivity is always displayed, including recognition of each member's needs through materials and programs.
- Ensure programs and services are related to the health care needs of the population served, including any complex needs and issues.

Under the direction of the Board of Directors and the chief clinical officer, the QI program facilitates achieving these goals by implementing activities and initiatives to promote the quality of care and service provided to members by Security Health Plan and our network of participating practitioners and providers.

Through our annual work plan, clinical and service initiatives are established and designed to achieve measurable improvements in specific areas of member care and service. Clinical initiatives focus on improving the quality of medical and behavioral health care provided to members and include QI clinical and service initiatives, care management programs, disease management programs, wellness promotion and clinical practice and preventive health guidelines promotion. Service initiatives focus on improving the member's experience of care and services.

Data sources used to identify potential areas for clinical focus include Healthcare Effectiveness Data and Information Set (HEDIS) measures, results from ongoing clinical QI studies or projects, member surveys and other internal sources based on medical and pharmacy claims. Barrier analysis information is derived from multiple disciplines. The Quality and Population Health Department is responsible for data collection and performance improvement activities, working collaboratively with other departments, such as Utilization Management, Pharmacy, Provider Network Management, Compliance, Customer Service, Provider and Member Experience.

Service initiatives aim to improve service and administrative processes related to members. Indicators include, but are not limited to, HEDIS annual results, member surveys, complaints, grievances, appeals and availability and accessibility analyses.

The 2026 QI program objectives are to:

- Comply with all NCQA, CMS and DHS quality requirements.
- Implement interventions to improve the quality of health care provided to our members, including closing gaps in care.
- Implement interventions to improve the service provided to our members.
- Monitor and trend member experience data related to clinical care (CAHPS, Enrollee Experience Survey or EES, HOS and behavioral health survey).
- Continually evaluate the effectiveness of Population Health Management (PHM) programs.
- Identify QI opportunities through tracking and evaluating member grievances, complaints, and appeals.
- Investigate and monitor the quality-of-care complaints and adverse events to evaluate patient safety.

- Improve clinical and functional outcomes.
- Execute activities to promote patient safety.
- Implement interventions to reduce health care disparities in clinical and non-clinical areas.
- Develop an action-oriented framework where equity is integrated throughout the fabric of QI initiatives to address disparities intentionally and collaboratively.
- Serve a culturally and linguistically diverse membership by performing one or more of the following:
    - Conduct patient-focused interventions with culturally competent outreach materials that focus on race, ethnicity, and language-specific risks.
    - Collect, analyze, and monitor data to identify and reduce health care disparities.
    - Provide information, training and tools to staff and practitioners to support culturally competent communication.
- Address health literacy, health disparity and cultural and linguistic needs of our members to deliver health care services that are effective, culturally acceptable, and easy to understand.
- Implement interventions to coordinate services and improve transitions of care for members with complex medical needs.
- Integrate quality improvement, credentialing, care management, case management and utilization management initiatives.
- Ensure member access and availability to our participating provider network.
- Promote and monitor continuity and coordination of care among medical providers, behavioral health providers and facilities and member care.
- Continue the Health Equity accreditation standard strategy for the 2026 accreditation resurvey.

4. QI program scope

The QI Program is based on measurements of selected indicators that reflect Security Health Plan population attributes and needs for each line of business. Opportunities for improvement are prioritized to focus on regulations, high-volume, high-risk, high-impact or high-cost clinical and service issues. The scope of the QI Program encompasses all product lines, provider and practitioner networks and delivery of care and services. Each line of business has key performance indicators and frameworks driven by federal, state and accreditation guidelines or requirements. The scope includes a full spectrum of clinical quality components that address preventive, acute, chronic, and behavioral health care needs, which include, but are not limited to:

- CMS Medicare Advantage quality program requirements
- DHS Medicaid and SSI quality program requirements
- NCQA Accreditation
- NCQA, CMS Special Needs Plan (SNP), Model of Care (MOC) quality program guidelines

- State quality program requirements
- Inpatient acute care
- Outpatient care, including primary care and specialist office settings
- Behavioral health services
- Adult and pediatric preventive care services
- Ambulatory care
- Institutional care (i.e., skilled nursing care, inpatient rehabilitation, transitional care)
- Non-institutional services (i.e., home care, rehabilitation services, durable medical equipment, infusion services)
- Emergency services
- Member experience
- Provider relations
- Pharmaceutical services
- Medical and utilization management
- Chiropractic services
- CMS chronic care improvement programs
- DHS performance improvement projects
- Complex case management services
- Population health management programs
- Assessment and evaluation of programs and services for members
- Satisfaction assessment with the accessibility of services and availability of practitioners and providers
- Quality assurance services for network medical and behavioral health management staff and affiliates

The program focuses on those aspects of care that will have the greatest impact on quality of care, safety, and satisfaction, including high volume, elevated risk or problem-prone activities or functions. Opportunities for improvement are identified through data review and analysis, utilization and case management, member and provider appeals, complaints, surveys, recommendations from Quality Committees, input from medical directors and other available sources.

5. Program oversight

Authority

The Board of Directors has ultimate responsibility for the QI Program, supporting the program through the provision of financial resources and staff for each operational area. The Board of Directors designates primary oversight of the QI program to the chief executive officer (CEO), chief clinical officer (CCO) and the Quality Improvement Committee (QIC).

The QI committee approves policies, reviews and evaluates results of QI activities via reports and committee minutes, summaries, institutes needed actions and ensures follow-up. The QIC will review and provide input and guidance related to quality improvement optimization. This includes clinical programs, provider network accreditation, provider network health outcomes,

performance measurement and reporting, pharmacy, and utilization management programs. The QIC will ensure the QI Program, including committees and work groups, supports the strategic areas of focus. This includes quality and safety, service excellence, stewardship, smart growth, and people. The following committees report to the QIC:

- Pharmacy and Therapeutics Committee
- Credentialing Committee
- Member Experience
    - Subcommittee: Appeals and Grievances
- Utilization management (P&P) committee
    - Subcommittee: UM & Tech Assessment

The QIC and its members will collaborate with other work groups and committees that impact the QI program activities. The committee will ensure work is prioritized and that work groups and committees execute on actions that need to be taken and vice versa. Work groups and committees include, but are not limited to:

- Compliance Risk Work Group
- Joint Operating Committee (health system and health plan)
- Quality Cabinet (health system and health plan)
- Stars Work Group (Medicare)
- Health plan subcommittee
- Language Access Planning Committee
- Behavioral Health Work Group
- Mental Health Parity NCTL

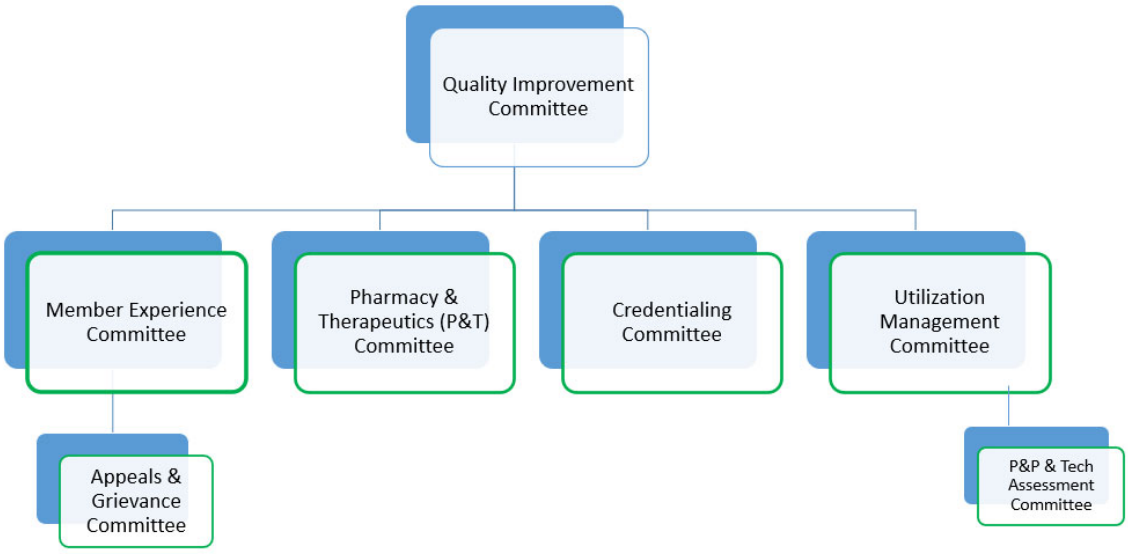
Peer review

Security Health Plan utilizes board-certified physicians to assist with the review of medical appropriateness and necessity. Medical director, associate medical directors, quality and the health services staff collaborate in making decisions concerning utilization management and appeals according to their areas of expertise. The medical directors are actively involved in various QI committees and network providers actively participate in these committees, assisting with policy development and participating in review of quality-of-care concerns in their areas of expertise. In addition to medical directors, providers from our owner systems participate in our quality committee structure. Peer review activities apply to all lines of business and internal and external providers.

6. Program structure and resources

QI program committee structure

The QI program structure has formal channels of reporting, which allow for a standardized flow of information. The following committees report within the Security Health Plan QI program structure.



The above committee structure has been established to ensure that the QI process positively affects quality of care, continuous improvement, and compliance. Objectives include ongoing monitoring, evaluation, and implementation of corrective actions.

Quality improvement committee (QIC) — Purpose: Oversees the development, implementation and evaluation of QI activities, including regulatory oversight and quality ratings (Stars, QRS, NCQA ratings, Medicaid Report Card) under the authority of the board of directors. Committee reports from the Credentialing, UM Committee, Pharmacy and Therapeutics and the Member Experience committees report to the QI committee. The QI committee consists of health plan staff clinical and non-clinical staff and affiliated providers from a variety of professions, including mental health.

Member Experience Committee

Purpose: The purpose of the Member Experience Committee is to ensure open lines of communication and understand trends impacting favorable member experience, from a variety of quantitative and qualitative sources and leverage insights to pursue tangible improvement in customer satisfaction. The committee provides strategic direction to the organization in the prioritization and ongoing review of member experience improvement activities, including complaints, access, adequacy, and satisfaction.

Appeals, Grievances, Complaints subcommittee — responsible for overseeing the appeals and grievance process, including quality of care and quality of service as well as complaints that are logged in various departments in the organization. Oversight will include:

- Analyzing and identifying trends and evaluating opportunities for coverage changes, process improvements and customer experience improvements.
- Evaluating information presented and making determinations on each case based on applicable contract provisions, including benefit, limitations, and

exclusions, medical policy, as applicable.

- Identifying areas of member dissatisfaction via appeals and grievance resolution and making recommendations for measures to be put in place for quality improvement. This includes but is not limited to problematic benefits, processes or procedures that generate multiple expressions of dissatisfaction, so these can be reviewed by plan management.

Pharmacy and Therapeutics (P&T) Committee – Serves as the policy-making board for the plan's prescription drug formulary as well as medications covered on medical benefit. The committee develops guidelines concerning pharmaceutical management processes and develops, implements, and updates utilization management criteria. The committee serves to ensure safe, rational, and cost-effective medication use.

- Purpose: oversee the development, implementation, safety, evaluation, and revision of the plan's commercial, Marketplace and Medicare Part D drug formulary as defined by CMS regulations and guidance (42 C.F.R § 423.120(b)) Responsibility: responsible for the review, guidance and clinical recommendation and approval for the therapeutic use of drugs as contained within the plan formularies.
- Serves as the final approval authority on matters pertaining to the clinical management of drug use, including recommendations on drug selection (e.g., formulary tier status of specific agents or classes of agents, prior authorization guidelines, or coverage of specific drug therapies as they relate to the appropriateness of use).

Credentialing committee – Assures that providers are of high quality and provide an high level of service to members. Responsibility:

- Review/approve the Administrative and Professional Criteria used to make credentialing/recredentialing decisions.
- Review, approve, or disapprove credentials of affiliation of applicant providers that do not meet one or more of the Administrative and Professional Criteria
- Review credentials, peer review materials, complaints, and other information as appropriate to approve or disapprove continued affiliation of providers.
- Guide the development, establish standards for and participate in provider performance monitoring, including:
    - Assessment of provider performance in the evaluation of provider complaints
    - Review of specific providers or practices as needed.
- Conduct initial and ongoing assessment reviews of facilities and organizational providers with health plan contracts to provide services to members.
- Annually review and revise the credentialing program description
- Provide feedback and direction on the implementation of credentialing and recredentialing policies and procedures.

- Approve and annually evaluate the performance of the agency delegated to provide credentialing or recredentialing services.

UM (P&P) committee and tech assessment subcommittee

Purpose: To oversee the development, implementation, and evaluation of the plan's utilization management functions such as: delegation, policy reviews, UM processes, pharmaceutical and medical technology assessments and formulary determination. Discussion, as needed, of the formal review process of new medical technology and new applications of existing medical technology to ensure that Security Health Plan members have equitable access to safe and effective care. Such technology includes medical procedures, behavioral health procedures, medical devices, and supplies.

Program resources

Security Health Plan recognizes that quality management and improvement is critical to the success of the organization, thus requiring adequate staffing and health information systems that collect, integrate, analyze, and report data necessary to implement and support the activities of the QI program. The information needs of the QI program activities are supported by, but not limited to, the following areas of the Health Plan:

- Quality and Population Health
- Care and /Case Management
- Utilization Management
- Credentialing
- Information Technology/Systems
- Analytics, Actuarial and Underwriting
- Claims
- Customer Experience
- Provider Network Management
- Product Development & Management
- Enrollment
- Marketing
- Pharmacy

The collection and integration of data from all network components aids in developing a comprehensive understanding of member needs. These data collection and reporting systems ensure prompt access to the necessary data for the QI program components. This data guides the selection of and data collection requirements for performance evaluation and the development of improvement projects.

The QI program team is comprised of individuals committed to oversight, ongoing analysis, evaluation and improvement of the quality and safety of clinical care and the quality of

services it provides to its members. The following roles include dedicated resources to support the QI program:

- Chief Executive Officer*
- Chief Clinical Officer*
- Chief Growth Officer*
- Chief Operating Officer
- Chief Financial Officer
- Chief Transformation Officer
- Chief Legal Officer
- Medical Director*
- Director of Quality and Population Health*
- Director of Actuarial, Underwriting and Risk Adjustment
- Director of Analytics
- Director of Utilization Management*
- Director of Pharmacy*
- Director of Care Management*
- Director of Information Systems
- Quality Manager
- Population Health Manager*
- Quality Improvement Nurses
- Quality and Accreditation Specialists
- Director of Provider Network Contracting*
- Director of Member Experience and Contact Center*
- Clinical Pharmacy Services Manager*
- Clinical Pharmacists
- Compliance Department
- Analytics Department
- Grievance and Appeal Department
- BC and SSI Member Advocates
- Government Programs Department
- Sales Department
- Product Development and Management Department
- Operations Department
- Training and Change Management Department
- Marketing Department
- Office of Health Equity and Experience

**Key oversight role*

The need for additional resources is continuously evaluated and in alignment with strategic planning.

Data resources
Appropriate data resources are maintained to support the implementation of the QI program.

- The QI staff collaborates with the Technology, Enterprise Data Analytics (EDA) and health plan Analytics departments for the development of QI studies/projects.
- The EDA and Analytics departments develop performance measurements, perform statistical analyses, develop reporting tools, and provide data tabulation for QI studies or projects.
- The Technology department oversees various internal and externally purchased software programs.

Program oversight staff structure
Security Health Plan QI program staff roles and responsibilities are as follows:

The ***chief executive officer*** (CEO) is responsible for all operations of the organization. The CEO allocates resources as appropriate and grants authority over all medical management services, including quality, utilization, and care management programs to the chief medical officer (CMO).

The ***chief clinical officer*** (CCO) has overall responsibility for all utilization, disease, case, pharmacy, population health and quality programs and initiatives. The CCO grants authority on various aspects of these areas to Directors and medical directors.

The ***medical directors*** are hired by the CCO. The medical directors perform utilization management activities and have the authority to make favorable, partial approval and adverse determinations based on medical necessity. Plan medical directors participate in appeals, the appeals committee, and the utilization management committee for medical and pharmacy policy. Medical directors include a variety of health professions, including a behavioral health medical director. The behavioral health medical director also assists the chief clinical officer in acting in a consulting capacity for other areas of the organization.

The ***director of quality and population health*** is responsible for activities relating to quality improvement and population health, including accreditation, quality reporting and other quality activities in addition to being responsible for the population health programs and initiatives. This role supervises the quality improvement nurses, quality and accreditation specialists, population health staff and member advocates. The director of health plan quality co-chairs the Quality Improvement Committee meetings.

The ***director of utilization management*** oversees the daily activities of all utilization management functions. .

The ***director of care management*** oversees the daily activities of all care and case management functions. The director provides direct supervision of the nurse managers.

The ***care management managers*** provide direct supervision of care managers (registered nurses), social workers and community support specialists for the DSNP, Transition of Care and behavioral health programs. In addition, they provide direct supervision of the patient care coordinators, engagement specialists and care managers (registered nurses) for the Chronic Care and Case Management programs.

The ***director of provider contracting*** reports to the VP of contracting and is responsible for oversight of credentialing, re-credentialing, contracting and monitoring participating provider quality activities.

The ***chief growth officer*** is responsible for product development, marketing, communications, sales, government programs and health policy, ensuring the organization remains competitive with new market entrants and existing competitors.

The ***director of experience and contact center*** reports to the chief transformation officer and oversees the member experience with the Health Plan, including the call center.

The ***director of pharmacy*** reports to the VP of pharmacy and is a registered pharmacist and is responsible for the overall management, structure, maintenance and administration of the pharmacy benefits, including oversight of the pharmacy claims processor. This position supervises the clinical pharmacy services managers, clinical pharmacist, and pharmacy operations manager. The pharmacy services director participates in utilization management and QI activities related to pharmacy services.

The ***clinical pharmacy managers*** report to the pharmacy services director. The clinical pharmacy managers assist the pharmacy services director in activities pertaining to the maintenance and administration of the pharmacy benefit, including matters relating to quality and utilization management. These positions coordinate and conduct the Medication Therapy Management (MTM) program and services, collaborating with the care management team. They are also responsible for the overall management of the Medicare Advantage Part D pharmacy benefits. Managers provide direct supervision to the pharmacy claims auditor and the pharmacy systems support specialists. This position may render denial decisions for coverage of pharmaceuticals.

Quality and Population Health Department areas of responsibility

The Quality and Population Health Department employs a quality director, star program manager, population health manager, clinical services manager, quality improvement nurses, quality and accreditation specialists. The quality team also includes outreach specialists, Medicare clinical lead, population health specialists, coordinators and health educators. These resources support all departments in accomplishing initiatives on the annual QI work plan, managing the implementation of program activities and overseeing the implementation and objectives of the program.

Quality staff also focus on the quality of health care relating to health equity. They focus on health disparities by developing, implementing, reviewing, and evaluating metrics, processes, policies, and programs. There is a strong collaboration with the health system Quality staff to identify the clinical outcomes that could be improved from quality improvement initiatives. The quality and population health department funds a health equity coordinator who is placed in the health system Office of Health Equity and Experience and aids with the Health Plan's health equity QI efforts. The coordinator assists in reviewing clinical outcomes and aids in identifying and developing initiatives to address health inequities.

7. Quality of clinical care

Aspects of clinical care relevant to membership are identified for ongoing monitoring and evaluation. Methodology includes data collection through various sources, including claims, electronic medical records, demographics, chart review and provider and member feedback. Opportunities for improvement are identified, and interventions are implemented based on data results. Quality improvement initiatives are evaluated continuously and summarized in the annual QI Program Evaluation. Following the evaluation of effectiveness, initiatives are revised, added, omitted, or continued.

Benchmarks are used in QI activities on an ongoing basis. Such benchmarks may include National, Regional or State norms, standards, or requirements for HEDIS, HOS (Health Outcomes Survey), CAHPS, EES (Enrollee Experience Survey), Pharmacy Data Events (PDE) or other regulatory requirements.

Performance metrics
Security Health Plan participates in annual HEDIS, CAHPS, EES HOS and PDE reporting. Emphasis is placed on those aspects of care that will have the greatest impact on the quality of member care, delivery of care, member safety and satisfaction. While all HEDIS, CAHPS, and HOS measures are monitored and reported annually, the following are primary areas of focus.

<u>Preventive health and wellness</u>

- HEDIS breast cancer screening
- HEDIS cervical cancer screening
- HEDIS colorectal cancer screening
- HEDIS well-child and adolescent visits
- HEDIS adult, child, and adolescent immunizations
- CAHPS flu immunizations
- HEDIS lead screening
- HEDIS prenatal and postpartum care
- HOS falls risk management
- HOS management of urinary incontinence in older adults
- HOS physical activity in older adults
- HOS improving or maintaining physical activity

- HOS improving or maintaining mental health
- HEDIS care for older adults – medication review and functional status assessment

Condition management

- HEDIS diabetes care
    - Diabetes HbA1c control <9 - glycemic status assessment
    - Diabetes eye exam
    - Kidney health evaluation
- HEDIS controlling blood pressure
- HEDIS statin therapy for patients with diabetes
- PDE statin use in persons with diabetes
- PDE medication adherence for diabetes
- PDE medication adherence for cholesterol statins
- PDE medication adherence for hypertension- RAS antagonists
- PDE medication therapy management

Complex/high-risk transitions of care

- HEDIS plan for all-cause readmissions
- HEDIS follow-up after Emergency Department (ED) visits for people with multiple chronic conditions
- HEDIS transitions of care
    - Notification of inpatient admission
    - Receipt of discharge information
    - Patient engagement after inpatient discharge
    - Medication reconciliation after discharge
- Concurrent use of opioids and benzodiazepines
- Polypharmacy: use of multiple anticholinergic medications in older adults

Behavioral health care

- HEDIS follow-up after hospitalization for mental illness
- HEIDS follow-up after ED admission for mental illness
- HEDIS follow up after ED visit for substance use
- HEDIS depression screening
- HEDIS initiation and engagement of substance use disorder treatment

Musculoskeletal conditions

- HEDIS osteoporosis management in women who had a fracture

DHS BadgerCare Plus P4P

- HEDIS childhood immunizations
- HEDIS immunizations for adolescents
- HEDIS lead screening in children

- HEDIS child and adolescent well visits
- HEDIS prenatal care with health disparity focus
- HEDIS postpartum care with health disparity focus
- HEDIS colorectal cancer screening
- HEDIS hemoglobin A1C control for patients with diabetes (control <8%)
- HEDIS controlling blood pressure
- HEDIS follow-up within 30 days after hospitalization for mental illness

DHS Supplemental Security Income P4P

- HEDIS follow-up within 30 days after hospitalization for mental illness
- HEDIS follow-up within 30 days after ED admission for mental illness
- HEDIS diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications
- HEDIS hemoglobin A1c control for patients with diabetes (control <8%)
- HEDIS breast cancer screening
- HEDIS cervical cancer screening

Dual-Eligible Special Needs Plan (D-SNP)

- HEDIS care of older adults med review
- HEDIS care of older adults pain assessment
- Other D-SNP measures
    - Pharmacotherapy management of COPD exacerbation
    - Persistence of beta-blocker treatment after a heart attack
    - Follow-up after hospitalization for mental illness
    - Potentially harmful drug-disease interactions in the elderly
    - Transitions of care
    - Use of high-risk medications in the elderly
    - Plan all-cause readmissions
- Health risk assessment tool (HRAT) completion within 90 days of enrollment
- Health risk assessment tool (HRAT) completed annually
- Individualized care plan (ICP) completion
- Individualized care team (ICT) completion
- Transition assessment completion (transition of care)

8. Quality of service

Aspects of service relevant to health plan membership are identified for ongoing monitoring and evaluation. Security Health Plan's QI methodology includes data collection through various sources, including demographics, network data, chart review and provider and member experience feedback. Opportunities for improvement are identified, and interventions are implemented based on data results. QI initiatives are evaluated on an ongoing basis and summarized in the annual QI Program Evaluation. Following the evaluation of effectiveness, initiatives are revised, added, omitted, or continued.

Performance Metrics

Medicare Advantage stars

- CAHPS getting needed care
- CAHPS getting appointments and care quickly
- CAHPS rating of health plan
- CAHPS rating of drug plan

Member experience with service

- Network adequacy - primary care; high volume behavioral health; high volume specialties; high impact specialties
- Network adequacy - cultural and linguistic preferences
- Network access - primary care; behavioral health; specialist; after hours
- Out-of-network claims
- Member understanding
- Benefit information accuracy
- Behavioral healthcare satisfaction
- Complaints - access/adequacy
- Complaints, grievances, and appeals, including
    - Appeal volume
    - Complaint volume
    - Behavioral health and non-behavioral health complaint volume

Dual-Eligible Special Needs Plan (D-SNP)

- Care management satisfaction survey
- Improved health status - care management survey
- Member engagement rate
- Grievances (access to care)

Member services

- Email response times to members, average answer/delay
- Calls answered/timeliness

9. Safety of clinical care

Quality of care and service concerns and adverse events

Security Health Plan monitors, tracks, and trends any expressed dissatisfaction by the member or member's authorized representative regarding health care services received from a specified practitioner that resulted in actual or potential harm to the member. Upon receipt of the quality-of-care complaint or adverse event, an initial review is made to determine if it is medically urgent. If the complaint is determined to be medically urgent (i.e., has the potential to affect the safety or health of a member immediately), the Customer Service and Quality &

Population Health departments take immediate action to investigate and resolve the complaint. All non-urgent quality concerns are managed according to timelines outlined in the regulatory guidelines issued by the line of business involved. Quality of care concerns are identified through various avenues that may include but are not limited to member complaints to customer service, provider complaints to customer service, medical management activities and grievance or appeal process.

In addition to quality-of-care concerns, other high-priority focus areas that are reviewed for member safety include the following:

Medication therapy management (MTM) program led by pharmacists interacts with members to review medications, supplements and over the counter (OTC) medicines. MTM can describe comprehensive medication reviews (CMRs) and targeted medication reviews (TMRs)

- CMR - a pharmacist communicates with the member (either over the phone or in-person), where they discuss all the medications, OTCs and supplements the member is on, discuss what they are for and if there are any medication-related issues and create a plan to resolve them alongside the patient or prescriber.
- TMR - an ongoing monitoring process where outreach it made to the member or prescriber concerning specific or potential medication-related problems that are identified (i.e., serious drug interactions, contraindications, age-related concerns, etc.)

Action plans are developed based on member needs and ways to reduce side effects, resolve barriers to adherence, prevent drug interactions and lower medication costs are addressed.

Member safety

- Provider sanctions monitoring
- Pharmacy criteria review, such as opioid management programs
- Medical record documentation - network provider medical record review standards
- Adverse event monitoring/never event monitoring
- Medicare stars — drug price accuracy
- Pharmaceutical safety
    - Drug utilization review
    - Educational materials about drug safety and clinical updates
    - Identification and notification of product recalls and market withdrawals
- Utilization management
    - Interrater reliability testing
    - Evaluations of medical necessity, appropriateness, and safety
    - Criteria and tech assessment reviews

10. Member experience with clinical care

Performance metrics

- CAHPS coordination of care
- CAHPS getting needed care
- CAHPS getting appointments and care quickly
- CAHPS rating of health care quality
- CAHPS rating of health plan
- CAHPS rating of drug plan
- CAHPS getting needed prescription drugs
- CTM/CMS complaints about the health plan
- CTM/CMS complaints about the drug plan
- IRE reviewing appeals decisions
- Part C call center- foreign language interpreter & TTY availability
- Part D call center- foreign language interpreter & TTY availability
- Part C members choosing to leave the plan
- Part D members choosing to leave the plan
- D-SNP
    - Care management satisfaction
    - Improved health status - care management survey
    - Member engagement rate
    - Grievances (access to care)
- Member services
    - Email responses to member inquiries
    - Average answer delay
    - Calls answered
    - Calls answered timely
- Total complaint volume
- Behavioral and non-behavioral health complaints and volume
- Appeal volume
- Net promoter score

Appeals, grievances, and complaints

The Appeals and Grievance Committee is responsible for overseeing the appeals and grievance process, including quality of care and quality of service as well as complaints that are logged in various departments in the organization. Oversight will include analyzing and identifying trends and evaluating opportunities for coverage changes, process improvements and customer experience improvements.

Security Health Plan has implemented a thorough and consistent procedure for responding to member dissatisfaction, utilizing a database to track and trend member grievances (written complaints) and complaints. Categories are defined to allow for analysis of complaint and grievance types, such as, but not limited to, quality of care, quality of service, access, and availability, behavioral health, and non-behavioral health.

A one-step appeal process allows the member, or a representative acting on behalf of the member, to appeal an adverse determination by submitting a written request.

Consumer Assessment of Health Care Providers and Systems (CAHPS) and Enrollee Experience Survey (EES)

The CAHPS and Qualified health Plan (QHP) EES surveys reflect members' experience with their health plan and providers. Security Health Plan administers surveys for Commercial, Marketplace, Medicaid, and Medicare lines of business. Survey categories include questions about:

- Health care in the past 6-12 months (access, availability, rating of care)
- Personal doctor (service, rating of provider)
- Care from specialists (access, availability, rating of specialist)
- Health Plan (customer service, ease of filling out forms, rating of plan)
- Prescription drug plan - Medicare (coverage, filling prescriptions, rating of plan)

Survey results are used in clinical quality evaluations, including Medicare CMS Star Rating, NCQA Health Plan Rating, CMS Marketplace Quality Rating and ETF (part of commercial product) Quality Credit. Results of the surveys are key to identifying needed areas of improvement in member experience.

Behavioral health member experience

Annually, Security Health Plan assesses the experience of members who utilized behavioral health services in the past 12 months. Experience data is collected on the following:

- Overall satisfaction (behavioral health provider, ease of getting appointment, quality of care, attitude of provider, behavioral health coverage)
- Care delivery (in person, virtual, telehealth, etc.)
- Access to behavioral health care (new patient, established patient, follow-up, urgent, emergent appointments)

In addition to the annual assessment, behavioral health customer service complaints are analyzed and reviewed.

Complaint review

The Member Advocates and Member Experience Committee:

- Reviews and analyzes member experience data and identifies opportunities to improve member experience
- Prioritizes and directs member experience improvement efforts
- Directs work to departments, committees, and groups, focusing efforts to improve member experience
- Reviews, evaluates, and monitors progress, and outcomes of member experience metrics, initiatives, work plans and data analytics
- Addresses and ensures that significant member-facing changes are brought to the

committee
- Facilitates staff education to foster a member-centric culture

Areas of complaint analysis include but are not limited to appeals and grievances, clinical services, care management, quality, pharmacy, utilization management, provider and network management, marketing, product management and customer service. NCQA categories attitude, service, billing, financial, cost sharing, quality of provider office, access, and quality of care, are also analyzed and presented to committees. In addition, analysis is performed by product line for Medicare, Medicaid, Marketplace and Commercial.

11. Informing members about quality

Security Health Plan disseminates information regarding the QI program, performance and initiatives to its members and providers via the Health Plan website, newsletters, press releases, social media, mailings, emails, provider presentations and provider manuals.

12. Quality compliance and oversight

Quality program documents: Quality improvement program description, work plan and QI evaluation are approved annually, and address quality and safety of clinical care, quality of clinical service, member experience, planned activities, goals, objectives, timeframes for reporting, committee oversight, staff responsible, monitoring and current or future considerations. The work plan is a dynamic document, which is reviewed, evaluated and updated on an ongoing basis to reflect progress made on QI activities. The work plan is presented to the Quality Improvement Committee for annual approval. Ongoing monitoring and reporting occur via various quality committees and work groups.

- Quality program documents
    - Quality program description
    - Quality Program work plan
    - Quality program evaluation, including committee structure review
- Population Health documents
    - Population health strategy
    - Population health assessment
- Utilization management documents
    - Utilization management program description
    - Utilization management program evaluation

Regulatory submissions: dedicated resources allocated to ensure compliance with regulatory submissions. These submissions include the administration of the annual HEDIS, CAHPS, EES and HOS requirements for NCQA, CMS, DHS, and state requirements.

- Regulatory submissions
    - Member experience survey administration, CAHPS and EES
    - HOS administration
    - HEDIS audited reporting

Quality ratings and requirements: dedicated resources are allocated to ensure the achievement of the highest ratings and compliance with quality program requirements.

- Quality performance scores
    - Medicare Advantage and Part D star rating
    - Medicaid pay for performance (BadgerCare and Supplemental Security Income)
    - NCQA ratings (Medicare, Medicaid, Commercial)
    - Marketplace quality rating system
    - ETF quality credit
- NCQA accreditation
    - Health Plan accreditation (Medicare, Commercial, Marketplace, Medicaid)
    - Health equity accreditation (Medicaid)
- D-SNP - MOC submission and approval
- DHS performance improvement project submissions (BadgerCare and Supplemental Security Income)
- CMS chronic care improvement project implementation
- Marketplace quality improvement strategy submissions
- Quality webpages, provider, and member manual updates
- Delegation oversight and evaluation – credentialing; recredentialing; utilization management

13. Medicare quality initiatives

The CMS Medicare Star Program uses a star rating system to measure Medicare Advantage and Part D plan performance. CMS uses information from member satisfaction and outcomes surveys, clinical and administrative data to give overall star performance ratings to plans. A plan can get a rating between 1 and 5 stars. A 5-star rating is considered excellent. These ratings help prospects compare plans based on quality and performance. Medicare also assigns plans an overall star rating to summarize the plan's overall performance. Security Health Plan's goal is to achieve a CMS 4.5- or 5-star designation annually. The Medicare Stars quality program manager has primary responsibility for oversight of the program, which includes work groups and participation in related quality committees.

Security Health Plan conducts a chronic care improvement program (CCIP) initiative. The intent of the CCIP includes the promotion of effective chronic disease management and the improvement of care and health outcomes for enrollees with chronic conditions. CMS requires the CCIP and recommends that plans conduct CCIPs over a three-year period.

2026-2028 CCIP Topic:
Eye exam for patients with diabetes
For diabetes patients, an annual dilated eye exam is crucial for detecting diabetic retinopathy and other issues like glaucoma/cataracts, even without symptoms, as high blood sugar damages tiny eye blood vessels, risking vision loss. Type 2 diabetics need one at diagnosis, Type 1 within 5 years, with yearly checkups recommended thereafter.

14. Medicaid quality initiatives

The Medicaid pay for performance (P4P) initiative focuses on improving the measurable quality of care for BadgerCare (BC) Plus and Supplemental Security Income (SSI) members. Its current scope includes managed care organizations (MCOs, also referred to as HMOs), with applicable capitation, withholdings that can be earned back by HMOs based on their performance relative to quality targets for various measures applicable to them. These measures relate to the priority areas for DHS while balancing the total number of measures in P4P. The goal is to reach all DHS goals to earn back at least 80% of withheld amounts for both the BC Plus and the SSI product. Staff in several roles include dedicated resources for QI efforts focused on the Medicaid populations.

Two performance improvement projects (PIPs)are required annually. To align with federal and state priorities and to further improvements in health outcomes for all Medicaid members in Wisconsin, HMOs must focus on reducing health disparities in the populations the HMOs serve for both PIPs. One PIP must focus on a clinical topic, and one must focus on a non-clinical topic.

<u>2026 PIP Topics:</u>

- ***BC Plus colorectal cancer screening***
  This health disparities reduction initiative focused performance in getting adults (45-75 years old) screened using various methods like colonoscopy, flexible sigmoidoscopy, CT colonography, or stool-based tests (FIT, sDNA) to catch polyps or early cancers, aiming to improve quality scores and health outcomes by promoting these crucial preventive tests. This topic addresses an equity gap in essential preventive care - rural members have lower performance outcomes than urban members. Improving compliance will enhance the health trajectory for members in these communities, aligning with Security Health Plan's mission of equitable care delivery. Security Health Plan will implement a multifaceted outreach campaign that includes auto-deployment of Cologuard kits, culturally competent and inclusive mailings, social media posts, promotions of Findhelp (a social care platform), continued quality contracts with a high-volume health care system to include provider pay for performance and a continued partnership with Notable to personalize patient experience, close gaps and send personalized patient outreach. This aligns with DHS and CMS goals of reducing health disparities and promoting preventive care access.

- ***SSI care management engagement***
  This improvement project will allow for a meaningful impact on the enrolled members in the SSI program by decreasing the number of Security Health Plan SSI rural members who have transportation barriers that prevent care. The rural population historically has systemic health care barriers and lower health outcomes. Lace of transportation contributes to the culture of health by becoming a fundamental piece of wellness programs for members. This PIP will reduce this disparity by providing additional information on available transportation resources and coordination of NEMT Medicaid benefits and community resources. Member support strategies will be improved by using member feedback obtained at quarterly Medicaid Transportation Advisory Council meetings.

<u>2025 PIP Topics:</u>

BC+ Child and Adolescent Well-Care Visits (WCV)–

This health disparities reduction initiative focused on reducing health disparities among membership to improve WCV for the non-white SHP BC+ members 3-21 years old. This topic addresses an equity gap in essential preventive care. For non-white populations, early detection of health issues can significantly affect long-term health outcomes and chronic disease prevention. Improving WCV compliance will enhance the health trajectory for children and adolescents in these communities, aligning with SHP's mission of equitable care delivery. SHP will implement a multifaceted outreach campaign that includes culturally competent and inclusive mailings, social media posts, provider education, Findhelp the social care platform, quality contracts with a high-volume healthcare system to include provider pay for performance and a partnership with Notable to personalize patient experience, close gaps and send personalized patient outreach. This aligns with DHS and CMS goals of reducing health disparities and promoting preventive care access.

SSI Care Management Engagement -

This improvement project will allow for a meaningful impact on the enrolled non-white members in the SSI program by increasing the number of SHP SSI non-white members that complete an initial assessment screening. The non-white population historically has had systemic healthcare barriers and lower health outcomes. Health screening assessments contribute to the culture of health by becoming a fundamental piece of wellness programs for members. They provide the member an effective tool to get a full picture of their health and well-being. By completing a health screening assessment, it creates a pathway for the member to make healthier lifestyle choices. By increasing the screening success rate of SHP's SSI non-white members, we are better able to identify the social needs of these members and connect these members to community resources so these needs can be addressed. SHP will implement a multifaceted outreach campaign that includes culturally competent and inclusive mailings, social media posts, provider education, increasing volume of calls, Findhelp the social care platform, a partnership with a community organization and a partnership with Notable to personalized patient outreach.

15. Population assessments

An annual assessment of the member population is conducted to ensure programs and interventions are driven by the characteristics and needs, including social determinants of health, of the members. The purposes of the population assessment report are to:

- Collect, integrate, and assess member data to inform its quality and clinical services strategies.
- Drive new, revised programs, services and activities that meet the needs of members and address health care disparities.
- Identify and assess the needs of relevant member subpopulations such as line of business, age, region, and provider group.
- Assess the needs of
    - Children and adolescent members
    - Members with disabilities
    - Members with serious and persistent mental illness (SPMI)
    - Members of racial or ethnic groups
    - Members with limited English proficiency
- Assess social determinants of the health of the member population.
- Determine actionable categories for appropriate intervention.

16. Value-based contracting

Value-based payment arrangements

Security Health Plan has long supported value-based payment arrangements with its contracted providers, understanding that the traditional fee-for-service model incentivizes the quantity of health care services and not the quality or outcomes of those services. These programs are part of a larger strategy to align how health care is delivered and paid for. The value-based contracts vary by provider, but when summarized, they include all lines of business. An annual review of contracted metrics is conducted, and changes are made to strive for alignment with priority quality metrics. Security Health Plan staff from quality and population health, care management, provider network management and pharmacy meet with our value based care clinics regularly to share performance data and discuss opportunities for improvement.

17. Continuity and coordination of care

Security Health Plan monitors and acts, as necessary, to improve continuity and coordination of care across the health care network. QI staff identify and act on opportunities to improve the quality of care by collecting and analyzing data and developing a systematic improvement plan. A timely and appropriate exchange of information between behavioral health and medical

providers is necessary to meet the triple aim objectives of improved health, decreased cost and member satisfaction.

An annual analysis for both continuity and coordination of medical care and continuity and coordination of medical and behavioral care is conducted and presented to the committee**.**

Monitoring activities may include, but are not limited to:

- Member movement between practitioners (diabetes eye exam, osteoporosis management, complaint data analysis, specialist to primary care data)
- Member movement across settings (plan all cause readmissions/transitions of care, follow-up after emergency department visit for people with multiple chronic conditions, emergency department to primary care provider, skilled nursing facility to emergency department)
- Continuity and coordination between medical care and behavioral health

Security Health Plan assists members in transitioning to other care when their benefits end, if necessary. Utilization management identifies individuals who have exhausted benefits and are still in need of care and notifies the member of alternatives and resources for continuing care. Security Health Plan also has policies and procedures in place to notify members affected by the termination of a primary or specialty care practitioner or site. Security Health Plan assists affected members in selecting a new practitioner and notifies members of the right to complete an active course of treatment for continuity of care, if appropriate.

18. Diversity and inclusion

Security Health Plan assesses the cultural, ethnic, racial, and linguistic needs of its members via the following data sources:

- CAHPS survey questions addressing culture, ethnicity, race, language, and need for assistance in completing the survey
- U.S. Census data on racial composition and language spoken at home for the population in each county within the service area
- Collecting languages spoken during the credentialing or recredentialing process
- Staff complete computer-based training (CBT) on Limited English Proficiency when hired and at least every three years
- Health assessment (HA) contains questions on race, ethnicity, and preferred written and spoken language needs
- State and CMS data on race and language
- Analysis of HEDIS data by race and ethnicity
- Member survey regarding Security Health Plan Language Services
- Provider directory allows members to search for providers by language
- Member complaint data related to cultural or linguistic needs

Security Health Plan's conflict and grievance resolution processes are culturally and linguistically appropriate. All cultural and linguistic complaints are logged and analyzed. Quality of care and service complaints are tracked, including if they were in writing or given over the telephone. Quarterly, the Quality and Population Health Department collates quality of care and quality of service complaints for all practitioners and identifies any outliers with two or more complaints in the six-month time period. This information may be utilized in the decision of re-credentialing, determined by the Credentialing Committee.

All complaints are tracked and trended by the Quality and Population Health Department and reported to the Member Experience Committee. The organization monitors and analyzes these to aid in the determination of the quality, satisfaction and effectiveness of implemented programs and initiatives. The analysis of this aids in the creation of preventative measures, including cultural and linguistic measures.

Security Health Plan assists members with the complaint and grievance process by aiding in the completion of forms and other necessary procedural steps. Security Health Plan provides these services in the member's language with translation services and/or provides communication in alternative formats such as TTY and large font forms. Security Health Plan ensures member accommodation if required or requested by the member during the complaint, grievance, and appeals process.

19. Serving members with complex health needs

The overall goal of Care Management is to assist members (Commercial, Marketplace, SSI, DSNP, Medicaid, Medicare Advantage) to regain optimum health or improved functional capacity, in the right setting and a cost-effective manner. It involves a comprehensive assessment of the member's condition, determination of available benefits and resources and development and implementation of a case management plan with individualized performance goals, monitoring, and follow-up.

Care managers contact members to coordinate with the member and their health care team to establish performance goals based on their needs. Member participants are those with high-risk care coordination needs, including physical or mental disabilities, multiple chronic conditions, and/or severe mental illness.

Factors distinguishing care management typically include a degree of complexity of illness or condition, level of management that is intensive and requiring an extensive number of resources to obtain optimal health or improved functioning.

Members eligible for complex case management are identified with one or more of the following risks:

- Acute health care needs, diagnoses, or hospitalizations
- High-cost claims

- Complex medical issues and/or comorbidities
- Poorly controlled disease states
- Frequent admissions (3 within 3 months)
- Multiple emergency department visits (> 3 ED visits)
- Predictive modeling identified risk level

Outreach is conducted to eligible members to assess the needs of members experiencing complex health issues and to engage them to participate in the program. Members can also contact Security Health Plan directly to be enrolled in complex condition management.

Members are discharged from care management when one of the following is met:

- Care coordination goals
- Goals are no longer appropriate
- Member declines continued interventions
- Member is no longer enrolled with the Health Plan

Member satisfaction is evaluated for the care management program to identify opportunities for improvement.

20. Behavioral health care management

Security Health Plan offers a variety of behavioral health services for all lines of business that address substance abuse disorders, serious and persistent mental illness, and transitions of care. Security Health Plan offers a variety of programs to its members and does not limit eligibility to one complex condition or to members already enrolled in other programs. In accordance with NCQA standards, Security Health Plan considers care management to be an opt-in/opt-out program. All eligible members have the right to participate or decline participation.

Security Health Plan collaborates with behavioral health practitioners to monitor and improve coordination between medical care and behavioral health. Annually, Security Health Plan collects and analyzes data and uses the information to identify opportunities to improve collaboration using the following:

- Exchange of behavioral health information
- Appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care (antidepressant medication management measure)
- Follow-up care for emergency department and hospitalization for alcohol and other drug abuse (AODA) and behavioral health diagnosis
- Appropriate use of psychotropic medications
- Antidepressant medication management
- Management, treatment, access, and follow-up for members with coexisting medical conditions.

- Behavioral health program implementation
- Special needs of members with severe and persistent mental illness
- Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medication.

Security Health Plan has a program that is staffed by social workers, registered nurse care managers and other clinical staff. Members may be identified for the program through case, disease, and utilization management. In addition, members who have been in the emergency room or hospitalized for a primary diagnosis of depression or members who lack a follow-up visit following discharge are telephonically contacted by the social worker care manager. The program provides education regarding illness, medication adherence, self-management, provider communication and supportive network (family, social, coping, community resources). Members are also referred to complex case management for additional follow-up and care coordination related to medication management and symptom education related to other chronic conditions impacted by the psychotropic medications. To monitor the appropriate uses of psychopharmacological medications, Security Health Plan analyzes the antidepressant medication management HEDIS measure. Medicare Advantage members also receive a medication therapy management review by a pharmacist to identify medication-related problems. Care managers work with Security Health Plan pharmacists as a resource for ongoing medication questions and follow-up for medication reviews and coordination with providers.

21. Delegation

Security Health Plan delegates activities for several utilization management services and credentialing services and maintains oversight of the provision of services through regular reports and auditing.

UM delegation agreements
The following are credentialing delegation agreements effective in 2026:
EviCore Health, LLC
Prime Therapeutics, formerly Magellan Rx
Northwood, Inc

Credentialing delegation agreements
The following are credentialing delegation agreements effective in 2026:
Allied Health of Wisconsin
Aspirus Network Inc.
BayCare
Door County Medical Center
Essentia Health System, Inc.
Group Health Cooperative of SC, Wisconsin
Mayo Clinic Health System
Meriter Health Services Inc.

Prevea
ProHealth Solutions
St. Luke's Hospital of Duluth
ThedaCare ACO
University of Wisconsin Hospital & Clinic

The delegation agreements are subject to approval and oversight by the Credentialing Committee. Credentialing and re-credentialing files are audited and evaluated no less than annually to ensure the delegated organization's activities are being conducted in accordance with Security Health Plan expectations and external accrediting standards. The assessment includes NCQA's 8/30 rule for all delegates. Group Health Cooperative of SC Wisconsin, Fulcrum, St. Luke's Hospital of Duluth and Mayo Clinic Health System are NCQA-accredited; therefore, annual file audits are not required. We retain the right, based on quality issues, to approve and/or terminate the affiliation of individual providers and/or sites.

22. Credentialing and contracting

Access and availability requirements and need of members are monitored on an ongoing basis. Providers and practitioners are added to the network service area as the need for additional services is identified. The committee reviews network practitioners and facility credentialing biannually.

Contracting with Community-based organizations (CBOs) will continue to be a focus as needs are identified; these CBO partnerships are critical to the success of our D-SNP and SSI populations. Security health plan makes its best effort to establish Memorandums of Understanding (MOU) with school-based services, substance use disorder health home pilot programs and health departments.

23. Collaborative activities

Security Health Plan engages in collaborative activities, projects, initiatives, and forums to improve the quality of care and services for members. These include, but are not limited to:

- Alliance of Community Health Plans
- Wisconsin Association of Health Plans
- Collaboration with county health departments and agencies, including prenatal care coordination and supplemental nutrition program for women, infants, and children
- Wisconsin Chronic Disease Quality Improvement Project
- Health system and Health plan Joint Operating Committee
- Security Health Plan Quality and Health System Quality and Safety
- Hierarchical condition category and stars –Health System and Health Plan collaborative, led by Marshfield Clinic Health System Enterprise Project Management Office

- Findhelp (social care resource and closed-loop referral software) - a Marshfield Clinic Health System and Security Health Plan collaboration
- Risk Adjustment and Stars, in-home health support and evaluations vendor
- Provider Collaboration - Security Health Plan fosters open communication with practitioners and providers to ensure mutual understanding and cooperation with quality improvement activities. This is realized in large part via our provider-owner system relationship and value-based contracting. It is also accomplished through presentations, provider newsletter, the provider resources webpage, the provider manual and e-blasts for providers and practitioners throughout the network.

24. Communicating results

Quality assessment program results are routinely reported to the Board of Directors and executive leadership team through presentations and QI program description approval at committee. Our network practitioners and members are also notified about our quality assessment program results via the website and newsletter articles. The quality and population health department will provide copies of our annual QI results when requested.

Performance improvement results are communicated in a variety of ways, including, but not limited to:

- Committee presentations/activity report summaries
- Articles in the provider newsletters
- Press releases
- Articles in the member communications
- Documentation in committee meeting summaries
- Presentations at staff meetings
- Strategy dashboards
- Security Health Plan website and social media

25. Annual evaluation of the QI program

Annually, a written evaluation of the QI program, designed to identify both program achievements and limitations in meeting program goals, is prepared. This written evaluation includes a description of QI initiatives, trending of performance measures for quality of care and service, an analysis of demonstrated improvements in the quality of clinical care and service provided to members, an evaluation of overall effectiveness of the QI program and recommendations for the upcoming year.

The QI committee is responsible for the review and approval of the QI program evaluation. Following QI committee feedback and approval, recommendations from this annual evaluation are incorporated into the QI work plan.

26. Annual work plan

The annual QI work plan is a dynamic document that contains the planned QI activities and objectives for improving:

- Quality of clinical care
- Safety of clinical care
- Quality of service
- Member experience

The work plan incorporates activities related to Security Health Plan quality improvement activities, including accreditation standards. The work plan specifies the objective, activity, goals, if applicable, time frame for completion, staff members responsible for each activity, monitoring of previously identified issues and evaluation of the QI program. QI staff monitors the QI work plan to ensure activities and timelines are met.

27. Functional areas, responsibilities, and reporting

Governing body - At Security Health Plan, the Board of Directors delegates the responsibility of development and implementation, approval and overseeing of the QI program description to the chief executive officer, chief clinical officer, and the QI committee. The QI committee reviews and approves the program description, work plan and evaluation annually. Program activities and reporting are incorporated into the committees (outlined in the *program structure and resources*) agendas.

Approval by the Quality Improvement Committee

QI program description authors:
Director of quality and population health
Quality and accreditation specialists

Appendices
2026 Quality Improvement Work Plan