Quality Assessment and Performance Improvement (QAPI) Program Evaluation

January 1 - December 31, 2018

*Data as available by 3/22/2019

Contents

Ambetter & Allwell from Sunflower QAPI Program Evaluation - 2018

Introduction

The purpose of this evaluation is to provide a systematic analysis of Ambetter and Allwell's performance of the Quality Improvement (QI) activities and to evaluate the overall effectiveness of the Quality Assessment and Performance Improvement (QAPI) Program. The QI Department has established reporting QI activities as outlined in the QI Work Plan. This evaluation focuses on activities and interventions completed during the period of January 1 - December 31, 2018. The QAPI, QI Work Plan and QI Program Evaluation review and approval occur at least annually by the Quality Improvement Committee (QIC) and the Plan's Board of Directors (BOD). Ambetter and Allwell from Sunflower began operations providing services to members in Kansas on January 1, 2018. The purpose for both Ambetter and Allwell is to "transform the health of the community, one person at a time". This is established through a local approach that strives to provide improved health status, successful outcomes, both member and provider satisfaction in an environment that focuses and promotes coordination of care.

Mission

The Plan strives to provide improved health status, successful outcomes, both member and provider satisfaction in an environment focused on coordination of care for both Ambetter and Allwell. Through collaborating with local healthcare providers, the Plan seeks to achieve the following goals for our stakeholders and members:

- Ensure access to primary and preventive care services in accordance evidence based standards;
- Ensure care is delivered in the best setting to achieve optimal outcomes and improving Quality of Life;
- Improve access to necessary specialty services;
- Encourage quality, continuity, and appropriateness of medical care;
- Provide medical coverage in a cost-effective manner.

All programs, policies and procedures have these goals in mind with respect to their design.

Purpose

The purpose of the Quality Improvement Program is to utilize sound methodologies allowing for Plan to objectively and systematically plan, implement and monitor ongoing efforts that demonstrate improvements in member safety, health status, outcomes, and satisfaction. Achievement of this is through the implementation of a comprehensive, organization-wide system for ongoing assessments to identify opportunities for improvement utilizing the Plan-Do-Study-Act (PDSA) method for rapid cycle process improvement to drive continuous Quality Improvement across Plan for both members and providers.

Program Overview

The Plan is committed to the provision of a well-designed and well-implemented QAPI Program. Ambetter and Allwell's culture, systems and processes include the purpose of transforming the health of the community one person at a time. The QAPI Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of health care provided to all members, including those with special needs. This systematic approach to quality improvement provides a continuous cycle for assessing the quality of care and services in such areas as preventive health, acute and chronic care, behavioral health, over and under-utilization, continuity and coordination of care, patient safety, administrative and network services.

Scope

The scope of the QAPI Program is comprehensive and addresses both the quality and safety of clinical care and quality of services provided to Ambetter and Allwell members including medical, radiology, behavioral health, dental and vision care. The Plan incorporates all demographic groups, lines of business, benefit packages, care settings, and services in its quality improvement activities, including preventive care, emergency care, primary care, specialty care, acute care, short-term care, long-term care, and ancillary services.

The QAPI Program monitors the following for both Ambetter and Allwell:

- Acute and chronic care management
- Behavioral health care
- Care Management
- Compliance with member confidentiality laws and regulations
- Compliance with preventive health guidelines and practice guidelines
- Continuity and coordination of care
- Data collection, analysis and reporting
- Delegated entity oversight
- Department performance and service
- Employee and provider cultural competency
- Fraud and abuse detection, prevention and reporting
- Home support service utilization for members as appropriate
- Information Management
- Selection and retention of providers (credentialing and re-credentialing)
- Utilization Management, including under and over utilization
- Marketing practices
- Member enrollment and disenrollment
- Member Grievance System
- Member satisfaction
- Health outcomes
- Customer Services
- Network performance
- Organization Structure
- Patient safety
- Primary Care Provider changes
- Pharmacy
- Provider and Plan after-hours telephone accessibility
- Provider appointment availability
- Provider Complaint System
- Provider network adequacy and capacity
- Provider satisfaction
- Provider Services
- Policies to support the QAPI program.

Goals

The Plan's primary quality improvement goal is to assess, monitor, and measure improvement of the health care services provided to members served by the Plan. The Plan will ensure

quality medical care for members, regardless of payer source, eligibility category or location of services whether provided in an acute setting, home and community-based setting.

QAPI Program goals include but are not limited to the following:

- A high level of health status and quality of life will be experienced by Plan members;
- Support of members to pursue options to live within their community to enhance their quality of life;
- Network quality of care and service will meet industry-accepted standards of performance;
- Plan services will meet industry-accepted standards of performance;
- Fragmentation and/or duplications of services will be minimized through integration of quality improvement activities across Plan functional areas;
- Member satisfaction will meet the Plan's established performance targets;
- Preventive and clinical practice guideline compliance will meet established performance targets. This includes, but is not limited to, compliance with immunizations, prenatal care, diabetes, asthma, early detection of chronic kidney disease and EPSDT (Early Periodic Screening, Diagnosis and Treatment Program) guidelines as these apply to the Ambetter and Allwell membership. Plan will measure compliance with clinical practice guidelines until 90% or more of relevant network providers are consistently in compliance;
- Compliance with all applicable state/federal regulatory requirements and accreditation standards.

Objectives

The Plan's QAPI Program objectives include, but are not limited to, the following:

- To establish and maintain a health system that promotes continuous quality improvement;
- To adopt evidence-based clinical indicators and practice guidelines as a means for identifying and addressing variations in medical practice;
- To select areas of study based on demonstration of need and relevance to the population served;
- To develop standardized performance measures that are clearly defined, objective, measurable, and allow tracking over time;
- To utilize Management Information Systems (MIS) in data collection, integration, tracking, analysis and reporting of data that reflects performance on standardized measures of health outcomes;
- To allocate personnel and resources necessary to:
    - support the quality improvement program, including data analysis and reporting;
    - meet the educational needs of members, providers and staff relevant to quality improvement efforts;
- To seek input and work with members, providers and community resources to improve quality of care provided to members;
- To develop partnerships with new stakeholders and providers to establish services and relationships to support home and community based services and LTC residential options;
- To oversee peer review procedures that will address deviations in medical management and health care practices and devise action plans to improve services;

- To establish a system to provide frequent, periodic quality improvement information to participating providers in order to support them in their efforts to provide high quality health care;
- To recommend and institute “focused” quality studies in clinical and non-clinical areas, where appropriate.

Committee Structure

Integration of Quality is a focus throughout Plan, and represents the strong commitment to the quality of care and services for members and providers. To this end, the Plan has established various committees, subcommittees, and ad-hoc committees to monitor and support the QAPI Program. The Board of Directors has ultimate authority for the QAPI Program. The Quality Improvement Committee (QIC) is the senior management lead committee reporting to the Board of Directors. Various subcommittees support and report to QIC as noted below.

Board of Directors

The Board of Directors oversees development, implementation and evaluation of the QAPI Program. The BOD has ultimate authority and accountability for oversight of the quality of clinical and non-clinical care and services provided to Members. The Board of Directors reports to the Centene Board of Directors, as the plan is a wholly owned subsidiary of Centene Corporation. The Board supports the QAPI Program by:

- Adopting the initial and annual QAPI Program and establishing mechanisms for monitoring and evaluating quality, utilization, and risk;
- Supporting recommendations from the Quality Improvement Committee for proposed quality studies and other QI initiatives;
- Providing the resources, support and systems necessary for optimum performance of QI functions;
- Designating the Chief Medical Director (CMD) as Senior Executive for Quality Improvement (SEQI); and
- Reviewing the QAPI Program, Work Plan, and QAPI Program Evaluation annually to assess whether program objectives met goals, and recommending adjustments when necessary.

The Board delegates the operating authority of the QAPI Program to the Quality Improvement Committee (QIC), with operational oversight by the SEQI. The Plan’s senior management staff, clinical staff, and network providers, who may include primary, specialty, behavioral, dental and vision health care providers are involved in the implementation, monitoring and directing of the relative aspects of the quality improvement program through the QIC, which is directly accountable to the BOD.

Quality Improvement Committee

The Quality Improvement Committee (QIC) is the senior level committee accountable directly to the Board of Directors. The purpose of the QIC is to provide oversight and direction in assessing the appropriateness of care and service delivered and to continuously enhance and improve the quality of care and services provided to members. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems; the identification of opportunities to improve member outcomes; the education of members, providers and staff regarding the Quality Improvement (QI), Utilization Management (UM), and Credentialing programs.

The QIC is comprised of the Plan's CEO/President, Chief Medical Director, Medical Directors, and QI Senior Leadership, along with other executive staff representing Medical Management (including Utilization Management and Case Management), Network Development/Contracting, Customer Service, Compliance, and Pharmacy departments, with other ad hoc members as necessary. Additional QIC attendees include staff responsible for clinical appeals and Waste Abuse and Fraud. The QIC meets on a quarterly basis, at a minimum with ad hoc meetings an option. For 2018, QIC met a total of five (5) times which included the quarterly meetings and one ad hoc meeting.

Credentialing Committee

The Credentialing Committee is a standing subcommittee of the QIC and is responsible for administering the daily oversight and operating authority of the Credentialing Program. The QIC is the vehicle through which credentialing activities reach the Board of Directors. The Credentialing Committee is responsible for the credentialing and re-credentialing of physicians, non-physician practitioners, facilities, long-term care providers, and other practitioners in the Plan's network, and to oversee the credentialing process to ensure compliance with regulatory and accreditation requirements. The Credentialing Committee facilitation is through Centene's corporate office and is comprised of the Chief Medical Director, Medical Directors, Centene's Corporate Credentialing Director, network physicians, and other Plan QI staff. The Credentialing Committee met twelve (12) times in 2018. The Credentialing Committee meets monthly and on an ad-hoc basis.

The Credentialing Department is responsible for ensuring all practitioners have appropriate licensure and experience in their field. Application of rigorous standards that verifies practitioner's license, education, training, experience, certification, malpractice history, work history, and quality of care attributes contribute to the credentialing process. To become a participating provider in the Plan's network, each practitioner must meet the minimum qualifications as outlined by the State of Kansas and the National Committee for Quality Assurance (NCQA). The Credentialing Department is at Centene's corporate offices. The table below reflects the 2018 Credentialing report for both Allwell and Ambetter from April to December of 2018 as there was system limitation on this data being available prior to April. This has been resolved.

Ambetter's number of practitioners in network for 2018 was 10,245 and Allwell had 8,911 which included that which is delegated for dental and vision providers. In 2018, there were 1,382 Ambetter and 805 Allwell providers who went through initial credentialing. Both, had practitioners who completed the re-credentialing process. Of those re-credentialed, 99.8% of those were re-credentialed successfully. Provider credentialing turnaround time averaged 9.4 days for Ambetter and 8.7 days for Allwell. It is important to note that a system limitation resulted in credentialing turnaround time only being available from April to December. That system limitation has been resolved. There were no provider terminations for either Ambetter or Allwell in 2018. This information is in the table that follows.

2018 Credentialing Statistics	Allwell	Ambetter
Total number of practitioners in network (includes delegated providers) as of 12/31/2018	8,911	10,245
Initial Credentialing (excludes delegated)		
Number initial practitioners credentialed	805	1,382
Average Credentialing TAT from Complete Application to Committee (Days)	8.7days*	9.4 days*
Re-credentialing		
Number of practitioners re-credentialed	780	634
Number of practitioners re-credentialed within a 36 month timeline	1,735	1,459
% re-credentialed timely	99.8%	99.8%

2018 Credentialing Statistics	Allwell	Ambetter
Terminated/Rejected/Suspended/Denied		
Number with cause	0	0
Number denied	0	0

**TAT data is only for April through December*

Pharmacy and Therapeutic Committee

The Pharmacy and Therapeutics (P&T) Committee is a standing subcommittee of the QIC and is responsible for administering the routine oversight and operating authority of the Pharmacy Program. The QIC is the vehicle through which communication of pharmacy monitoring and reporting activities occurs with the Board of Directors. The P&T Committee ensures the plan provides a high quality, cost effective preferred drug list (PDL), an effective pharmacy program, and addresses quality and utilization issues related to pharmaceutical prescribing patterns, practices, and trends for both Allwell and Ambetter. The P&T Committee is a multidisciplinary team composed of the Associate Medical Director, Pharmacy Director, network physicians, and other executive staff. For 2018, P&T met two (2) times.

Utilization Management Committee

Routine and consistent oversight and operating authority of utilization management activities is delegated to the Utilization Management Committee (UMC) which reports to the QIC and ultimately to the Plan's Board of Directors. The UMC is responsible for the review and appropriate approval of medical necessity criteria, protocols, and utilization management policies and procedures. Additionally, the UMC monitors and analyzes relevant data to detect and correct patterns of potential or actual inappropriate under- or over-utilization, which may impact health care services, coordination of care, appropriate use of services and resources as well as member and practitioner satisfaction with the UM process. The UMC is composed of Chief Medical Director, Medical Director(s), Vice President of Medical Management, and other operational staff as needed. Network physicians also participate in this committee to provide input on process, policies and data. For 2018, UM Committee met four (4) times. Typically, the UM Committee meets quarterly.

HEDIS Steering Committee

The HEDIS Steering Committee oversees the Plan's HEDIS process and performance measures. The Committee reports directly to the QIC and reviews monthly HEDIS rate trending, identifies data concerns, and communicates both plan and corporate initiatives to Senior Leadership. The Committee directs clinical, non-clinical, member and provider initiatives to improve selected HEDIS measure performance. The HEDIS Steering Committee oversees the implementation, progression and outcomes monitoring of initiatives specific to HEDIS, recommends resources necessary to support the on-going improvement of HEDIS scores, reviews/establishes benchmarks or performance goals for HEDIS and oversee delegated vendor roles in improving HEDIS scores. The Committee meets a minimum of quarterly and the HEDIS Coordinator or Manager facilitates the meetings. Membership includes the senior leadership of QI, the CEO/President, Chief Medical Director, Medical Directors, and Senior Leadership of Medical Management, with representation from Contracting/Network Management, Member/Provider Services, and Pharmacy. The HEDIS Steering Committee meets quarterly and met four (4) times in 2018.

Grievance and Appeals Committee

The Grievance and Appeals Committee (GAC) is a subcommittee of the QIC and is responsible for tracking and analysis of member grievances and appeals including type, timeliness of resolution, performing barrier and root cause analysis, and making recommendations regarding

corrective actions as indicated. The GAC is composed of the Chief Medical Director, Medical Directors, Pharmacy Director, QI leadership, Grievance Coordinators, Clinical Appeals Coordinators, Clinical Appeals Supervisor and representatives from Customer Service, Claims, Provider Relations, Community Health Service team, Medical Affairs and Medical Management. The GAC provides summary reports to the QIC at regular intervals, but no less than quarterly. Meetings typically are quarterly or more frequently as needed. The GAC met four (4) times in 2018.

Peer Review Committee

The Peer Review Committee (PRC) is an ad-hoc committee of the QIC. It is responsible for reviewing inappropriate or aberrant service by a provider including alleged quality of care concerns, adverse events, and sentinel events where initial investigation indicates a significant potential or a significant, severe adverse outcome has occurred, or other cases as deemed appropriate by the Chief Medical Director. This committee includes participation by both network physicians and health plan medical directors. The PRC members utilize their clinical judgment in assessing the appropriateness of clinical care and recommending a corrective action plan that will best suit the particular provider's situation. For 2018, PRC for Physical Health met on fifteen (15) occasions to review cases and make recommendations as appropriate. For the Behavioral Health PRC, that group met five (5) times in 2018.

Performance Improvement Team

The Performance Improvement Team (PIT) is an internal, cross-functional quality improvement team that facilitates the integration of a culture of quality improvement throughout the organization. The PIT is responsible for gathering and analyzing performance measures, performing barrier and root cause analysis for indicators falling below desired performance, and making recommendations regarding corrective actions/interventions for improvement. The PIT is also responsible for overseeing the implementation of recommended corrective actions/interventions from the QIC and/or its supporting subcommittees, monitoring the outcomes of those improvement efforts and reports back to the designated committee.

The PIT meets monthly and includes representation from each functional area within the health plan. Membership includes staff that conducts or directly supervises the day-to-day activities of the departments, i.e. Case Management, Compliance, Community Health Services, Contracting, Customer Services, Network Development, Prior Authorization, Provider Relations, Quality Improvement or other members as determined by the topic under discussion. The PIT met twelve (12) times in 2018, with several subcommittee meetings of the PIT to address items such as the member experience survey, QRS and Stars initiatives. The PIT typically meets monthly. Seven (7) subcommittees report to the PIT as noted below in the descriptions for the committees.

CAHPS/Member Experience Workgroup

The focus of the CAHPS/Member Experience team serves as a work group that reviews the CAHPS or results of the member satisfaction survey, identify the opportunities for improvement, barriers and methods to mitigate the barriers. The goal of this committee is to continue to make strides improving the member experience as evidenced through improved survey results while utilizing PDSA. The committee meets quarterly and more often as necessary. A member of the Senior Quality leadership or the designated Member Experience lead from the Quality team facilitates the meetings. Members of the committee consist of representatives from Customer Service and Provider Service, Vendor Management, Quality Improvement, Medical Management, Pharmacy, Marketing, LTSS, Network Development/Contracting and Community

Health Services. This workgroup typically meets on a quarterly basis but may have Ad Hoc meetings as needed. In 2018, the work group met on eight (8) occasions.

Vendor Joint Operations Committees

The Vendor Joint Operations Committees (JOCs) are active sub-committees of the PIT. Vendor JOC meetings have the primary function to provide guidance to, and oversight of, the operations affecting the scope of functions of delegated vendors, including review of periodic activity reports from delegated vendors, ensuring compliance with all NCQA standards and regulations related to the delegation relationship, and recommending actions to address any identified opportunities for improvement in delegated services. The purpose of the Vendor JOCs is to provide oversight and assess the appropriateness and quality of services provided to members. The Vendor JOCs includes representation from each plan functional area as well as representation from the delegated vendors. These meetings occur on a quarterly basis but may occur more frequently as needed.

Provider Joint Operations Committees

The Provider Joint Operations Committees (JOCs) are active provider committees that occur at least quarterly and report to PIT. These committees are with high volume providers with the primary function is to allow the providers to provide input on the following: Plan policies, Plan clinical programs and processes; payment and UM activities; provider satisfaction and profiling activities, provide assistance to identify concerns and provide input for improvement of provider relations and support. Additionally, from time to time, this presents the opportunity to engage providers to provide input on implementation of new policies, processes, and tools. In 2018, there were seven (7) Provider Joint Operations Committee meetings held specific for Ambetter and none for Allwell. Allwell meetings will occur in 2019.

Physician Advisory Committee

The Physician Advisory Committee (PAC) is comprised of practicing primary care physicians in the Ambetter and Allwell networks who provide clinical advice and quality oversight from the physician perspective to the health plan on programs offered, policies and processes. The Chief Medical Director facilitates the PAC, meeting on a quarterly basis. This allows for a close working relationship with the Chief Medical Officer and Network leadership to ensure maintenance of the highest standards in care quality, efficiency, transparency, and relentless pursuit of improved health outcomes for members. In 2017, there were six (6) network primary care physicians on the committee, which also includes representation from the Contracting, Network Development, Provider Relations, Quality Improvement and Medical Affairs. In 2018, this committee convened three (3) times.

Behavioral Health Advisory Committee

In 2018, implementation of the Behavioral Health Advisory Committee (BHAC), which is, includes network Behavioral Health providers. The purpose of BHAC is to allow for communication of the Plan's programs, policies, and processes with the provider network supporting the opportunity to discuss and provide feedback to the plan. Additionally, it allows for providers to make recommendations and identify key issues encountered by members and providers. The Plan's Behavioral Health Medical Director or appointed BH Provider chairs this committee. The meetings occur on a quarterly basis. This committee reports to the PIT committee. In 2018, this committee met three (3) times due to its initiation.

Ambetter Member Advisory Committee

The Ambetter Member Advisory Committee (AMAC) allows Ambetter members to participate in meetings twice a year where the health plan provides information on programs, policies,

processes, services and various data points to include but not limited to quality. This allows members to provide feedback and input on areas where the Health Plan can make improvements and share their experiences as well. The Community Relations Representative chairs the committee. This committee reports to the PIT committee and convened two (2) times in 2018.

Stars Allwell Workgroup

Stars Allwell Workgroup (SAW) is unique to the Allwell line of business working to identify improvement opportunities, specific objectives, barriers, and steps to mitigate barriers. The workgroup is also responsible for selection and implementation of improvement activities. The workgroup includes cross-functional leaders (e.g., Compliance, Member Services, Utilization Management, Contracting, Provider Services, Medical Management, Quality Improvement), as well as employees who conduct or directly supervise the day-to-day activities related to clinical and operational improvement initiatives. A primary responsibility of the SAW is to ensure compliance with, and achieves optimal performance on all required and identified performance measures. To monitor success in the implementation of each intervention, monitoring rates monthly, and determining if initiatives were successful or not, then pursuing other opportunities for impact. Root cause analysis is another avenue utilized to determine opportunities. The QI Senior Leader or designee chairs this workgroup. The workgroup meeting frequency is quarterly or more often as necessary and reports to PIT. This workgroup met five (5) times in 2018.

Quality Department

Quality Leadership in 2018

The plan Chief Medical Director served as the SEQI and provided continued leadership and oversight of QI. Three team members received promotions from within the Quality team. Two of those promotions were to Managers and one was to a Supervisor. Quality Leadership continues to conduct routine assessments of work volume and progress on plan priorities to allow for reallocation of staff resources to address needs encountered in work volume trends and also to address priority areas to ensure the member and provider needs are met as integral parts of the business all while driving continuous quality improvement. In December of 2018, the Chief Medical Director accepted an opportunity to serve as Chief Medical Director with a larger Centene Plan. Therefore, two Medical Directors were delegated the responsibilities of the CMD until a new CMD is appointed. In addition, in the interim, the Senior Director of Quality reports directly to the Plan President and CEO.

Quality Improvement Department

The Quality Improvement department is dynamic with a wide range of experience, knowledge and leadership throughout. This team is resourceful and works collaboratively, both internally and externally. There was turnover of five (5) staff persons in 2018 in the QI Department. The turnover was in relation to two staff members who left the Plan; three of those seized opportunities to join our corporate team. New team members filled all of the open positions in 2018. Two Risk Adjustment team members joined the Operations team in 2018, who had previously been on the Quality team. In 2018, The QI resources were evaluated and it was determined additional resources were needed to meet the needs of the QAPI Program. As a result, there was a gain of two full time staff positions. One addition was an Accreditation Specialist to support both Ambetter and Allwell, and a QI Specialist to provide a focus on Ambetter Performance Improvement. The QI department is now composed of the following positions for both Ambetter and Allwell unless otherwise specified:

- Chief Medical Director, serving as the Senior Executive for Quality Initiatives (SEQI) (member by position and role)
- Medical Director of Utilization Management (member by position and role, not formal reporting structure - 2)
- Senior Director, QI (Nurse)
- Managers, QI
    - Accreditation and CAHPS/Member Experience (Social Worker)
    - Appeals and Grievances (Nurse) for Ambetter
    - Performance Improvement (Nurse)
    - HEDIS (Social Worker)
- QI Specialist for Allwell Stars
- QI Specialist for Surveys
- QI Auditors for Ambetter
- Accreditation Specialist
- QI, Coordinator (2)
- RA, Coding Analyst
- RA, Member Coordinator
- Centene Corporate support

QAPI Program Effectiveness

Throughout 2018, the QI Department continued its collaboration with all organizational departments to facilitate continuous improvement in performance by empowering all stakeholders through education, communication, utilizing the PDSA methodology with regard to data analysis, interventions and outcomes. The Plan has continued to improve the quality of care and services provided to the membership through continuous assessment of patterns, trends, identification of barriers to desired outcomes and making adjustments that promote meeting the needs of those served and with the utilization of innovation and feedback.

The Plan continues to strive to include network physicians in the program through committee participation and incorporate their feedback, Provider Profiles and other initiatives. The Plan believes network physician involvement ensures policies and initiatives reflect the needs of Kansans in the context of the local healthcare delivery system. Further, network physician involvement encourages the spread of evidence-based practice through Clinical Practice Guideline, HEDIS measures and other care improvement programs.

Quality Improvement Work Plan

The QI Department has a QI Work Plan that details all activities to ensure it is operational. Activities include a due date and a synopsis of the activity including implementation and the progress. The Plan's QI Department collaborates with all organizational departments to develop and maintain a comprehensive Quality program.

The 2018 QI Work Plan defines the activities, the person(s) responsible for the activity, the date of expected task completion and the monitoring techniques that used to ensure completion within the established timeframe. The QI Work Plan goes to the QIC on an annual basis for approval, through the annual evaluation process and at regular intervals throughout the year. Additionally, the work plan goes to the Board of Directors at least annually but more often as needed. The Plan's Board of Directors and QIC reviewed and approved the QI Work Plan in 2018 and updates occurred in an ongoing fashion throughout the year.

Quality Improvement Program Integration

The QI Program Evaluation, QI Program Description, and the QI Work Plan are integrated. The year-end QI Program Evaluation identifies barriers, opportunities for improvement, results and recommended interventions. The QI Evaluation allows for modifications to the next year's QI Program Description and the key metrics of the QI Work Plan.

2018 Strengths and Accomplishments:

- Ambetter from Sunflower achieved NCQA Accreditation in its first year of operations
- Quality Improvement leadership expanded to include four nurses and two social workers with Quality Improvement experience
- Quality Improvement reports up to the Chief Medical Director, who is directly involved in Quality initiatives as the SEQI
- Committee membership and structure evaluation continues in ongoing fashion to allow revision to support functional activities.
- Network providers actively participating in various Quality committees to provide input and feedback to drive continuous Quality Improvement across the organization
- Quality improvement initiatives and focus studies identified, using data trends starting to take more shape with plan experience
- Utilization of skill and experience in HEDIS operations to allow for the plan to optimize abstractions/over-reads both during year round and hybrid season with continued efforts towards optimization of data captured through state immunization registry, member outreach to optimize collection of supplemental data, including records from in-home assessments and other opportunities for potential impact on HEDIS measures for MY2018.
- Utilized PDSA to improve process for documenting and reporting efforts at continuous quality improvement
- Evaluation and updates to systems to incorporate reporting criteria to reduce reporting errors and automate some reporting functions.
- Implementation of Provider Profiles sent out to engage providers on closing care gaps and optimize supplemental record acquisition
    - Provider profiles sent for two Ambetter HEDIS measures
    - Provider profiles sent for two Allwell HEDIS measures
- Ongoing evaluation, modification, and update of templates for trending of Grievances, Appeals, and Quality of Care issues data for more in depth analysis and display for team members and Committee, allowing for identification of quality improvement opportunities.
- Ongoing efforts to review grievance and appeals documentation, revising and creating more consistency to reduce member confusion.
- Evaluation of Ambetter External Reviews to identify trends and opportunities for improvement with health plan processes
- Collaborate with vendors to identify opportunities to improve efficiencies and satisfaction through education of providers, health plan staff and members
- Development and use of reports to monitor and to identify cases at risk of not meeting turn-around time (TAT) for grievances and appeals before they are out of TAT.
- Monitoring of reports to do surveillance of routine QOC issues on whole population, allowing focused review when there are findings and trending of certain types of at risk diagnosis patterns.

- Continued partnership with the Plan's Data Analytics team to improve data integrity, revise provider profiles and accuracy related to member outcomes, strategic initiatives and to meet state reporting requirements.
- Care Management worked with 78 Allwell members in 2018.
- Care Management worked with 221 Ambetter members in 2018.
- The Ambetter call center in Lenexa took 17556 calls, had an average speed of answer of 20 seconds, with a service level of 90.12% and an abandonment rate of 1.29%.
- The Allwell call center in Lenexa took 572 provider calls, had with an average speed of answer of 18 seconds, with a service level of 88.01% and an abandonment rate of 2.05%.
- Ambetter utilized WebIZ state immunization registry to capture Childhood Immunization data for HEDIS
- Ambetter achieved an overall claims payment average TAT of 12 days, with an average of over 15,000 claims per month (excluding vendors).
- Allwell achieved an overall claims payment average TAT of 12 days, with an average of over 270 claims per month (excluding vendors).
- Added Provider Profile Reminders as an 'end of year push' initiative focusing on 2 HEDIS measures for both Allwell and Ambetter
- For Ambetter, Provider P4P programs will launch in 2019, starting small with 3 key providers with at least one location in Leavenworth: Sunflower Medical Group, Encompass Medical Group, Prime HealthCare Physician Service
- Reporting Care Management HEDIS notes data from our TruCare system for any notes regarding medical records.
- AMM Antidepressant monthly mailing list for monthly letter campaign.
- HEDIS A1C outreach campaign with Care Management without continuous enrollment requirements for all business lines to identify members early for opportunity to engage to close care gaps.

Opportunities for Improvements:

- HEDIS rates continue to be an area of focus through member outreach, education and collaboration with various partners including providers, health departments, schools and organizations;
- Explore and evaluate resources and opportunities for education and incentives to improve rates with goal to meet or exceed the 75th Quality Compass Percentile.
- Implement text messaging technology to engage members and assist in care gap closure
- Implement Provider P4P arrangements for 2019.
- Continuous evaluation of data and exploring new interventions to strive towards continuously improving Member and Provider satisfaction with services, care and operations based on survey results and other avenues of feedback including both member and provider appeals and grievances.
- Develop and expand trending reports for data analysis and focused interventions as a part of PDSA within all health plan departments.
- Implement additional outreach to internal and external partners to share results of quality improvement activities and open doors for feedback.
- Continued efforts to improve processes, provide education and work to improve appeals and grievances for both members and providers which will also impact satisfaction for both

Compliance Program

The Compliance Department, in conjunction with Centene Corporate, is responsible for ongoing monitoring and investigation of potential waste, abuse and fraud related to providers, members, and internal staff. Additionally, the Compliance department collaborates with the Quality department with an established process for documenting and responding to the Department Of Insurance (DOI) complaints. The Compliance department is responsible for establishing and maintaining an effective compliance program that meets the seven elements as defined by Office of Inspector General (OIG).

For Ambetter from Sunflower, CMS performed an audit in 2018 of the QHP. The Plan recently received the draft report on that audit.

Quality and Utilization Assessment and Performance Improvement Program Effectiveness

Throughout 2018, the Quality department has collaborated with the organization's departments to promote and facilitate continuous quality improvement by empowering all internal and external stakeholders through education, communication, data analysis and evaluation. The Plan accomplishes this through utilizing data from utilization of services, various surveys, grievances, appeals, and claims where representatives from various health plan departments work together in collaboration through established committees, workgroups and ad hoc meetings to determine opportunities for improvement, identify barriers and strategies for improvement with the PDSA methodology. The collaboration is ongoing and may involve multiple teams simultaneously. The Plan has continued to improve the quality of care and services provided to the Ambetter and Allwell memberships through perpetual efforts aimed at continuous quality improvement that involves the assessment of patterns, trends, and identification of barriers to attain desired outcomes.

The Plan has identified strengths and opportunities for improvement, which are in more detail within action plans in the full-specified annual evaluation report. The review of 2018 interventions are key to the planning and continuation of interventions for the coming year as needed for measures requiring continued improvement.

Strengths:

- Received NCQA Accreditation within first year with Ambetter
- Integration of physical and behavioral health
- Implemented provider profiles for HEDIS care gap closure for both Ambetter and Allwell
- Utilizing innovation to drive Quality through building foundation for Provider P4P arrangements, and working to increase collaboration with providers, health departments, schools and other organizations to improve the quality of care members receive

Opportunities for Improvement:

- Efforts to promote provider and specialist communication for optimal coordination of care
- Provider education to increase efficiencies and to increase their awareness of the efforts to close care gaps for preventive and well care for members
- Explore opportunities to continue to innovate to drive quality improvement through more collaborative efforts with providers and other community resources

- Drive more interventions for demonstration of increased quality of care received by members with evidence based measures such as HEDIS

Processes and operational systems are identified opportunities in both Ambetter and Allwell to improve with regard to stabilization, which allows for innovation, producing positive results, and in some instances, efforts may reveal additional opportunities as the plan matures, in serving Ambetter and Allwell members. The findings from the analysis completed for 2018 did not indicate the need for major revisions to the Plan's QAPI, operations, or service delivery systems. The Plan will take the necessary steps to demonstrate continuous quality improvement on the areas identified as priorities for improvement in 2019. The aim is to improve the health and well-being of both Ambetter and Allwell membership and increase partnership approach with providers. The purpose will continue to be to transform the health of the communities we serve, one person at a time.

Population Characteristics

Ambetter from Sunflower started providing services to members in Kansas on January 1, 2018 in Johnson and Wyandotte counties. The Ambetter plan offered four levels of service members could select participation in, through Ambetter. There were 17,617 members in total, who selected Ambetter from Sunflower for their benefits. The following table depicts the selected levels, by members, to participate.

Ambetter Product	Membership Numbers
Gold Secure Care	966
Silver Zero Cost Share	84
Bronze Essential Care	5,478
Silver Balanced Care	11,089
Total	17,617

Age Group	2018
0-10	5%
20-Nov	8%
21-30	15%
31-40	15%
41-50	16%
51-60	23%
61-70	15%
71-80	1%
81-90	1%
91+	1%

Gender	2018
Male	44%
Female	56%

In reviewing Ambetter top five diagnosis for both Adult and Children members, there were some consistencies noted. For example, the top medical diagnosis for both adults and children involved exams that were routine or general and revealed no abnormal findings. Immunizations were also the second highest for both Ambetter groups. *Acute Pharyngitis Unspecified* and *Acute Upper Respiratory Infections Unspecified* were the second and third listed for children. *Fever Unspecified* rounded out the top five for children, while *Primary Hypertension* followed by *Routine Gynecologic Exams Without Abnormal Findings* and screening mammograms listed for adult top medical diagnosis. Behavioral Health diagnosis for both adults and children revealed *Anxiety Disorder Unspecified* as the top diagnosis. For children, *ADHD Unspecified Type* diagnosis listed second, third and fifth are *generalized anxiety disorder* coming in at fourth. However, for the adults generalized anxiety disorder came in second followed by major depression followed at fourth and fifth with nicotine dependence diagnosis. These details are in the following tables.

Top 5 Medical Diagnosis Child (Ages 0-17) Range: January 1, 2018-December 31, 2018		
Diagnosis Code	**Diagnosis**	**# Unique Member**
Z00129	ENC RTN CHLD HLTH EX W/O ABNRM FIND	964
Z23	ENCOUNTER FOR IMMUNIZATION	819
J029	ACUTE PHARYNGITIS UNSPECIFIED	225
J069	ACUTE UP RESPIRATORY INFECTION UNS	203
R509	FEVER UNSPECIFIED	155

Top 5 Medical Diagnosis Child (Ages 0-17) Range: January 1, 2018-December 31, 2018		
Diagnosis Code	**Diagnosis**	**# Unique Member**
Z00129	ENC RTN CHLD HLTH EX W/O ABNRM FIND	964
Z23	ENCOUNTER FOR IMMUNIZATION	819
J029	ACUTE PHARYNGITIS UNSPECIFIED	225
J069	ACUTE UP RESPIRATORY INFECTION UNS	203
R509	FEVER UNSPECIFIED	155

Top 5 Medical Diagnosis Adult (Ages 18+) Range: January 1, 2018-December 31, 2018		
Diagnosis Code	**Diagnosis**	**# Unique Member**
Z0000	ENC GEN ADULT EXAM W/O ABNORM FIND	5,118
Z23	ENCOUNTER FOR IMMUNIZATION	3,926

I10	ESSENTIAL PRIMARY HYPERTENSION	3,729
Z01419	ENC GYN EX GEN RTN W/O ABNORM FIND	2,498
Z1231	ENC SCR MAMMO MALIG NEOPLASM BREAST	2,359

Top 5 Medical Diagnosis Adult (Ages 18+) Range: January 1, 2018-December 31, 2018		
Diagnosis Code	**Diagnosis**	**# Unique Member**
Z0000	ENC GEN ADULT EXAM W/O ABNORM FIND	5,118
Z23	ENCOUNTER FOR IMMUNIZATION	3,926
I10	ESSENTIAL PRIMARY HYPERTENSION	3,729
Z01419	ENC GYN EX GEN RTN W/O ABNORM FIND	2,498
Z1231	ENC SCR MAMMO MALIG NEOPLASM BREAST	2,359

Top 5 Behavorial Health Diagnosis Child (Ages 0-17) Range: January 1, 2018-December 31, 2018		
Diagnosis Code	**Diagnosis**	**# Unique Member**
F419	ANXIETY DISORDER UNSPECIFIED	38
F909	ADHD UNSPECIFIED TYPE	34
F900	ADHD INATTENTIVE TYPE	30
F411	GENERALIZED ANXIETY DISORDER	29
F902	ADHD COMBINED TYPE	28

Top 5 Behavorial Health Diagnosis Child (Ages 0-17) Range: January 1, 2018-December 31, 2018		
Diagnosis Code	**Diagnosis**	**# Unique Member**
F419	ANXIETY DISORDER UNSPECIFIED	38
F909	ADHD UNSPECIFIED TYPE	34
F900	ADHD INATTENTIVE TYPE	30
F411	GENERALIZED ANXIETY DISORDER	29
F902	ADHD COMBINED TYPE	28

Top 5 Behavorial Health Diagnosis Adult (Ages 18+) Range: January 1, 2018-December 31, 2018		
Diagnosis Code	**Diagnosis**	**# Unique Member**

F419	ANXIETY DISORDER UNSPECIFIED	1,475
F411	GENERALIZED ANXIETY DISORDER	1,070
F329	MAJ DEPRESS D/O SINGLE EPIS UNS	933
F17210	NICOTINE DEPEND CIGARETTES UNCOMP	576
F17200	NICOTINE DEPEND UNS UNCOMPLICATED	542

Allwell from Sunflower started providing Allwell Advantage with Pharmacy benefits to members in Johnson and Wyandotte counties on January 1, 2018. In total, 166 members chose to participate in Allwell. When looking at further details of this population, the largest age group served were those from 61 to 70 years of age followed by those in the 71 to 80 year old group. There were no members under age 21 years, who were in the MAPD plan, but results show 2% in the ages of 21 to 40 years of age and a similar group noted in the age group of 41 to 50 years of age. Those within the 51 to 60 age group noted an increase to 9% while there was a noted decrease in members choosing these options for the 71 to 80 age group. Only 1% of those 91 years and older chose a MAPD product. Additionally, the percent of female members were 58% compared to the male membership at 42%. These details are in the following tables.

Age Group	2018
0-10	0%
11-20	0%
21-30	1%
31-40	1%
41-50	2%
51-60	9%
61-70	57%
71-80	21%
81-90	8%
91+	1%

Gender	2018
Male	42%
Female	58%

The Allwell membership demonstrated the top five medical diagnoses starting with *Essential Primary Hypertension* as the top diagnosis, followed by *Hyperlipidemia Unspecified*. Immunization visits listed third, followed by *Adult Exam Without Abnormal Findings* as fourth, and fifth being *Type II Diabetes Without Complications*. For behavioral health top five diagnosis, *Major Depression* came in first followed by *Anxiety Disorder Unspecified*, *Nicotine Dependence on Cigarettes*, then *Generalized Anxiety Disorder* listed fourth and *Unspecified Dementia Without Behavioral Disturbance* came in fifth. These details are in the following tables.

Top 5 Medical Diagnosis Adult (Ages 18+) Range: January 1, 2018-December 31, 2018		
Diagnosis Code	**Diagnosis**	**# Unique Member**
I10	ESSENTIAL PRIMARY HYPERTENSION	111

E785	HYPERLIPIDEMIA UNSPECIFIED	77
Z23	ENCOUNTER FOR IMMUNIZATION	57
Z0000	ENC GEN ADULT EXAM W/O ABNORM FIND	51
E119	TYPE 2 DM WITHOUT COMPLICATIONS	41

Top 5 Behavorial Health Diagnosis Adult (Ages 18+) Range: January 1, 2018-December 31, 2018		
Diagnosis Code	**Diagnosis**	**# Unique Member**
F329	MAJ DEPRESS D/O SINGLE EPIS UNS	19
F419	ANXIETY DISORDER UNSPECIFIED	15
F17210	NICOTINE DEPEND CIGARETTES UNCOMP	10
F411	GENERALIZED ANXIETY DISORDER	8
F0390	UNS DEMENT W/O BEHAVIORAL DIST	6

Ambetter and Allwell both offer language assistance services to members who require translation services. Services are available for both telephonic and on-site interactions. The Plan Care Management, Customer Service, or Provider/Practitioner staff arranges these services. The following table provided represents the top languages for which members have requested translation services by unique interactions during the assessment of 2018. The Plan also has Spanish-speaking Care Management, Customer Services Representatives and Quality Improvement staff available. The Ambetter Customer Service Supervisor and Call Quality Analyst are also Spanish speaking to ensure Spanish-speaking members receive appropriate services by the health plan. Spanish speaking is the highest utilizer for both the Ambetter and Allwell membership. The following table provided depicts the Language Service Line Requests that occurred from January 1, 2018 through December 31, 2018 for both Ambetter and Allwell membership.

Language Line Utilization for Ambetter & Allwell

KS Ambetter	**184**	**100%**
Amharic	4	2.17%
Arabic	4	2.17%
Bengali	1	0.54%
Burmese	7	3.80%
Cantonese	1	0.54%
Farsi	3	1.63%
Gujarati	1	0.54%
Haitian Creole	2	1.09%
Hindi	5	2.72%
Korean	12	6.52%
Mandarin	25	13.59%
Persian	2	1.09%

KS Ambetter	184	100%
Polish	1	0.54%
Punjabi	9	4.89%
Russian	11	5.98%
Spanish	81	44.02%
Vietnamese	15	8.15%
KS Allwell	**52**	**100%**
Arabic	1	1.92%
Cantonese	2	3.85%
Hindi	4	7.69%
Korean	1	1.92%
Mandarin	4	7.69%
Spanish	39	75.00%
Tagalog	1	1.92%

Quality Performance Measures and Outcomes

NCQA Accreditation

The Plan received the NCQA Accreditation status for the Ambetter from Sunflower line of business from the National Committee for Quality Assurance (NCQA), effective in December of 2018.

The results from the 2018 Ambetter onsite Interim survey revealed the following overall strengths:

- Strong Corporate support
- Streamlined and well-documented policies and processes.

The Plan continues to work on noted opportunities identified by NCQA during the Ambetter 2018 Interim Accreditation survey. Those opportunities include:

- Providing support to practitioners or providers in the Plan network to achieve population health management goals;
- Notifying practitioners about their right to receive the status of their credentialing application, upon request; and
- Describing the delegated activities and the responsibilities of the organization and delegated entity and the process by which the organization evaluates the delegated entity's performance, for purposes of credentialing, performed at the corporate parent level.

Plan continues to work with corporate resources to improve performance in these domains.

Plan strives for continuous NCQA readiness, which involves ongoing review of all plan and quality improvement processes to be consistent with NCQA standards. Continued focus on opportunities for refinements made to hardwire accreditation compliance into processes including development of a process for policy review, and training of new staff on documentation requirements. In 2018 readiness reviews/audits, and ongoing health plan NCQA education and reminders, continued. Plan has a Manager of Quality Improvement and an Accreditation Specialist for NCQA accreditation efforts to ensure the plan has a focus on continued readiness for the Ambetter from Sunflower Marketplace line of business. Plan also works very closely with corporate resources to maintain

NCQA compliance and readiness. Plan will undergo NCQA Accreditation First Survey for the Ambetter from Sunflower Marketplace line of business first quarter of 2020.

The Plan continues NCQA Accreditation readiness practices, as applicable, for the Allwell from Sunflower Medicare line of business. Currently, Plan is not seeking an accreditation status as directed by the corporate parent, Centene.

Healthcare Effectiveness Data Information Set (HEDIS®)

HEDIS® is one of the most widely used data sets applied in performance measurement in the United States. HEDIS includes performance measures pertaining to effectiveness of care, access/availability of care, satisfaction with the experience of care, cost of care, health plan descriptive information, health plan stability, use of services, and informed health care services. The Plan uses HEDIS criteria for all applicable clinical studies as part of the NCQA accreditation process. Preliminary reports, provided by Centene's corporate office, for monthly review, utilizing administrative data that allows the Plan to assess the plan's performance and take the appropriate actions to better impact member health, well-being, and preventative care.

HEDIS Indicators

HEDIS is a collection of performance measures developed and maintained by NCQA. Participation in the program enables organizations to collect and submit verified data in a standardized format. The Plan continues to submit HEDIS data annually in accordance with the performance measure technical specifications. The Plan also continued to design and implement key interventions to increase the Plan's HEDIS rates reported for the calendar year.

The Plan has been collecting data for Allwell and Ambetter since January 2018, and loading the information into its certified-HEDIS software. The Plan focuses efforts to improve on HEDIS measures by factoring in those that are required for NCQA accreditation, and those that have Star ratings. The Plan continued to track progress on these measures, on a monthly basis throughout 2018, while actively working interventions throughout 2018. Due to timing of this report, the final results will not be available until the final HEDIS 2019 results are available. Results will likely be in July of 2019. Additionally, the results are with respect to low membership for the Allwell population.

Childhood Immunizations

For **Ambetter**, the Plan utilizes immunization data from the Kansas State Immunization Registry or WebIZ as supplemental data. This data utilization started in 2018 by the Plan. The Plan uses the auditor approved CDC mapping table for the CVX immunization codes, in order to map them over from WebIZ to allow translation to the CPT codes for acceptance in our HEDIS software. Measurement year 2018 is a baseline year for this measure. Several interventions target for these members during 2018. The interventions are below.

Childhood Immunizations Interventions for 2018 were:

- Alerts for Customer Service Representatives and Medical Management to indicate members who have care gaps and can remind them of the need for an appointment and/or assist with making one along with treatment, if needed
- Birthday card mailings
- Start Smart for Your Baby Program – outreach to parents of newborns to educate on Periodicity schedule
- Proactive Outreach Management (POM) calls made to parents/guardians of children to remind them of schedule for well-child visits, including immunizations

- HEDIS Quick Reference Guide distribution to new providers and annual updates to existing providers with ICD-10 updates
- Provider EPSDT Reference Kit developed and distributed to high volume providers
- Obtaining WebIZ Immunization Registry data, Web-IZ data pulls for CIS were completed in January, February, May, July, August, September, October, November and December.

The following table demonstrates the Plan's current Ambetter administrative results related to the HEDIS measures on Childhood Immunizations. Combo 10 evaluates compliance with completion of all 10 immunizations. Ambetter's total denominator for this population was nine (9) members; the rates may appear higher than expected for the baseline year. It is important to note that the final HEDIS 2019 rate is not available at the time of this report; therefore, an administrative rate is in the following table.

HEDIS MEASURE	HEDIS 2019 (MY2018) Admin*
DTaP Immunizations	44.44%
H Influenza Type B Immunizations	66.67%
Hepatitis A Immunizations	88.89%
Hepatitis B Immunizations	55.56%
Influenza Immunizations	0%
Measles, Mumps and Rubella Immunizations	77.78%
IPV Immunizations	66.67%
Pneumococcal Conjugate	66.67%
Rotavirus Immunizations	55.56%
Chicken Pox (VZV)	88.89%
Combo 10	0%

**Awaiting HEDIS 2019 Final Hybrid Rates*

The Plan is continuing to analyze data for opportunities to improve on compliance with vaccination completion. However, the Plan recognized from HEDIS data for HEDIS 2018, that it is common for the child to complete the vaccines, but often after their second birthday. This does not demonstrate compliance with the technical specifications. Therefore, the Plan will continue to educate on the importance of completing prior to the child's second birthday. In addition to continuing many of the 2018 interventions in 2019, the Plan will also continue to explore opportunities to expand partnerships with more health departments and providers, to close care gaps on childhood immunizations.

Adolescent Immunizations

Much of Ambetter's immunization data comes from the Kansas State Immunization Registry or WebIZ as supplemental data. This data utilization started in 2018 by the Plan. The Plan uses the auditor approved CDC mapping table for the CVX immunization codes, in order to map over from WebIZ to allow translation to the CPT codes for acceptance in our HEDIS software. Measurement year 2018 is a baseline year for this measure. Several interventions target for these members during 2018. The interventions are below.

Adolescent Immunizations Interventions for 2018 were:

- Distributed Provider Care Gaps to providers on members who were non-compliant for immunizations.
- Alerts provided in documentation system for Customer Service Representatives and Medical Management to indicate members who have care gaps and can remind them of the need for an appointment and/or assist with making one along with treatment, if needed.
- HEDIS Quick Reference Guide distribution to new providers and annual updates to existing providers with ICD-10 updates.
- Provider EPSDT Reference Kit was updated and available to providers via Plan Website.
- Obtained KDHE Immunization Registry data. Web-IZ data pulls completed for IMA in January, February, May, July, August, September, October, November, and December.

The following table provided, demonstrates Plan current administrative results related to the HEDIS measures on Ambetter Adolescent Immunizations. Combo 2 evaluates compliance with completion of all suggested adolescent immunizations. Ambetter's total denominator for this population was 16 members; the rates may appear higher than expected for the baseline year. It is important to note that the final HEDIS 2019 rate is not available at the time of this report; therefore, an administrative rate is in the table.

HEDIS MEASURE	HEDIS 2019 (MY2018) Admin*
Meningococcal	66.59%
Tdap	82.69%
HPV	19.23%
Combo 2	17.79%

**Awaiting HEDIS 2019 Final Hybrid Rates*

The Plan reviewed the data from Adolescent Immunizations interventions in 2018 and determined a knowledge gap was common related to the HPV vaccination. Additionally, missed opportunities proved to be a barrier with care gap closure for adolescent immunizations. Therefore, the Plan will continue many of the interventions utilized in 2018 for 2019 while also continuing to explore methods to increase knowledge and understanding of the benefits the Tdap, Meningococcal, and HPV vaccinations offered to adolescents. The Plan will also explore additional partnerships with health departments as well as other providers on closing those care gaps and determining where there are opportunities to expand provider payment incentives.

Comprehensive Diabetes Care

The Plan worked on this HEDIS measure and its sub measures in 2018, for **Allwell** and **Ambetter** members, to help members have a better understanding of diabetes. This includes the importance of routine monitoring, proper diet, and exercise all aimed at helping to improve their management of diabetes. All of the items can help potentially lessen or avoid complications that result from diabetes. The Plan worked in collaboration with Envolve Vision Care for the diabetic eye exam efforts on gap closure. Quest/ExamOne also collaborated with the Plan to help impact members who were still non-compliant with their diabetes monitoring. This intervention allowed members the option to have their lab draws, blood pressure, height, and weight measurements taken in their own home, by a Quest/ExamOne staff member. The Plan followed-up with members who were not interested in the

in-home visits, by the Medical Management Team, to help members find a provider, make appointments, arrange transportation, educate the members on the importance to have these tests done annually, and referred members as appropriate for the Disease Management services available to them via Nurtur.

Comprehensive Diabetes Care Interventions for 2018:

- Envolve Vision's HEDIS Outreach - Diabetic Retinopathy Exam sub measure; Quarterly progress reports started in May of 2018 and will continue through 2019.
- Rewards program incentives
- Medical Management performs outreach to non-compliant members and diabetic members in Care Management
- Customer Service and Medical Management training on measure to discuss care gaps with members on calls; reminders sent prior to care gap reports going out to members
- Use of KRAMES educational materials to educate members about diabetes care
- Provider profile report based first on attribution then assignment distributed to providers of non-compliant members.
- Partnerships with FQHC's to close member care gaps

The following table provided demonstrates results related to the **Ambetter** Comprehensive Diabetes Care HEDIS measure. It is important to note that the final HEDIS 2019 rate is not available at the time of this report. Those results will be available in July 2019.

Ambetter HEDIS MEASURE	HEDIS 2019 (MY2018) Admin*
CDC- Blood Pressure Control	0.32%
CDC- Eye Care	22.16%
CDC- HbA1c Testing	91.16%
CDC- HbA1c Adequate Control (<8%)	15.91%
CDC- HbA1c Poor Control	19.09%
CDC- Monitoring for Nephropathy	90.24%

**Awaiting HEDIS 2019 Final Hybrid Rates*

The table provided below demonstrates results related to the **Allwell** Comprehensive Diabetes Care HEDIS measure. It is important to note that the final HEDIS 2019 rate is not available at the time of this report. Those results will be available in July 2019.

Allwell HEDIS MEASURE	HEDIS 2019 (MY2018) Admin*
CDC- Blood Pressure Control	0%
CDC- Eye Care	50.00%
CDC- HbA1c Testing	83.33%
CDC- HbA1c Adequate Control (<8%)	11.11%
CDC- HbA1c Poor Control	16.67%
CDC- Monitoring for Nephropathy	100%

**Awaiting HEDIS 2019 Final Hybrid Rates*

The Plan analyzed HEDIS data in 2018 to determine where opportunities exist to improve compliance with CDC measures. Member knowledge, understanding, and education continues to be a focus that the Plan continues to work on to address this barrier. In order to improve member engagement on these measures, the members have to have the knowledge and understanding of the significance for the testing. The knowledge and understanding will allow the appropriate treatment of their disease, which also promotes delaying progression of their diabetes and the complications that may result. The Plan will continue to analyze the interventions implemented in 2018, as well as continue to explore options for expanding partnerships with providers.

Timeliness of Prenatal Care

The Plan worked on this HEDIS measure and its sub measures in 2018, for Ambetter members, to help them have a better understanding of the importance of prenatal and postpartum care. This includes the importance of regular prenatal visits, quitting smoking or drinking alcohol, and taking supplements. Regular prenatal visits can help the member doctor monitor the pregnancy, along with assist in identifying any problems or complications before they become serious. All of these talking points can help ensure the health and safety for the member and their baby.

Timeliness of Prenatal Care Ambetter Interventions for 2018:

- HEDIS Quick Reference Guide distribution to new providers and annual updates to existing providers with ICD-10 updates.
- Prenatal and Post-Partum appointment reminder information includes IVR/Text/Email through Eliza, a Centene vendor.
- Pregnant members are enrolled in Start Smart for Your Baby, Centene'

The following table provided demonstrates results related to the Ambetter Timeliness of Prenatal Care HEDIS measure. It is important to note that the final HEDIS 2019 rate is not available at the time of this report. The results will be available in July 2019.

HEDIS MEASURE	HEDIS 2019 (MY2018) Admin*
Timeliness of Prenatal Care	36.36%

**Awaiting final HEDIS 2019 rates*

The Plan continues to explore opportunities for improvement on Ambetter's Timeliness of Prenatal Care, which includes addressing barriers like member knowledge deficits, provider opportunities and transportation issues. The Plan will continue to monitor the impact of the Prenatal Care Provider Payment Incentive arrangement for impact on completion of the Notice of Pregnancy and timely completion of the first prenatal visit. This intervention began in 2018 with planned continuation in 2019. In addition, the Plan will continue to utilize a variety of interventions in 2019 with the goal of furthering timeliness completion of the first prenatal visits.

Additional HEDIS Measures

Additional HEDIS measures that the Plan focused on in 2018 were Breast Cancer Screenings, Cervical Cancer Screenings, Annual Monitoring for Patients on Persistent Medications, Adult Access to Preventive/Ambulatory Health Services, and Well Child 34. Those measures and their interventions are below.

Breast Cancer Screening (BCS) Interventions for Allwell and Ambetter**,** unless otherwise specified:

- Mailer to female members
- Provider Profile mailer
- Member education
- Customer Service, Medical Management, and Quality Improvement reminders during member contacts to help close care gaps
- Rewards program (only for Allwell): Members can earn $20 to use at Walmart after completion of screening
- HEDIS Quick Reference Guide distribution to new providers and annual updates to existing providers with ICD-10 updates.

Cervical Cancer Screening (CCS) Interventions for Allwell and Ambetter:

- Mailer to female members
- Care Gap Reports available on Provider Portal
- Member education
- Customer Service, Medical Management, and Quality Improvement reminders during member contacts to help close care gaps
- HEDIS Quick Reference Guide distribution to new providers and annual updates to existing providers with ICD-10 updates.

Well Child 3-6 (W34) Interventions for Ambetter:

- Care Gap Reports available on Provider Portal
- Customer Service, Medical Management, and Quality Improvement reminders during member contacts to help close care gaps
- HEDIS Quick Reference Guide distribution to new providers and annual updates to existing providers with ICD-10 updates.

Adult Access to Preventive/Ambulatory health Services (AAP) Interventions for Allwell:

- Member education
- Customer Service, Medical Management, and Quality Improvement reminders during member contacts to help close care gaps
- HEDIS Quick Reference Guide distribution to new providers and annual updates to existing providers with ICD-10 updates.

Annual Monitoring for Patients on Persistent Medications (MPM) Interventions for Allwell:

- Member education
- Customer Service, Medical Management, Pharmacy, and Quality Improvement reminders during member contacts to help close care gaps
- HEDIS Quick Reference Guide distribution to new providers and annual updates to existing providers with ICD-10 updates.

The following table provided demonstrates results related to the Ambetter Cervical Cancer Screening and Well Child 3-6 HEDIS measures. It is important to note that the final HEDIS 2019 rate is not available at the time of this report. The results will be available in July 2019. The table states the administrative data for HEDIS 2019, as this is the baseline year for these two measures.

HEDIS MEASURE	HEDIS 2019 (MY2018) Admin Rate*

Cervical Cancer Screening	21.97%
Well Child 3-6	58.8%

**Awaiting final HEDIS 2019 rates*

The following table provided demonstrates results related to the Allwell Adult Access to Preventive/ Ambulatory Health Services and Annual Monitoring for Patients on Persistent Medications HEDIS measures. It is important to note that the final HEDIS 2019 rate is not available at the time of this report. Those results will be available in July 2019. The table provided below the administrative data for HEDIS 2019, as this is our baseline year for these two measures.

HEDIS MEASURE	HEDIS 2019 (MY2018) Admin Rate*
Adult Access to Preventive/Ambulatory Health Services	86.06%
Annual Monitoring for Patients on Persistent Medications-Annual Monitoring for Members on ACE inhibitors or ARB's	82.76%
Annual Monitoring for Patients on Persistent Medications-Annual Monitoring for Members on Diuretics	87.5%
Annual Monitoring for Patients on Persistent Medications-Total	84.44%

**Awaiting final HEDIS 2019 rates*

The Plan continues to assess data from these two Allwell measures to improve member compliance through identification of opportunities to address barriers. Historical information is impactful to demonstrate member exclusion or compliance with these measures. Therefore, the Plan continues to explore how to gain those records for use in the HEDIS project. This is important to members who may be new to the plan or had instances of care multiple years prior to becoming a Plan member. The Plan will continue to use interventions from 2018 while also continuing to explore additional provider partnerships aimed at care gap closures for Well Child Visits and cervical cancer screenings.

Patient Safety/Quality of Care

The Plan monitors the safety of its members through identification of potential and/or actual quality of care (QOC) events. The Plan's Quality Improvement Department monitors member and provider issues related to quality of care on an ongoing basis. A QOC Severity Level table classifies issues into five levels (*None*, *Low*, *Medium*, *High*, and *Critical*) based on the potential or actual serious effects. The documentation of these issues allows for tracking and trending to identify patterns and to apply corrective action plans when issues warrant. Documentation of all cases is in a database, the data undergoes quarterly review and reporting as appropriate. Practitioners or providers with multiple potential quality of care issue referrals per quarter may be subject to additional review/investigation. Provider reporting to the Credentialing Committee is at the discretion of the Peer Review Committee. Quarterly reports to QIC occur and to the Credentialing Department for consideration at the time of provider re-credentialing. Definition of potential quality of care issues are any alleged act or behavior that may be detrimental to the quality or safety of patient care, or it is not compliant with evidence-based standard practices of care, or that signals a potential sentinel event.

Quality of care events include but are not limited to the following:

- Admit following outpatient surgery
- Altercations requiring medical intervention
- CMS Never Events
- Decubitus Ulcers in LTC
- Enrollee elopement/escape from facility
- Enrollee Injury or Illness during BH Admission
- Enrollee suicide attempt
- Falls/Trauma
- Fetal Demise
- Hospital Acquired Infections
- Medication errors that occur in an acute care setting
- Newborn Admission within 30 days of newborn discharge
- Post-op Complications – air embolism; surgical site infections, DVT/Pulmonary Embolism Readmission (31 days)
- Sexual Battery
- Unexpected Member Death / Fetal Demise
- Unplanned return to operating room
- Urinary Tract Infection in LTC facility

The Plan reviews events both at an aggregate and provider/facilty level. The following graphics show the type and severity of QOCs reviewed by the Plan in 2018. As noted in the ffirst graphic, the Plan's data on QOCs demonstrates all cases referred for review as potential QOC, in 2018, were determined to not meet the criteria for a QOC. The second graphic provided depicts the severity level results from the cases refered as potential QOC events. Their severity level (*None*) was based on the review of records provided to the Plan. This allowed for the reviewer to determine if there was a QOC concern and subsequently assign a severity level.

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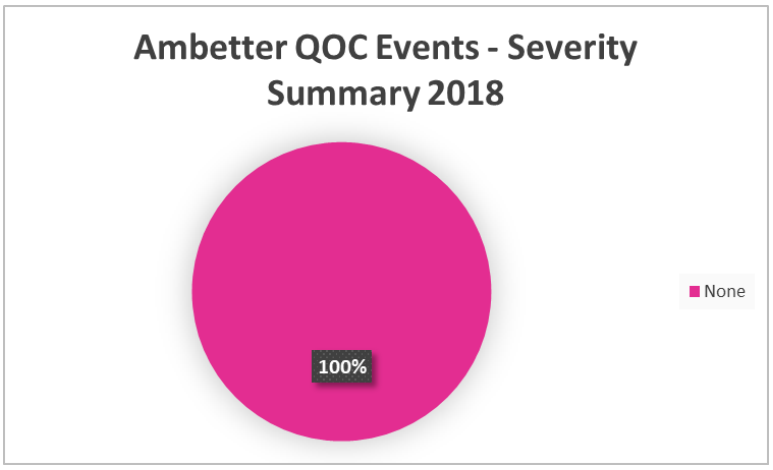
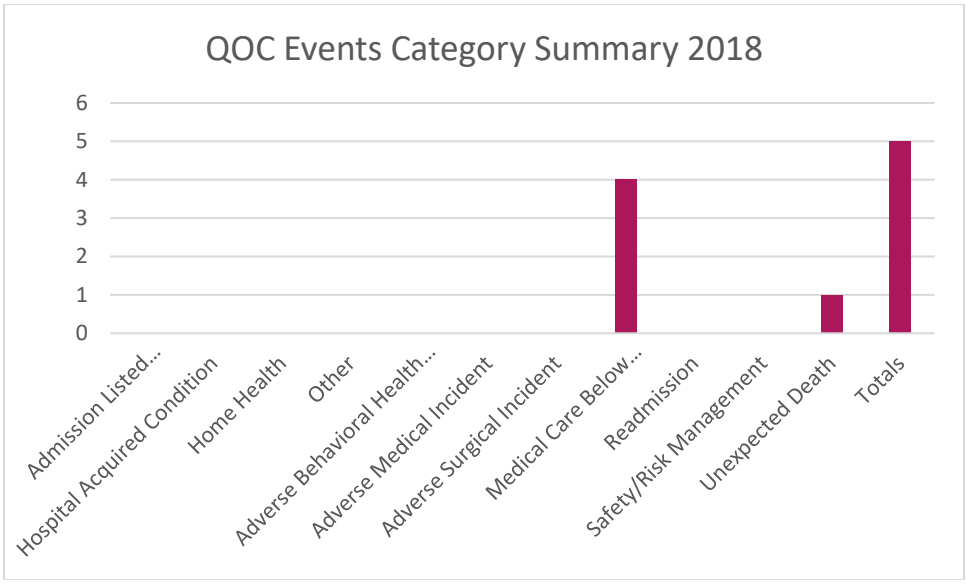


There were five (5) **Ambetter** QOC events completed in 2018. The volume of QOCs was low given the total membership for the year being 17,617. Four (4) out of the five (5) fell into the *Medical Care Below Standard* category, as noted on the following graphic. All five (5) QOC referrals had a final severity level of *None*. There were no providers identified with three (3) or more potential QOC events for the year.



There were no potential QOCs referred to the Plan for **Allwell** members in 2018.

Ambetter Access and Availability - Call Statistics (Member and Provider Calls)

Ambetter monitors telephone access to assure members and providers can access assistance from the health plan during core business hours.

The Customer Service and Medical Management Departments have corporate measures to meet telephone access standards for our Affordable Care Act product, Ambetter. Ambetter from Sunflower launched on January 1, 2018. The Plan is responsible for Provider Services, Utilization Management

and Case Management call statistics for our providers and members. In 2018, the Customer Service Department met the Plan's parent company, Centene Corporation, performance goals for Provider Services inbound call statistics. The Plan's Customer Service department had a total call volume of 3,734 for 2018. The Plan answered 80% of all calls within 30 seconds. The 2018 abandonment rate was 2.17%, which demonstrates meeting the goal of less than 4%. The Plan has identified the need to continue cross training staff to improve overall satisfaction and to exceed the standard. The Plan will continue monitoring and reporting telephone access on a monthly basis to allow for tracking, trending, and identifying any opportunities while striving to continue to meet or exceed the requirements.

Allwell Access and Availability - Call Statistics (Member and Provider Calls)

Allwell monitors telephone access to assure members and providers can access assistance from the health plan during core business hours.

The Customer Service and Medical Management Departments have corporate measures to meet telephone access standards for our Medicare product, Allwell. Allwell from Sunflower launched on January 1, 2018 in Kansas. The Plan is responsible for Provider Claims, Utilization Management and Case Management call statistics for our provider and members. In 2018, the Customer Service Department met the Centene and CMS performance goals for Provider Claims inbound call statistic. The Plan's Customer Service department had a total call volume of 345 for 2018. The Plan answered 80% of all calls within 30 seconds. The 2018 abandonment rate was 3.19%, which demonstrates meeting the goal of less than 4%. Because of these performance goals, the Plan has identified the need to continue cross training staff to improve overall satisfaction and to work towards exceeding the standard. The Plan will continue monitoring and reporting telephone access on a monthly basis to allow for tracking, trending and identifying any opportunities while striving to continue to meet or exceed the requirements.

Cultural and Linguistic Capabilities

The Plan believes the practitioner network is able to meet the linguistic and cultural needs of the membership, based on the availability of translation services, which members are accessing, the availability of practitioners in the network that speak other languages, and based on the lack of grievances regarding cultural/linguistic issues. There were no other significant cultural or linguistic needs identified for Sunflower Allwell residents. Interpreter services are available by the Plan for both members and providers. Translation of written materials are available to any Plan member as needed.

Rights and Responsibilities

Member's Rights and Responsibilities are available upon member enrollment with the Plan in the Member Handbook. The handbook provides a description of both the Case Management and Disease Management programs, the types of diseases managed and the telephone number to obtain more information. Members receive an updated Member Handbook annually. Member Rights and Responsibilities are a part of the training curriculum for all new Customer Service Representatives.

Practitioner Availability

Practitioner availability assessment occurs annually for primary care practitioners (PCPs), high-volume and high-impact specialty care practitioners, and high volume behavioral health practitioners.

PCP definition is physician(s) with a primary specialty designation of family/general medicine, internal medicine, pediatric medicine, or a subspecialty related to those specialties. Advanced practice clinicians under the personal supervision of an eligible physician may also be eligible. The PCP may

practice in a solo or group setting or at a Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Department of Health Clinic, or similar outpatient clinic. With prior written approval, the Plan may allow a specialist provider to serve as a PCP for members with special healthcare needs, multiple disabilities, or with acute or chronic conditions as long as the specialist is willing to perform the responsibilities of a PCP.

For the 2018 Practitioner Availability Analysis, the Plan identified high-volume specialists as Obstetrics/Gynecology and high-impact specialists as Hematology/Oncology. For this report, the Plan used the State definition for "Hematology/Oncology", which includes both oncology practitioners and oncologists with a specialty in hematology. Hematology/Oncology is defined to be practitioners with a specialty of "329-Oncologist" which includes these taxonomies - 207RH0003X (Hematology and Oncology), 2080P0207X (Pediatric Hematology-Oncology), and 261QX0203X (Oncology, Radiation).

Ambetter and Allwell behavioral health practitioners (BHP) and substance use disorder (SUD) providers are Behavioral Health Specialists. Behavioral Health Specialists includes Psychiatrist, Psychologist, or Licensed Master Social Worker, Advanced Clinical Practitioner, (LMSW-ACP), Licensed Professional Counselor (LPC) and Licensed Marriage and Family Therapist (LMFT). BHP/SUD are specialty care practitioners (SCPs), Psychiatry and Psychiatry Rehabilitation Medicine that are managed by Sunflower Health Plan. The Plan is accountable for all services. The plan establishes the practitioners and providers as the following: Psychiatrists, Clinical Psychologists, and Masters Level Clinicians. The geographic distribution of behavioral healthcare practitioners for Ambetter and Allwell lists them as Psychiatrists.

The Plan defines geographic distribution standards for PCPs and high-volume/high-impact specialists, and ratio/numeric standards for PCPs and high-volume specialists. The following tables list the standards, measurement method, and measurement frequency for each practitioner type for availability along with the results for each practitioner.

Results by Practitioner Type - Ambetter

Practitioner Type	Standard	Results	Goal Met
Primary Care	90% of metro members have at least 1 Primary care provider within 10miles or 15 minutes.	100%	Yes
Primary Care Extended	90% of metro members have at least 1 Primary Care Extended within 10miles or 15 minutes.	100%	Yes
Ambulatory Health Care Facilities - Infusion Therapy/Oncology/Radiology	90% of metro members have at least 1 provider in 40 miles and 60 minutes	100%	Yes
Obstetrics and Gynecology	90% of metro female members have at least 1 OB/GYN within 40 miles or 60 minutes.	100%	Yes
Psychiatry	90% of metro members have at least 30 miles or 45 minutes	100%	Yes

Results by Practitioner Type - Allwell

Practitioner Type	Standard	Results	Goal Met
Primary Care	90% of metro members have at least 1 Primary care provider within 10 miles or 15 minutes.	100%	Yes
Cardiology	90% of metro members have at least 1 cardiology provider within 20 miles or 30minutes.	100%	Yes
Obstetrics and Gynecology	90%% of metro female members have at least 1 OB/GYN within 30 miles or 45 minutes	100%	Yes
Oncology Medical /Surgical	90% of metro members have at least 1 Oncology provider within 45 miles or 30 minutes	100%	Yes
Psychiatry	100% of metro members have at least 1 psychiatrist within 30 miles or 45 minutes	100%	Yes

The Plan met the access standards for Ambetter and Allwell for all provider types measured for this report and for compliance with CMS oversight of the products. The Plan's Network team continues to monitor network adequacy on a monthly basis to identify gaps quickly and actions implemented to complete contracting activities that close any gaps that appear.

Network Monitoring & Recruitment Strategies

The Plan has noted the following items as long-term network gap solutions that involve additional recruitment strategies:

- Identifying potential providers through other sources such as competitor websites, allwellmedicare.gov, NPPES, licensing websites, listings from the local medical societies and provider associations, case managers, Customer Service representatives, established community relationships, other internet resources and personal recommendations from network providers in the area.
- Utilizing listings of newly licensed providers and state reports of providers issued new NPI numbers, which may include identifying providers through sources such as Kansas Board of Healing Arts (KSBHA) and local Medical Societies.
- Reviewing non-par claim reports.
- Approaching PCPs and other providers with limited or closed panels, and request that they open their panels to new members
- Identifying out of network providers utilized by Plan members in the past.
- Maintaining relationships with providers who have declined to join the network.
- Identifying sources of provider dissatisfaction and strengthening retention strategies.

Provider Satisfaction Survey

The Centene Corporation Provider Satisfaction Survey (PSS) is an evaluation of Plan providers' satisfaction and includes an evaluation of satisfaction with communication between behavioral health practitioners and primary care practitioners. The annual Provider Satisfaction Survey allows for assessment of the level of primary care practitioner satisfaction with behavioral health practitioner communication. Centene utilizes SPH Analytics, a National Committee for Quality Assurance (NCQA) Certified Survey Vendor, to conduct the provider satisfaction survey for all Centene health plans. SPH Analytics followed a one-wave mail and internet with phone follow-

up survey methodology to administer the provider satisfaction survey from August to October 2018. Plan's sample size was 1,647 of all providers in network. SPH Analytics collected 221 surveys (85 mail, 26 internet, and 108 phone) from the eligible provider population. After adjusting for ineligible providers, the mail/internet survey response rate was 7.5%, and the phone survey rate was 15.5%. A response rate total calculation of 23% for those providers who are eligible and able to respond. The methodology demonstrating the response rates for mail, internet and phone survey responses is below as well as the incorporated ineligible provider responses.

Mail/Internet Component

85 (mail) + 26 (Internet) / 1,647 (sample) – 159 (ineligible) = 7.5%

Phone Component

108 (phone) / 945 (sample) – 247 (ineligible) = 15.5%

For the base-line 2018 survey, Plan included those who could participate in providing feedback to include HCBS providers and nursing facilities. The 2018 survey results demonstrated the following demographics for response to the survey: 64.7% primary care providers, 23.5% specialty practices, Home Community Based Services (HCBS) 14.2%, followed by 12.7% for nursing facilities, and, 5.9% for Behavioral Health Clinicians. Of those who responded to the survey, 55% were responses from the office manager, 34.4% nurse/other staff responding, with 10.1% for physicians and 0.5% for Behavioral Health Clinicians who responded on the survey.

Overall Satisfaction with Plan

2018 Provider Satisfaction Composite Scores	2018 Summary Rate
Overall Satisfaction	66.30%
Comparative Rating of Sunflower compared with all other contracted health plans	35.20%
Finance Issues	33.60%
Utilization & Quality Management	28.70%
Network/Coordination of Care	20.70%
Pharmacy	13.10%
Health Plan Call Center Service Staff	27.90%
Provider Relations	40.90%
Recommended to Other Physicians Practices	38.20%

The above table demonstrates the 2018 baseline results for the Overall Satisfaction with Plan. The Network/Coordination of Care focuses on the number and quality of specialists in the Plan provider network, timeliness of feedback/reports from specialists, timeliness of exchange of information/ communication/ reports from behavioral health providers and also how frequently behavioral health providers provide verbal/written communications to other providers on their patients. This is also an area of focus for the CAHPS survey for Care Coordination for Plan in 2019.

Access to Primary Care - After-Hours Care Access (Accessibility of Primary Care Services)

Plan monitors primary care provider appointment accessibility against its standards, identifies opportunities for improvement and initiates actions as needed to improve results. Plan incorporates data and results from the practitioner office surveys, member complaints/

grievances, and results on customer service telephone triage access on a regular basis and actions are initiated when needed to improve performance. This report describes the monitoring methodology, results, analysis, and action for each measure. The following tables denote the standards and performance. In 2018 Plan initiated the Ambetter and Allwell lines of business, there were no QHP, HOS, MCAHPS completed in the 2018 calendar year to assist with the comparison of data.

Appointment Access Definitions - Standards and Methodology

The Plan defines urgent care appointments as within 48 hours from the time of the request. Routine appointment accessibility for PCPs are not to exceed three weeks from the date of member requests. Access to a specialty care appointment within 30 days of request is the standard. The Plan also monitors office wait times and defines an acceptable wait time as within 30 minutes from time member enters a practitioner office, for both PCPs and specialists.

The Plan surveyed a sample of participating (in network) credentialed practitioners, both PCPs and specialists (includes OB/GYN), with Sunflower Health Plan in 2018. No practitioners were excluded from the sample the Plan utilizes practitioner data from the Plan's provider management system, Portico. The process of a standardized survey allows for data collection; 1,074 practitioners were included for the 2018 analysis. The Plan's appointment availability surveys request confirmation that the practitioner can accommodate members' appointment needs based on current practitioner availability for routine and urgent appointments.

Results & Analysis: Specialty Care Routine/Urgent Care Appointments – Office Surveys (Ambetter)

The tables below demonstrates the results from 2018 assessment of Plan providers by types to include primary care, oncologists, OB/GYN providers and behavioral health providers. For the primary care providers (PCP), 200 were included in the Ambetter sample initially and 75 completed the survey fully, a 38% completion rate. The Plan failed to meet the goals for primary care urgent appointments within 48 hours, and primary care routine appointments not to exceed 3 weeks for new patients, but met performance goals for meeting standards for established patients. The survey for the Ambetter high impact specialists' targeted 100 oncology practitioners with 11 completing the survey, an 11% completion rate. For high-volume specialists, there were 100 OB/GYN in the survey and 33 completed the survey, a 33% completion rate. The results demonstrated failure to meet the goal for high-volume and high-impact providers sampled on: urgent appointments within 48 hours. Though, did meet the goal for first routine appointment within 30 days for OB/GYN and Oncology. OB/GYN met the second available routine appointment standard. For Behavior health, there were prescribers (10) and non-prescribers (100) in the survey with 2 and 18, respectively, completing the survey, 20% and 18% completion rate. For Urgent Care neither Prescriber nor Non-Prescriber Behavioral Health providers met the goal for Urgent Care standards. The Plan directs members with non-life-threatening emergencies to the ER. In all categories, regardless of patient status.

The Plan considers the third available appointment to be the best overall indicator of appointment availability, as the first and second available appointments may actually reflect available urgent appointment or appointments available due to cancellations for a given day, which may not represent average accessibility.

Office Surveys - Primary Care Routine and Urgent Care Appointment Access (Ambetter)

Ambetter -PCP	Access Standard	Performance Goal	Appointment Results	Goal Met
Urgent Care	Primary care urgent appointments within 48 hours	90% of PCPs report availability of urgent appointment within timeframe	New Patients - 66%	No
			Established Patients – 72%	No
Routine Care - New Patients	Primary care routine appointments not to exceed 3 weeks	90% of PCPs report availability of routine appointment within timeframe	1st Available - 83%	No
			2nd Available - 81%	No
			3rd Available - 81%	No
Routine Care - Established Patients	Primary care routine appointments not to exceed 3 weeks	90% of PCPs report availability of routine appointment within timeframe	1st Available - 95%	Yes
			2nd Available - 91%	Yes
			3rd Available - 91%	Yes
Wait Time	Primary care wait time not to exceed 45 minutes	90% of PCPs report availability of wait time within timeframe	86%	No

Office Surveys - Specialty Care Routine/ Urgent Care Appointment Access (Ambetter)

Ambetter -SPC	Access Standard	Performance Goal	Appointment Results	Goal Met
Urgent Care (Oncology)	Oncology care for urgent appointments within 48 hours	90% of high-impact specialists report availability of urgent appointment within defined timeframe	New Patients – 55%	No
			Established Patients – 55%	No
Routine Care - New Patients (Oncology)	Oncology care for routine appointments within 30 Days	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 91%	Yes
			2nd Available - 82%	No
			3rd Available - 82%	No
Routine Care - Established Patients (Oncology)	Oncology care for routine appointments within 30 Days	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 91%	Yes
			2nd Available - 82%	No
			3rd Available - 82%	No
Wait Time (Oncology)	Oncology care wait time not to exceed 45 minutes	90% of high-impact specialists report availability of wait time within timeframe	100%	Yes
Urgent Prenatal Care (OB/GYN)	OB/GYN care for urgent appointments within 48 hours	90% of high-impact specialists report availability of urgent appointment within defined timeframe	New Patients – 52%	No
			Established Patients – 58%	No

Ambetter -SPC	Access Standard	Performance Goal	Appointment Results	Goal Met
Prenatal Care - New Patients (OB/GYN) – 1st Trimester	OB/GYN routine care within 30 days of the First Trimester	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 93%	Yes
			2nd Available - 93%	Yes
			3rd Available - 90%	Yes
Prenatal Care - New Patients (OB/GYN) – 2nd Trimester	OB/GYN routine care within 30 days of the Second Trimester	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 90%	Yes
			2nd Available - 90%	Yes
			3rd Available - 86%	No
Prenatal Care - New Patients (OB/GYN) – 3rd Trimester	OB/GYN routine care within 30 days of the Third Trimester	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 90%	Yes
			2nd Available - 90%	Yes
			3rd Available - 86%	No
Prenatal Care - Established Patients (OB/GYN) – 1st Trimester	OB/GYN routine care within 30 days of the First Trimester	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 97%	Yes
			2nd Available - 94%	Yes
			3rd Available - 90%	Yes
Prenatal Care - Established Patients (OB/GYN) – 2nd Trimester	OB/GYN routine care within 30 days of the Second Trimester	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 97%	Yes
			2nd Available - 94%	Yes
			3rd Available - 90%	Yes
Prenatal Care - Established Patients (OB/GYN) – 3rd Trimester	OB/GYN routine care within 30 days of the Third Trimester	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 94%	Yes
			2nd Available - 90%	Yes
			3rd Available - 87%	No
Wait Time (OB/GYN)	OB/GYN care wait time not to exceed 45 minutes	90% of high-impact specialists report availability of wait time within timeframe	97%	Yes

Office Surveys - Behavioral Health Routine/ Urgent Care Appointment Access (Ambetter)

Ambetter - BH	Access Standard	Performance Goal	Appointment Results	Goal Met
Urgent Care (Behavioral Health Prescribers)	Behavioral Health care for urgent appointments within 48 hours	90% of high-impact specialists report availability of urgent appointment within defined timeframe	New Patients – 0%	No
			Established Patients – 0%	No
Routine Care - New Patients (Behavioral Health Prescribers)	Behavioral health care for routine	90% of high-impact specialists report availability of routine	1st Available - 50%	No
			2nd Available - 50%	No

Ambetter - BH	Access Standard	Performance Goal	Appointment Results	Goal Met
	appointments within 10 Days	appointment within defined timeframe	3rd Available - 50%	No
Routine Care - Established Patients (Behavioral Health Prescribers)	Behavioral health care for routine appointments within 10 Days	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 50%	No
			2nd Available - 50%	No
			3rd Available - 50%	No
Non-Life Threatening Emergent Care (Behavioral Health Prescribers)	Behavioral Health Non-Life Threatening Emergent Care within 6 hours	90% of surveyed Behavioral Health Prescribers within defined timeframe	100%	Yes
Urgent Care (Behavioral Health Non- Prescribers)	Behavioral health care for urgent appointments within 48 hours	90% of high-impact specialists report availability of urgent appointment within defined timeframe	New Patients – 50%	No
			Established Patients – 50%	No
Routine Care - New Patients (Behavioral Health Non-Prescribers)	Behavioral health care for routine appointments within 10 Days	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 100%	Yes
			2nd Available - 100%	Yes
			3rd Available - 86%	No
Routine Care - Established Patients (Behavioral Health Non-Prescribers)	Behavioral health care for routine appointments within 10 Days	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 100%	Yes
			2nd Available - 89%	No
			3rd Available - 83%	No
Non-Life Threatening Emergent Care (Behavioral Health Non-Prescribers)	Behavioral Health Non-Life Threatening Emergent Care within 6 hours	90% of surveyed Behavioral Health Non-Prescribers within defined timeframe	94%	Yes

Results & Analysis: Specialty Care Routine/Urgent Care Appointments – Office Surveys (Allwell)

The tables below demonstrates the results from 2018 assessment of Plan providers by types to include primary care, oncologists, OB/GYN providers and behavioral health providers. For the primary care providers (PCP), 200 were included in the Allwell sample initially and 75 completed the survey fully, 38% completion rate. The Plan failed to meet the goals for primary care urgent appointments within 48 hours, and primary care routine appointments not to exceed 3 weeks for new patients, but met performance goals for meeting standards for established patients. The survey for the Allwell high impact specialists' targeted 50 oncology practitioners with 10 completed the survey, 20% completion rate. For high-volume specialists, there were 100 OB/GYN providers in the survey and 31 completed the survey, 31% completion rate. The results demonstrated failure to meet the goal on high volume and high impact providers sampled on: urgent appointments within 48 hours. Though, did meet the goal for first routine appointment within 30 days for OB/GYN and Oncology. OB/GYN did meet the second routine appointment standard. For Behavior health, there were prescribers (25) and non-prescribers (100) with 5 and 30, respectively, completing the survey, 20% and 30% completion rate. For Urgent Care neither Prescriber nor Non-prescriber Behavioral Health

providers met the goal for Urgent Care standards. The Plan directs members with non-life-threatening emergencies to the ER in all categories, regardless of patient status.

The Plan considers the third available appointment to be the best overall indicator of appointment availability, as the first and second available appointments may actually reflect available urgent appointment or appointments available due to cancellations for a given day, which may not represent average accessibility.

Office Surveys - Primary Care Routine and Urgent Care Appointment Access (Allwell)

Allwell - PCP	Access Standard	Performance Goal	Appointment Results	Goal Met
Urgent Care	Primary care urgent appointments within 48 hours	90% of PCPs report availability of urgent appointment within timeframe	New Patients - 66%	No
			Established Patients – 72%	No
Routine Care - New Patients	Primary care routine appointments not to exceed 3 weeks	90% of PCPs report availability of routine appointment within timeframe	1st Available - 83%	No
			2nd Available - 81%	No
			3rd Available - 81%	No
Routine Care - Established Patients	Primary care routine appointments not to exceed 3 weeks	90% of PCPs report availability of routine appointment within timeframe	1st Available - 95%	Yes
			2nd Available - 91%	Yes
			3rd Available - 91%	Yes
Wait Time	Primary care wait time not to exceed 45 minutes	90% of PCPs report availability of wait time within timeframe	86%	No

Office Surveys - Specialty Care Routine/ Urgent Care Appointment Access (Allwell)

Allwell - SPC	Access Standard	Performance Goal	Appointment Results	Goal Met
Urgent Care (Oncology)	Oncology care for urgent appointments within 48 hours	90% of high-impact specialists report availability of urgent appointment within defined timeframe	New Patients – 40%	No
			Established Patients – 40%	No
Routine Care - New Patients (Oncology)	Oncology care for routine appointments within 30 Days	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 90%	Yes
			2nd Available - 80%	No
			3rd Available - 80%	No
Routine Care - Established Patients (Oncology)	Oncology care for routine appointments within 30 Days	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 100%	Yes
			2nd Available - 90%	Yes
			3rd Available - 90%	Yes

Allwell - SPC	Access Standard	Performance Goal	Appointment Results	Goal Met
Wait Time (Oncology)	Oncology care wait time not to exceed 45 minutes	90% of high-impact specialists report availability of wait time within timeframe	90%	Yes
Urgent Prenatal Care (OB/GYN)	OB/GYN care for urgent appointments within 48 hours	90% of high-impact specialists report availability of urgent appointment within defined timeframe	New Patients – 47%	No
			Established Patients – 52%	No
Prenatal Care - New Patients (OB/GYN) – 1st Trimester	OB/GYN routine care within 30 days of the First Trimester	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 93%	Yes
			2nd Available - 93%	Yes
			3rd Available - 89%	No
Prenatal Care - New Patients (OB/GYN) – 2nd Trimester	OB/GYN routine care within 30 days of the Second Trimester	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 90%	Yes
			2nd Available - 90%	Yes
			3rd Available - 86%	No
Prenatal Care - New Patients (OB/GYN) – 3rd Trimester	OB/GYN routine care within 30 days of the Third Trimester	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 90%	Yes
			2nd Available - 90%	Yes
			3rd Available - 86%	No
Prenatal Care - Established Patients (OB/GYN) – 1st Trimester	OB/GYN routine care within 30 days of the First Trimester	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 97%	Yes
			2nd Available - 93%	Yes
			3rd Available - 93%	Yes
Prenatal Care - Established Patients (OB/GYN) – 2nd Trimester	OB/GYN routine care within 30 days of the Second Trimester	90% of high-impact specialists report availability of routine appointment within defined timeframe	1stAvailable - 97%	Yes
			2nd Available - 93%	Yes
			3rd Available - 93%	Yes
Prenatal Care - Established Patients (OB/GYN) – 3rd Trimester	OB/GYN routine care within 30 days of the Third Trimester	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 97%	Yes
			2nd Available - 93%	Yes
			3rd Available - 93%	Yes
Wait Time (OB/GYN)	OB/GYN care wait time not to exceed 45 minutes	90% of high-impact specialists report availability of wait time within timeframe	100%	Yes

Office Surveys - Behavioral Health Routine/ Urgent Care Appointment Access (Allwell)

Allwell -BH	Access Standard	Performance Goal	Appointment Results	Goal Met
Urgent Care (Behavioral Health Prescribers)	Behavioral health care for urgent appointments within 48 hours	90% of high-impact specialists report availability of urgent appointment within defined timeframe	New Patients – 0%	No
			Established Patients – 40%	No
Routine Care - New Patients (Behavioral Health Prescribers)	Behavioral health care for routine appointments within 10 Days	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 50%	No
			2nd Available - 0%	No
			3rd Available - 0%	No
Routine Care - Established Patients (Behavioral Health Prescribers)	Behavioral health care for routine appointments within 10 Days	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 20%	No
			2nd Available - 20%	No
			3rd Available - 20%	No
Non-Life Threatening Emergent Care (Behavioral Health Prescribers)	Behavioral Health Non-Life Threatening Emergent Care within 6 hours	90% of surveyed Behavioral Health Prescribers within defined timeframe	100%	Yes
Urgent Care (Behavioral Health Non- Prescribers)	Behavioral health care for urgent appointments within 48 hours	90% of high-impact specialists report availability of urgent appointment within defined timeframe	New Patients – 59%	No
			Established Patients – 60%	No
Routine Care - New Patients (Behavioral Health Non-Prescribers)	Behavioral health care for routine appointments within 10 Days	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 96%	Yes
			2nd Available - 93%	Yes
			3rd Available - 89%	No
Routine Care - Established Patients (Behavioral Health Non-Prescribers)	Behavioral health care for routine appointments within 10 Days	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 100%	Yes
			2nd Available - 93%	Yes
			3rd Available - 93%	Yes
Non-Life Threatening Emergent Care (Behavioral Health Non-Prescribers)	Behavioral Health Non-Life Threatening Emergent Care within 6 hours	90% of surveyed Behavioral Health Non-Prescribers within defined timeframe	97%	Yes

After-Hours Access - Ambetter

In 2018, Plan utilized Morpace to perform a survey for After Hours Care and the Plan reviewed member grievances. The Morpace survey sampled 100 Plan Providers, 49% of the providers were fully compliant, 495/100. There were 51% found noncompliant, 51/100. The Plan follows-up with the noncompliant providers to alert to the status and resurveys the provider for compliance.

After-Hours Care Survey			
Number of Ambetter Providers in Sample	**Number Fully Compliant**	**Number of Noncompliant**	**% of Providers Fully Compliant**
100	49	51	49%

Results & Analysis: Primary Care After-Hours Care Access – Complaints - Ambetter

Member grievances (i.e. complaints) regarding accessibility of services from January 1, 2018 through December 31, 2018 were reviewed. Grievances regarding after-hours access are in the Access-Other subcategory. There were three grievances in the Access-Other subcategory in calendar year 2018 for Ambetter. Review of these grievances determined there were zero complaints regarding primary care after-hours access in 2018 for Ambetter. The Plan established a goal of <0.50 member complaints and the goal was met in 2018, with a rate of 0.00/1000 member complaints regarding primary care after-hours access.

After-Hours Access - Allwell

In 2018, Plan utilized Morpace to perform a survey for After Hours Care and the Plan reviewed member grievances. The Morpace survey sampled 100 Plan Providers, 49% of the providers were fully compliant, 495/100. There were 51% found noncompliant, 51/100. The Plan follows-up with the noncompliant providers to alert to the status and resurveys the provider for compliance.

After-Hours Care Survey			
Number of Allwell Providers in Sample	**Number Fully Compliant**	**Number of Noncompliant**	**% of Providers Fully Compliant**
100	49	51	49%

Results & Analysis: Primary Care After-Hours Care Access – Complaints - Allwell

Member grievances (i.e. complaints) regarding accessibility of services from January 1, 2018 through December 31, 2018 were reviewed. Grievances regarding after-hours access are in the Access-Other subcategory. There were *no* grievances in the Access-Other subcategory in calendar year 2018 for Allwell. Review of these grievances determined there were zero complaints regarding primary care after-hours access in 2018 for Allwell. The Plan established a goal of <0.50 member complaints and the goal was met in 2018, with a rate of 0.00/1000 member complaints regarding primary care after-hours access.

Member Satisfaction

The Plan analyzed member satisfaction information to identify aspects of performance that do not meet member expectations and initiate actions to improve performance. The Plan monitors multiple aspects of member satisfaction, including:

- Member grievances
- Member satisfaction survey data

Member Grievances

The Plan's Grievance & Appeal Committee and Quality Improvement Committee review grievance and appeal data on a quarterly basis. Analysis occurs at the Quality Improvement Committee, which is composed of departmental leaders and network physicians and enables the Plan to initiate quality

improvement efforts to improve member satisfaction as needed. The following is a summary of the results and analysis for January 1, 2018 through December 31, 2018.

Ambetter

The following table below represents the member grievances totals by category in accordance with corporate and NCQA guidelines and then per 1000 members for 2018. The grievance category with the highest volume was Billing/Financial at 51.7%. In review of these grievances, results show the most common financial issue was in regards to non-PAR provider balance-billing members. Attitude/Service – Health Plan was the second leading category at 24.8%.

Member Grievance Category	2018	2018 per 1000
Access to Care	36	2.04
Attitude/Service - Health Plan	51	2.89
Attitude/Service - Provider	12	0.68
Billing/Financial	106	4.87
Practitioner Office Site Quality	0	0
Delegated Vendor/Service	0	0
Quality of Care Issue	0	0
Total	205	10.48

Department of Insurance (DOI) Complaints

Ambetter members have the right to file a complaint against the Plan with the Department of Insurance (DOI). The Plan will process the DOI complaint as a grievance when the insurance commissioner provides the Plan with a written description of the complaint. The Quality Improvement Committee (QIC) and the Grievance and Appeals Committee (GAC) review DOI Complaints on a quarterly basis. Analysis occurs at the QIC and GAC (which are composed of departmental leaders and network physicians) which enables the Plan to initiate quality improvement initiatives to improve member satisfaction as needed.

The graph below demonstrates the Department of Insurance (DOI) Complaints by category for the entire year of 2018. There were 48 complaints received with Eligibility Issues being the highest category received at 17 complaints. An example of the type of complaint that would fall into this category is a member who had their policy cancelled after not making their premium payments.

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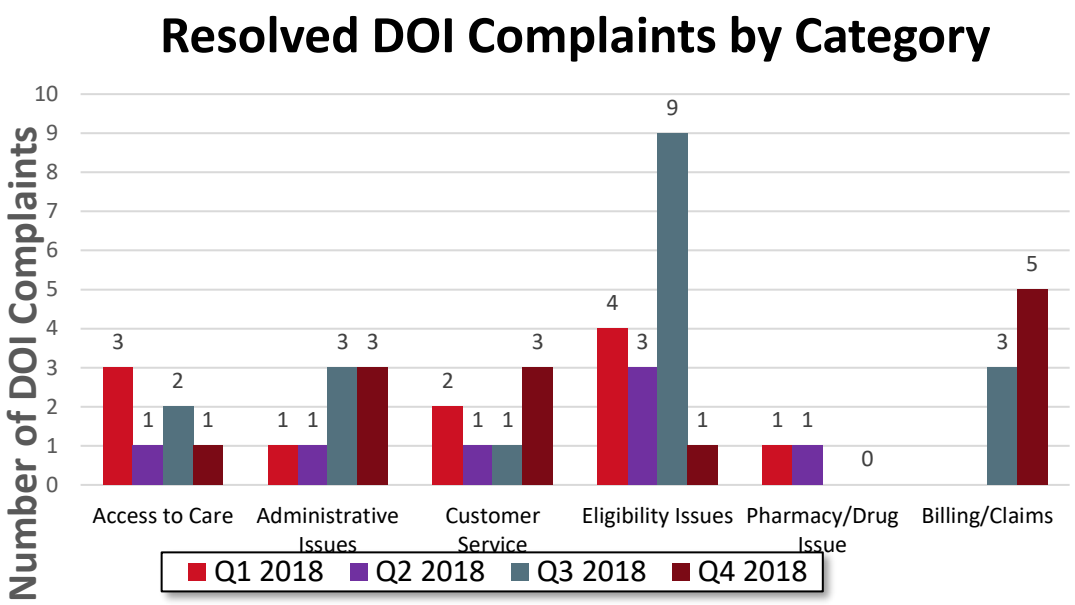


Allwell

The included table below represents the grievance totals by category and then per 100 members for 2018. Corporate investigates Member grievances for the Allwell line of business. There were 13 total member grievances for 2018. Five of the thirteen or 38% were regarding customer service issues, mainly incorrect PCP on file. Then *Benefits* with two grievances and the remaining categories each had one.

Ambetter Member Satisfaction Survey

The Plan conducts annual member satisfaction survey utilizing the Qualified Health Plan Enrollee Experience Survey (QHP EES) to allow for evaluation and comparison of health plan ratings by members. This is also a requirement of the ACA contract, to support accreditation with the national Committee for Quality Assurance (NCQA). Ambetter from Sunflower will complete our first annual QHP EES survey in 2019, surveying members who participated with Ambetter in 2018, the health plan's initial year. The Plan will utilize a SPH Analytics for delivery, data collection and report completion of the QHP EES survey in 2019.

Allwell Member Satisfaction Survey

The Plan conducts an annual member satisfaction survey utilizing the Allwell Consumer Assessment of Healthcare Providers and Systems (MCAHPS). The Plan will complete the first MCAHPS in 2020, not eligible to field the survey in 2019 due to low member enrollment requirement.

Allwell Health Outcomes Survey

The Healthy Outcomes Survey (HOS) administration occurs annually to a random sample of Medicare beneficiaries drawn from the plan and surveyed in the spring who meet the requirements of participating in the survey including membership volume and length of Allwell operations. Two years later, these same respondents receive the survey again. Health Outcome Survey allows for evaluation and comparison of health plan ratings by members. This is also a requirement of CMS. Allwell from Sunflower will complete the first annual HOS surveys in 2019, surveying members who participated with Allwell in 2018, the health plan's initial year. The 2018 Allwell membership population did not meet the threshold number to field the HOS survey. In 2019, the Allwell membership increased, meeting the number threshold to field the HOS survey.

Behavioral Health Member Survey

The Plan did not offer a behavioral health survey to Allwell and Ambetter members in 2018 due to low enrollment. These low enrollment numbers could have an impact on the validity of the survey results. The Plan does plan to conduct a behavioral health survey to Allwell and Ambetter members in 2019.

Continuity and Coordination of Care between Medical and Behavioral Healthcare

The Plan's Medical Management team demonstrates an integrated model with both Physical and Behavioral Health together. The Plan annually assesses the following areas of collaboration between medical and behavioral healthcare:

- Exchange of information between behavioral health care and primary care practitioners and other relevant medical delivery system practitioners or providers;
- Appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care;
- Appropriate use of psychotropic medications;
- Management of treatment access and follow-up for patients with coexisting medical and behavioral disorders;
- Implementation of a primary or secondary preventive behavioral health program; and
- Special needs of members with severe and persistent mental illness.

The table below demonstrates monitoring of these areas.

Specific Area Monitored	Description of Monitor
Exchange of Information	Rate of practitioner satisfaction with behavioral health practitioner communication as reported through the annual provider satisfaction survey.
Appropriate Diagnosis, Treatment and Referral of BH Disorders Commonly Seen in Primary Care	Antidepressant Medication Management (AMM) HEDIS Measure: Acute Phase & Continuation Phase
Appropriate Use of Psychotropic Medications	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)

Specific Area Monitored	Description of Monitor
Screening and Management of Coexisting Disorders	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD) HEDIS measure.
Preventive Behavioral Program	Number of members identified and screened for perinatal depression.
Special Needs of Members with Serious and Persistent Mental Illness	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) HEDIS measure.

Exchange of Information between Behavioral Health and Primary Care

Plan collects data and identifies opportunities to improve the exchange of information through the annual provider satisfaction survey, which includes evaluation of satisfaction with communication between behavioral health practitioners and primary care practitioners. Levels of primary care practitioner satisfaction with behavioral health practitioner communication collection occurs through the annual provider satisfaction survey.

In the standardized survey tool administered by SPH Analytics for Sunflower's 2018 Provider Satisfaction Survey, two questions measure the timeliness and the frequency of communication from behavioral health practitioners to primary care practitioners. Responses for the specific questions are in the table below for 2018.

Provider Satisfaction Questions	2018 Percent Satisfied	2018 Responses Composite/Attribute
4E: Please rate the timeliness of exchange of information/ communication/reports from the behavioral health providers?	16.10%	Excellent - 3.2%
		Very Good - 12.9%
		Good - 57.3%
		Fair - 17.7%
		Poor - 8.9%
		(n=124)
4F: How often do you receive verbal and/or written communication from behavioral health providers regarding your patients?	24.10%	Always - 3.8%
		Usually - 20.3%
		Sometimes - 45.1%
		Often - 24.8%
		Rarely - 6.0%
		(n=133)

Plan was unable to compare performance on the 2018 survey against a benchmark, as SPH Analytics does not provide Book of Business benchmarks for the two relevant questions since these are custom questions. Similarly, the composite for the Network/Coordination of Care section of the

survey does not include these custom questions so was not reviewed for this report. Plan's goal for the 2019 provider satisfaction survey is an increase of 5% on each survey question. Plan will continue to work on improvement, as it is imperative to the members and their overall health.

The Plan has integrated the behavioral health provider network. The Plan will continue to promote the exchange of information through completion of an assessment for each member upon behavioral health inpatient discharge. The Plan identifies a member's PCP and faxes the discharge assessment, which includes information regarding discharge medications and behavioral health providers with whom the member has follow-up care arranged. Discharge summaries containing protected health information related to HIV/AIDS or substance abuse treatment are not eligible for re-disclosure to the member's PCP unless the member provides specific written consent to release the information obtained by the Plan. Efforts aim to obtain this consent to allow the records to share with the PCP. Care managers and care coordinators also address this with members during initial or ongoing outreach, providing education to members regarding the importance of providing consent to allow the information to sharing with their PCP.

Below are barriers in relation to the exchange of information between medical and behavioral healthcare providers, Plan continues to work to address these.

- Members do not have an established relationship with a PCP.
- Staff unable to identify the PCP for the member, therefore cannot facilitate exchange of information.
- Member knowledge deficit regarding importance of and process for providing consent to share treatment records that include HIV/AIDS or substance abuse treatment information.
- Physicians are unaware their patients are seeing behavioral health clinicians and/or who the behavioral health providers are.
- Behavioral health clinicians are not aware of who the assigned PCP is for the member.
- Members leaving acute inpatient for psychiatric care maintain the stigma of mental illness and often do not want their other providers or support systems to know about their behavioral health hospitalization.
- Members with acute psychosis are difficult to coordinate services for as they are resistant to others outside of their perceived support group.

Plan continues to work on the following opportunities, with the intention of mitigating the barriers with regard to making impact on improving communication between behavioral health providers and primary care:

- Member education to help establish relationship with a PCP.
- Staff education and ongoing auditing of inpatient cases.
- Member education regarding providing consent for information to be shared to allow for communication of treatment including HIV/AIDS and substance abuse treatment for improved coordination of care
- Education of medical providers regarding a member's behavioral health providers.
- Member education regarding importance of sharing information between providers.
- Education of behavioral health providers regarding a member's PCP.
- Work with members to understand that mental health also influences all areas of their health and quality of life and encourage coordination of care with other providers.
- Minimize the number of people who are contacting the member. Identify a primary case owner who will coordinate with other members of the care team.

Appropriate Diagnosis, Treatment and Referral of BH Disorders Commonly Seen in Primary Care

Plan collects and analyzes data regarding appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care, and appropriate use of psychotropic medications through assessment of the Antidepressant Medication Management (AMM) HEDIS measure. Practitioners from both primary care health and behavioral health treat members with depressive disorders and prescribe antidepressant medications. The Plan's integrated physical and behavioral health case management team collaborates to coordinate services to meet the member specific needs.

The AMM HEDIS measure has two indicators:

- *Effective Acute Phase Treatment* - the percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
- *Effective Continuation Phase Treatment* - the percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

Plan's results on the HEDIS measures for effective acute and continuation phase of treatment are in the table below.

Antidepressant Medical Management	Ambetter HEDIS 2019*	Allwell HEDIS 2019*
Effective Acute Phase Treatment	69.16%	0.00%
Effective Continuation Phase Treatment	54.21%	0.00%

**Preliminary results final HEDIS 2019 rates available in July 2019*

These rates will serve as baseline rates for the Plan as the Ambetter and Allwell products are new in 2018. Final HEDIS 2019 rates will be available in July 2019.

Plan offers the depression-screening tool used for complex case management and for pregnant members. Members who have elevated depression scores receive the opportunity to participate in case management, which, offers support with Plan's behavioral health case management team.

Analysis of the data lead to the identification of the following barriers where efforts will focus for improvement:

- Member knowledge deficit regarding importance of adherence, ways to manage side effects, etc.
- The treating provider may not be aware the member is not consistently taking their prescribed medication.
- Treating providers not familiar with the depression clinical practice guideline.
- Providers unaware of available behavioral health services available to the member.

The opportunities identified as interventions to address the barriers are below and areas of focus:

- Article in the provider newsletter, educated providers about Plan's adopted clinical practice guidelines, including the depression guideline.
- Sunflower staff training on the diagnosis of depression and evidence-based practices for depression.

Screening and Management of Coexisting Disorders

The Plan will complete the initial NCQA report for this area in 2019 with HEDIS and quality improvement metrics for analysis and for inclusion for this monitor.

Utilization Program Overview

Purpose

The purpose of the Utilization Management (UM) Program Description is to define the structures and processes utilized within the Medical Management Department for both physical and behavioral health, including assignment of responsibility to appropriate individuals, in order to promote fair, impartial and consistent utilization decisions and coordination of medical and behavioral care for the health plan members.

Scope

The scope of the Utilization Management Program (UM Program) is comprehensive and applies to all eligible members across all product types, age categories and range of diagnoses. The UM Program incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, behavioral health care, community based services, short-term care, long term care and ancillary care services. The scope of activities include screening, intake, assessment, utilization management, discharge planning and aftercare, case management, crisis management, referrals, collaboration with providers/practitioners, disease management, preventative health activities and psychiatric medication utilization review.

Goals

The goals of the UM Program are to optimize members' health status focusing on recovery and a, sense of well-being, productivity, and access to quality health care, while at the same time actively managing cost trends. The UM Program aims to provide quality services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care. This program focuses on individualized treatment strategies that promote resiliency and recovery using evidence-based practices.

Implementation

The UM Program seeks to advocate the appropriate utilization of resources, utilizing the following program components: 24-hr nurse triage, authorization/precertification, second opinion, ambulatory review, and retrospective for medical health care services, case management, disease management when applicable, maternity management, preventive care management and discharge planning activities. Additional program components implemented to achieve the program's goals include tracking utilization of services to guard against over- and under-utilization of services and interactive relationships with practitioners to promote appropriate practice standards. The Primary Care Physician (PCP) is responsible for assuring appropriate utilization of services along the continuum of care.

Authority

The Plan Board of Directors (BOD) has ultimate authority and accountability for the oversight of the quality of care and services provided to members. The BOD oversees development, implementation and evaluation of the Quality Improvement Program. The Plan BOD delegates the daily oversight and operating authority of the utilization management (UM) activities to the Plan's Quality Improvement Committee (QIC), which, in turn, delegates responsibility for the UM

Program to the UM Committee (UMC), including the review and appropriate approval of medical necessity criteria and protocols and utilization management policies and procedures. The UMC is responsible for reviewing all utilization management issues and related information and making recommendations to the Plan's QIC, which reports to the BOD. The UM Program is reviewed and approved by the Plan's BOD on an annual basis.

The Chief Medical Director has operational responsibility for and provides support to the Plan's UM Program. The Plan Chief Medical Director, Vice President of Medical Management (VPMM) and/or any designee as assigned by the Plan President and CEO are the senior executives responsible for implementing the UM program including cost containment, medical quality improvement, medical review activities pertaining to utilization review, quality improvement, complex, controversial or experimental services, and successful operation of the UMC. A board certified psychiatrist and licensed behavioral health practitioners are involved in the implementation, monitoring and directing of behavioral health aspects of the UM Program, and a dentist is involved in the implementation, monitoring and directing of dental health aspects of the UM program. A pharmacist oversees the implementation, monitoring and directing of pharmacy services. In addition to the Chief Medical Director, the Plan may have one or more Medical and/or associate Medical Directors.

The Chief Medical Director's responsibilities include, but are not limited to coordination and oversight of the following activities:

- Assists in the development/revision of UM policies and procedures as necessary to meet state statutes and regulations
- Monitors compliance with the UM Program
- Provides clinical support to the UM staff in the performance of their UM responsibilities
- Assures that the Medical Necessity criteria used in the UM process are appropriate and reviewed by physicians and other practitioners according to policy

Program Integration

The UM Program, Pharmacy and Therapeutics (P&T) Program, Quality Improvement (QI), Credentialing, and the Fraud and Abuse Programs are closely linked in function and process. The UM process utilizes quality indicators as a part of the review process and provides the results to the Plan's QI department. As case managers perform the functions of utilization management, which includes member quality of care measures indicators prescribed by the Plan as part of the patient safety plan. Additionally as the Quality department awareness of issues occurs, Quality works directly with members of the Medical Management team to discuss and follow up with the member to ensure safety and immediate remediation as needed. Documentation of all required information is available to the QI department for review and resolution. As a result, the utilization of services is interrelated with the quality and outcome of the services.

Any adverse information that is gathered through interaction between the UM staff and the practitioner or facility staff is also vital to the re-credentialing process. Such information may relate, for example, to specific case management decisions, discharge-planning, precertification of non-covered benefits, etc. The information is available to the QI Department in the format prescribed by Plan for review and resolution as needed. The Chief Medical Director or Medical Director determines if the information warrants additional review by the Plan Peer Review or Credentialing Committee. If committee review is not necessary, the information is available for provider trending and/or review at the time of the provider goes through re-credentialing process.

UM policies and processes serve as integral components in preventing, detecting, and responding to Fraud and Abuse among practitioners and members. The Medical Management Department will work closely with the Compliance Officer and Centene's Special Investigations Unit to resolve any potential issues as appropriate.

In addition, the Plan coordinates utilization/care management and education activities with local community providers for activities that include, but are not limited to, as below, as applicable to Allwell and Ambetter members, respectively:

- Early childhood intervention.
- State protective and regulatory services.
- Women, Infant and Children Services (WIC).
- EPSDT Health Check outreach.
- Substance Abuse Screenings.
- Juvenile Justice.
- Services provided by the local community mental health centers and substance abuse providers.
- Services provided by local public health departments.

Complex Case/Care Management

Care management/coordination of care is a collaborative process of assessment, planning, prioritizing, coordinating, and ongoing monitoring and re-evaluation of the services required to meet the members' individual needs. Care management (CM), focuses on development of member specific plans of care that focus on organizing, securing, integrating, and modifying the resources necessary to maximize and support the wellness and autonomy of the member. This allows CM to work through advocacy, communication, education, identification of services resources and service facilitation. The goal of case management is to provide quality health care along a continuum, decrease the fragmentation of care across settings, emphasize prevention, enhance the member's quality of life and ensure efficient utilization of patient care resources.

The Plan takes Special Efforts to identify members who have catastrophic or other high-risk conditions to ensure timely access, continuity and coordinated integration of care. This includes, but, is not limited to, those members classified as children or adults with special health care needs; those with catastrophic, high-cost, high-risk, or co-morbid conditions; those who have been non-adherent in less intensive programs; or those that are frail, elderly, disabled, or at the end of life. The Plan works to identify members through multiple avenues such as, claims and data reviews, direct referrals from health providers, hospital staff, health plan staff, member, family and caregivers, community programs and supports. Once members are identified, who will potentially benefit from care management, they are assigned a care manager. The care manager may be either a registered nurse or social worker, or sometimes both working as an integrated team, dependent on the needs identified during the assessment with the member. The care manager will complete an assessment, develop a care plan with the member and work with the member and the member's identified care and support team to obtain the necessary services and supports for the member. In order to optimize the outcome for all concerned, care management services are best offered in a climate that allows direct communication between the care manager, the member, and appropriate service personnel, while maintaining the member's privacy, confidentiality, health, and safety through advocacy and adherence to ethical, legal, accreditation, certification, and regulatory standards or guidelines. The care plan

development includes consideration of the member and/or caregiver's goals, preferences, and stated level of involvement in the care management plan of care.

Care plans for members include all of the elements below at a minimum:

- Identifying barriers to adherence to the care plan and recommended solutions for each barrier. Barriers may include but are not limited to issues such as:
  - Language or literacy issues, include general literacy limitations and health literacy
  - Visual or hearing impairment
  - Psychological/mental impairment
  - Financial and/or health insurance coverage limitations
  - Transportation
  - Cultural and/or spiritual preferences or values
  - Limited knowledge of condition(s)
  - Low motivation or ambivalence toward implementing change
  - Lack of, or limited, social or care giver support
  - Environmental factors
- Prioritized goals, which consider member and caregiver strengths, needs and preferences. Prioritization of goals occurs and includes prioritization by either numerical order or based on high, medium, or low priority. Design of goals includes being achievable and helping the member make changes towards the most optimal recovery possible.
- Interventions based on the member's risk factors, problems and/or needs, agreed upon goals, and personal preferences.
- Determination of a period for measuring progress on meeting care plan goals and reevaluation of the plan.
- Self-management plans to assist members in managing their own condition. The member must acknowledge understanding and agreement to the specific activities identified in the self-management plan and this agreement must be included in the Centene Documentation System (CDS). Care management activities involved in developing and communicating a member's self-management plan include:
  - Education provided to members, their family/guardian, or other caregivers to help manage the member's condition(s). This may include written educational materials or verbal instructions provided by the care manager.
  - The specific information/materials and the method of providing information to the member (i.e. verbally, letter, pamphlet, etc.) are available in the CDS.
  - When possible, self-management activities that can affect biometric data and are available, such as weight and blood pressure in the CDS.
  - Follow up by the care manager to assess completion of self-management activities.
- Documentation of the plan of care in the CDS.

The care manager monitors the member's progress against care management plans/goals by contacting the member at the defined intervals according to the acuity level and plan of care, and/or the member's individual need or preference, as agreed upon by the member/family and the care manager. The table below demonstrates the frequency of contact based on acuity level.

Acuity	Needs	Recommended Frequency of Contact
Critical/High	Multiple co-morbidities, more than one chronic condition, presence of co-morbid, behavioral and/or mental health issues, and/or episode of serious illness or injury; discharge planning, and outpatient coordination of service needs; complex or chronic condition, symptomatic and at risk for admission or readmission.	Minimum of weekly contact until stable. Once stable, allow 2 weeks until complications are stabilized, barriers removed, and/or needed services are in place. Monthly contact unless condition deteriorates.
Moderate	Complex condition with many health care needs; condition is mostly stable with adequate caregiver support. If member assigned as high acuity previously, member is compliant with the care plan and making progress toward meeting care plan goals.	Weekly, biweekly or monthly contact
Low	Primarily psychosocial needs; no current unmet need for health care services but may have a history of condition that places the member at risk for potential problems or complications. If member assigned to a higher acuity level previously, member is compliant with the care plan, has met some goals, and making significant progress toward meeting remaining care plan goals.	One or two contacts and evaluation for care coordination discharge as appropriate

The care manager reassigns a member's contact frequency during the course of care management and monitors implementation of the plan of care and progress toward desired outcomes. When the frequency of contact changes, communication to the member/caregiver occurs and their verbal agreement to the change in frequency of contact documentation is available in the CDS. The care manager may also contact the member's PCP, other treating providers, and other individuals such as a behavioral health care manager, school nurse or personnel, community care manager, medical home care manager, and/or representatives of community organizations or resources to which the member referrals for input regarding progress against the care plan. Ongoing assessments of the members progress includes:

- Change in the member's medical or behavioral status
- Change in the member's family situation or social stability
- Change in the member's functional capability and mobility
- The progress made in reaching the defined goals
- The member's adherence to the established plan of care
- Member's acquisition of self-management skills
- Changes in member/family satisfaction with care management activities
- The member's quality of life
- Benefit limitations

The care manager will also monitor for appropriate discharge from case management. The care manager may receive input from the PCP, member, family/guardian, and other caregivers or health care providers involved in the member's plan of care, to determine the appropriateness of closing a case. The care manager may refer the member to another program with lower

intensity of services, such as care coordination or disease management, determined by ongoing or anticipated needs.

The use of the following criteria to determine when discharge from care management should occur.

- The member terminates with the Plan
- The member and/or family/guardian refuses to participate or requests to opt out of the Care Management Program
- The member reaches the maximum medical improvement or established goals regarding improvement or medical stability (which may include preventing further decline in their condition when improvement is not medically possible)
- The care manager or designee has been unsuccessful at contacting the member after following the unable to contact protocol
- The member expires

Once identification of the member as eligible for discharge from care management services, the care manager ensures appropriate notification occurs. The care manager discusses the impending discharge from care management with the member and/or family/guardian as appropriate. The care manager explains to a member who wishes to decline care management, how it can be of help to them and encourages them to use care management services. Sharing of community resources may also occur as an option. The care manager contacts the member's PCP and other providers when appropriate, regarding the impending discharge. Lastly, a letter discharging the member from the care management program is available from the CDS and sent to the member and the PCP, documenting the reason for discharge and a reminder to contact the care manager in the future, if medical concerns arise. Participation in Care Management Member Satisfaction Survey may with the member's closure letter, per Health Plan policy. See P&P CM.08 *Care Management Member Satisfaction Survey*. The Plan has determined the care management identification criterion being utilized was adequately identifying the population at risk. The data reviewed in this population assessment does not indicate a need for any fundamental changes in the care management program at this time, the Plan's protocol for complex care management will remain essentially the same in 2019 as no material changes in the membership relative to product line, age/gender, language, and race and ethnicity were identified. Sources of the data includes but are not limited to:

- Claim or encounter data
- Predictive modeling software
- Hospital discharge data
- Pharmacy data
- UM data - e.g. hospital admission data, NICU reports, inpatient census, precertification/prior authorization data, concurrent review data
- Emergency Department (ED) Utilization reports
- Laboratory data
- Readmission reports
- CMS Enrollment Process and other State/CMS supplied data
- Information provided by members or their care givers, such as data gathered from Health Risk Assessments
- Information provided by practitioners, such as Notification of Pregnancy (NOP) forms

Although it was determined that a fundamental change in the program is not warranted at this time, there continues to be changes made to the overall care management services provided by Ambetter and Allwell as the health plan matures and moves into the second year of operations in these lines of business. Some of the improvements include:

- Post-discharge nurse positions to contact all members not in case management after their discharge from the hospital.
- Integration of Behavioral Health and Physical Health
- Continuation of dedicated Transplant Care Manager Nurses to assist transplant members.
- Continuation of a Sickle Cell Care Management Program to assess and educate all sickle cell members, assists with resources, coordinates care between providers, and any other functions necessary.
- Efforts focus on assisting new mothers to obtain four well-child visits within the first 6 months of life to ensure babies are receiving timely immunizations and meeting appropriate developmental milestones.
- Ongoing efforts to increase the percentage of Notice of Pregnancy forms completed on pregnant women to identify the high-risk pregnancies and offer Start Smart Case Management, which includes identifying any mother at risk for pre-term deliver and working with the physician and the member to consider 17P injections to reduce the risk of a pre-term birth.
- A continued close partnership with Utilization Management staff to arrange safe discharges for NICU babies.
- Integrated Case Management training program for staff as well as a Plan based internal study group to further encourage/assist CM team members in preparing for and obtaining their CCM certification through CMSA.
- Continued strengthening of coordination of care between departments. The Plan continues weekly rounds on inpatient members. The plan also utilizes integration with Complex Case Management Rounds, behavioral health and physical health integrated rounds to discuss, coordinate care/services with contracting providers and vendors.
- Training and implementation of Care Management Transformation, which is a coordinated care model that goes beyond the Integrated Care model. It consists of a member journey and care router process to guide members to the right level of care, with integrated, coordinated care teams that holistically address physical, BH, and social needs with appropriate staffing/expertise, utilizing evidence based, population specific care pathways.
- The Plan has a wide range of educational materials for members. This includes materials on various disease states and life events. The materials are brightly colored and easy to read and provide many talking points for care managers during contact with members.
- The Plan utilizes Krames Patient Education materials database, which contains patient education materials for thousands of diagnoses, medications, and medical procedures.
- Focused outreach and efforts surrounding Opioid utilization. With this epidemic being complex in nature an IDT, team works with members and providers impacted by this. The Plan feels the best approach is with an interdepartmental approach including pharmacy, provider relations, care management, both physical and behavioral, and medical affairs. In depth, training will be provided to the staff so that they may better support our members. In addition, there will be focused outreach to providers to address the matters regarding prescribing practices.

Appeals

Member Appeals

The Plan defines an appeal as a member's request for the health plan to review an adverse benefit determination in cases where the member is not satisfied or disagrees with the previous decision made by The Plan. Practitioners or others may appeal on behalf of a member as the member's authorized representative with the member's consent.

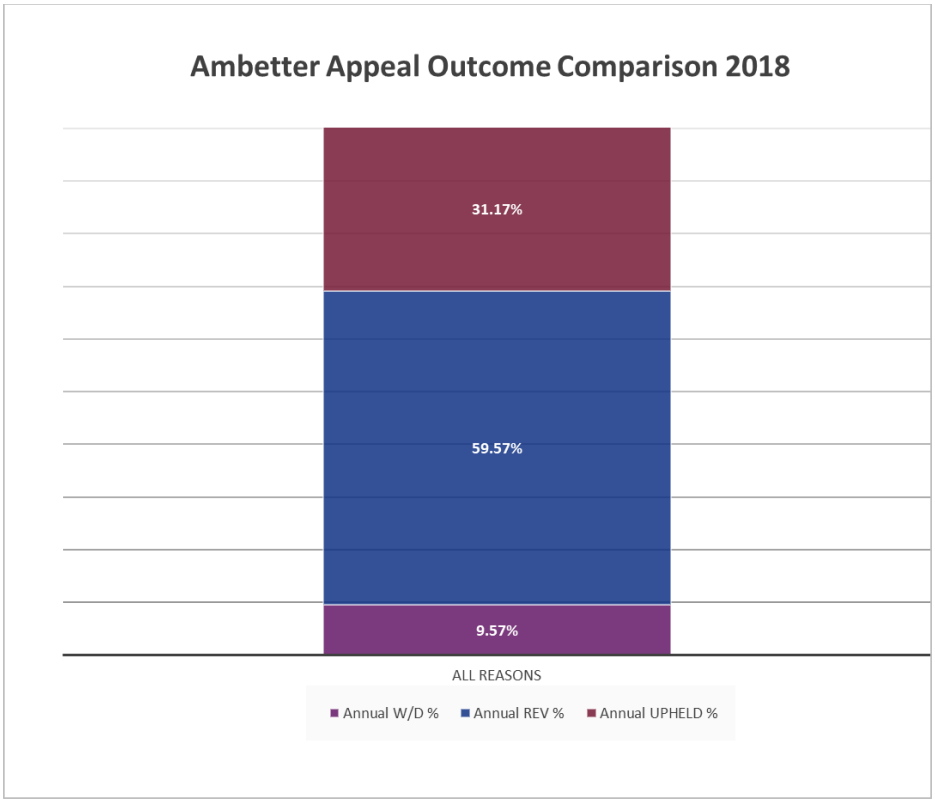
Ambetter

The following table demonstrates the Member Appeals resolved by category for the entire year of 2018 as well as the per 1000 calculation. The categories noted below are in accordance with corporate and NCQA guidelines.

Member Appeal Reasons	2018	2018 per 1000
Claim Dispute	21	1.19
ER - Out of Plan/OON	2	0.11
Inpatient - Admission	18	1.02
RX - Does Not Meet PA/Exceptions	193	10.96
RX - Off Label	2	0.11
RX - Not Covered per Benefit Plan	2	0.11
Surgical - Gastric Bypass	2	1.11
Hospital - Other	14	0.79
Administrative	3	0.17
Surgery	1	0.06
Therapy	2	0.11
Home Health	1	0.06
DME	19	1.08
Outpatient Procedure	26	1.46
Facility (SNF)	1	0.06
Consultation	1	0.06
Behavioral Health Service	3	7.17
Diagnostic	13	7.74

For 2018, *RX – Does Not Meet PA/Exception* made up the majority of the member appeals at 193 or 59.57% of the total member appeals. Of those 193 appeals, 111 or 57.51% were overturned on appeal. The most common class of medication appealed is opioids. The second highest category for appeals is *Outpatient Procedure* with 26 or 8%. Review of appeals data occurs on a monthly basis and education occurs with the identification of trends.

In 2018, 59.57% of member appeal decisions were reversed and 31.17% upheld on appeal. The Plan will continue to provide education to providers and encourage them to submit required documentation with the initial request for services/authorizations.



Allwell

The corporate team processes the Member appeals for Allwell. There was 1 member appeal received in 2018. This was a pharmacy appeal related to a denied medication. This denial was overturned on appeal.

Provider Appeals

Provider appeals consist of internal reviews of partial or whole claim denials as well as authorization denials made by The Plan. Monitoring of theses assists in identifying opportunities to improve processes or assist providers in resolving claims issues. The Plan reviews provider appeals data at the Grievance and Appeals Committee (GAC) and Quality Improvement Committee (QIC) quarterly meetings. QIC includes departmental leadership and network physicians, which allows for discussion of the data, trends, and allows initiatives for implementation to help address trends identified in the provider appeals data. These initiatives can include but are not limited to provider education, education of plan staff, education of provider office staff and also review of internal plan processes for opportunities.

Ambetter

In 2018, there were ten provider appeals requiring medical necessity review by the Plan. Five out of the ten appeals were regarding denial for *Timely Filing* of a service request or authorization.

Provider Appeal Categories	2018
Timely Filing	5
Diagnostic - Genetic Testing	1
Inpatient - Admission	1
Inpatient - SNF/Continued Stay	0
Hospital - Other	0
Other - Mental Health Services	0
Outpatient - Procedure	3
Total	10

Allwell

For Allwell in 2018, the plan processes Provider appeals requiring medical necessity review. There were no provider appeals requested for review in 2018 for Allwell.

Preventive Health Outcomes

Clinical Practice Guidelines (CPG)

The Plan utilized the following clinical and preventive health practice guidelines in 2018 review of policy. The Plan made providers aware of the guidelines and their expected use through the provider newsletters, inclusion in the provider manual, and on the Allwell and Ambetter website. Monitoring of performance on CPGs includes applicable HEDIS measures. Below are the CPGs:

- ADHD
- Adult Preventive
- Anxiety Disorder
- Asthma
- Back Pain
- Diabetes
- CHF / Heart Failure
- CAD
- COPD
- Hyperlipidemia
- Hypertension
- Hypertension in Children
- Immunizations
- Lead Screening
- Pediatric Preventive
- Perinatal Care
- Sickle Cell
- Major Depressive Disorder
- Schizophrenia
- Substance Use Disorders
- Tobacco Cessation
- Weight Management

An annual review and update of all Clinical Practice Guidelines (CPGs) and Preventive Health Guidelines (PHGs) occurs at the Plan. Opportunities in 2018 related to practice guidelines were to continue and expand provider profiles in 2019 to a larger provider group to help increase knowledge, awareness and compliance.

Plan efforts Undertaken in 2018:
Plan completes annual review of CPGs and PHGs, reviews, and updates as appropriate based on the policy and procedure requirements. The goal was met in 2018 and will continue efforts in 2019 as below.

- Continue to notify practitioners about the guidelines via newsletter and website announcements.
- Continue member and provider outreach and education-based initiatives regarding all guidelines
- Continue to meet applicable NCQA Standards throughout 2018 and will continue in 2019 to meet standards.

The Plan maintains preventative care guidelines as a reference on the Plan website and updates them annually or as the guidelines change. These guidelines include adult preventive, immunizations; lead screening, pediatric preventive and perinatal care as applicable to Allwell and Ambetter. These guidelines are available in hard copy upon request to providers.

Delegation Oversight

Disease Management

Disease management is a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with or at risk for chronic medical conditions. Disease management programs generally are offered telephonically, involving interaction with a trained nursing professional, and require an extended series of interactions, including a strong educational component. In addition, some members qualify for Telehealth monitoring which includes equipment installation in the member's home. Ambetter and Allwell both offer disease management to those members as reflected in the table below:

Line of Business	Asthma	COPD	Diabetes	Heart Disease	Heart Failure	Hyperlipidemia	Hypertension	Tobacco Cessation	Low Back Pain
Ambetter	x	-	x	x	-	x	x	x	x
Allwell	x	x	x	x	x	-	x	-	-

Delegated Vendor Oversight

The Plan selected delegated vendors to oversee certain activities to ensure quality of care for its members. The Plan retains accountability for delegated services and monitors their performance through annual audits and by requiring monthly performance measures reporting. These measures include, but are not limited to, the following:

- Timely submission of grievance and appeals data for vendors contracted for those services
- Prior authorizations by service type
- Provider network
- Claims and encounter data

The following is a listing of the delegated vendors for 2018. The first five vendors who are wholly owned subsidiaries of Centene:

1. **Envolve Vision** - Plan's vision care provider. Envolve Vision provides utilization management, network development and maintenance, credentialing of their network, and claims payment data.
2. **Envolve Pharmacy Solutions** - Plan's pharmacy benefits manager. US Script provide information for prior authorizations, utilization management, verification of active licenses for all participating pharmacies, and claims payment data.

3. **Envolve People Care (EPC, formerly Nurtur and NurseWise)** - Plan's disease management provider, after-hours call center and nurse advice line. EPC provides disease management as noted in the table above under Disease Management section. The after-hours call center and nurse advice line provides bilingual care with registered nurses, which complete health screenings, and after hours nurse advice.
4. **Envolve Dental** – Plan's dental benefit manager. They provide prior authorizations, utilization management, network development and maintenance and claim payment information.
5. **USMM (U.S. Medical Management)** – In-home healthcare services, mail-in lab test kits and risk adjustment in-home visits.
6. **National Imaging Associates (NIA)** - Plan's high-tech radiological imaging provider. NIA provides prior authorizations, credentialing of their network and first level appeals. Provides post-service audits related to therapy services for speech, physical and occupations therapies for appropriate utilization. NIA also is the vendor for post-service utilization review of speech, physical and occupational therapies.
7. **Optum** - Assists Plan in obtaining risk assessment information and data collection for members for Allwell specifically.
8. **Eliza** – Vendor who provides health maintenance reminders via Interactive Voice Response system for Ambetter and is a nationally contracted vendor.
9. **Logisticare** – Plan's transportation vendor for Allwell.

Quarterly meetings occur with each vendor to review and monitor performance metrics and address any issues affecting Ambetter and Allwell. Centene Corporation completes the annual vendor oversight audits on behalf of Ambetter and Allwell and includes any Kansas specific requirements in the audit, as well as conducting applicable file reviews of Ambetter and Allwell members. In conjunction with Centene Corporate and the other Centene health plans, the Plan reviews the vendor evaluation results. As needed, the Quality Improvement Director reviews the results with the Vendor Manager and the Compliance Manager to identify any necessary interventions. All potential interventions are discussed with a multi-disciplinary Plan team and ultimately with the Quality Improvement Committee as needed. Regular meetings with *(*occur related to the specific projects that they work on for the Plan. As necessary, action plan implementation occurs to allow for monitoring and demonstration of improvement desired.

The Plan evaluates each delegated entity's capacity to perform the proposed delegated activities prior to the executing of a delegation agreement. The Plan retains accountability for any functions and services delegated. Therefore the Plan monitors the performance of the delegated entity through annual approval of the delegated programs (Credentialing, UM, QI, etc.), routine reporting of key performance metrics and annual or more frequent evaluation to determine whether the delegated activities are being carried out according to the contract, accreditation standards and program requirements. The Plan retains the right to reclaim the responsibility for performance of delegated functions, at any time, if the delegate is not performing adequately.

Newly delegated entities are required to have a pre-delegation audit prior to contract implementation. All entities are subject to annual audits and submit regular reports of key functions to the Delegated Vendor Oversight Committee.

The table provided below contains the results of vendor audits conducted in 2018 and scope of the review. It is important to note, vendors can be on a Quality Improvement Plan (QIP) from the corporate audits, while there were not findings specific to the plan on all of those matters.

Vendor and Type	Date of Audit	Areas Audited	Scored Below 90% & QIP Implemented
NIA	Dec-18	Credentialing	Yes
		Recredentialing	Yes
		Complaints - Member	No
		Complaints - Provider	No
		Customer Service Call Handling - Provider	No
		Medical Necessity Denials	No
		Administrative Denials	No
		Medical Necessity Appeals	No
Envolve	Phase 1 – April 2018	Claims	No
		Credentialing	No
		Denials Admin	No
		Medical Necessity	No
		Member Calls	Yes
		Member Complaints	No
		Provider Calls	No
		Provider Directory	Yes
		Recredentialing	No
Envolve Pharmacy Solutions	Phase 1 – June 2018 Phase 2 – August 2018	Denials Administrative	No
		Paid Claims	No
		Member Complaints	No
		Credentialing	No
		Re-Credentialing	Yes
		Call Handling	No
		Rejected Claims	No
		Denials Medical Necessity	No
Envolve Dental	Phase 1 – May 2018 Phase 2 – July/August 2018	Denials Administrative	No
		Claims	No
		Member Complaints	Yes
		Credentialing	No
		Re-Credentialing	Yes
		Provider Directory	Yes
		Provider Calls	No
		Appeals Medical Necessity	No

Vendor and Type	Date of Audit	Areas Audited	Scored Below 90% & QIP Implemented
		Denials Medical Necessity	No
Envolve People Care (NAL & DM)	Phase 1 – May 2018 Phase 2 – September 2018	Customer Service Calls – Member	No
		RN Triage	No
		Medical Necessity	Yes
		Disease Management	Yes
		Admin Denials	Yes
		Nurse Support	No
		Provider Directory	No
		Crisis Calls	No
		Call Handling	No
Optum	Nov-18	Disease Management	Yes
		HRA / Wellbeing	No
		Nurse 24 Line (Triage)	No
		Complaints - Member	No
		Complaints - Provider	No
		Provider Overpayment Recoveries	No
		Credit Balance	No
USMM	N/A	N/A	N/A

Review and Approval

Annually, the Plan aggregates data, intervention details, HEDIS, appeals, grievance, and various survey data to compile the annual evaluation demonstrating the progress made in the preceding year on improving the quality of care and services members receive to form the Quality Assessment and Performance Improvement Program Evaluation. Upon completion of this evaluation, submission to the QIC for review and approval occurs. Following review and approval by QIC, submission to the BOD for review and approval then occurs.

Approval

The Quality and Utilization Assessment and Performance Improvement Program Evaluation for 2018 review and approvals occur as follows:

Quality Improvement Committee Chair Approval: _____

Date of QIC: 3/28/19

Board Chair Approval: _____

Date: 5/16/19