Sunflower State Health Plan

Quality Assessment and Performance Improvement/Utilization Management Program Evaluation

January 1 - December 31, 2013

INTRODUCTION

The purpose of this evaluation is to provide a systematic analysis of Sunflower State Health Plan's (Sunflower) 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 is focused on activities and interventions completed during the period of January 1 - December 31, 2013. The QAPI, QI Work Plan and QI Program Evaluation are reviewed and approved at least annually by the Quality Improvement Committee (QIC) and the Sunflower State Health Plan's Board of Directors (BOD).

MISSION

Sunflower strives to provide improved health status, successful outcomes, and member and provider satisfaction in an environment focused on coordination of care. As an agent of Kansas Department of Health and Environment (KDHE) and Kansas Department of Aging and Disability Services (KDADS) and partner with local healthcare providers, Sunflower seeks to achieve the following goals for our clients, KDHE and KDADS, and Sunflower members:

- Ensure access to primary and preventive care services in accordance with the Department of Health and Environment - Division of Health Care Finance and KDADS standards;
- Ensure care is delivered in the best setting to achieve optimal outcomes;
- Improve access to necessary specialty services;
- Encourage quality, continuity, and appropriateness of medical care;
- Provide medical coverage in a cost-effective manner.

All Sunflower programs, policies and procedures are designed with these goals in mind.

PURPOSE

The purpose of the Quality Improvement Program is to utilize sound methodologies to objectively and systematically plan, implement and monitor ongoing efforts that demonstrate improvements in member safety, health status, outcomes, and satisfaction. This is accomplished through the implementation of a comprehensive, organization-wide system for ongoing assessments to identify opportunities for improvement.

MEMBER DEMOGRAPHICS AND SERVICE AREA

Sunflower State Health Plan began operation as a managed care health plan serving the Kansas Medicaid population on January 1, 2013. Sunflower intends to continue to grow its membership by providing excellent customer service including contacting all new members, welcoming them to the Plan, and providing information about covered services including those related to disease prevention. Sunflower plans to retain members by offering coordination of care, financial incentives for targeted healthy behaviors, health education workshops, healthy lifestyles programs, disease management, case management, a network of providers that meets the needs of the membership, and conducting a member satisfaction survey with follow-up interventions to address any identified opportunities for improvement.

Assessment of Sunflower's 2013 membership population was completed in first quarter 2014. A systematic review was undertaken to determine if there have been material changes in the population that would require the case management program to be substantially revised.

Membership Characteristics

The current Sunflower membership makeup is shown in the tables below:

Product	% of Population
CHIP	15%
Foster Care	4%
LTC Dual	6%
LTC Non-Dual	3%
SSI Dual	5%
SSI Non-Dual	8%
TANF	60%
Total	**100%**

Age Group	% of Population
0-10	47%
11-20	26%
21-30	7%
31-40	5%
41-50	4%
51-60	4%
61-70	3%
71-80	2%

Gender	% of Population
M	54%
F	46%

As seen above, Temporary Assistance to Needy Families (TANF) and Children's Health Insurance Program (CHIP) members make up the majority of the Sunflower membership, with children aged 0-10 compiling almost half of the membership. Males and females are fairly equally distributed. The table below reflects the 2013 membership for each product by month.

Product	2013-01	2013-02	2013-03	2013-04	2013-05	2013-06	2013-07	2013-08	2013-09	2013-10	2013-11	2013-12
TANF	76,943	81,559	82,735	83,050	82,812	82,400	82,698	82,636	83,145	83,198	83,564	84,002
CHIP	17,570	18,815	19,429	19,956	20,404	20,784	20,784	21,023	20,977	21,208	21,155	21,115
Foster Care	4,654	4,896	5,018	5,137	5,217	5,092	5,047	5,031	5,018	5,065	5,069	5,015
SSI Dual	6,146	6,410	6,414	6,496	6,390	6,332	6,242	6,220	6,231	6,417	6,357	6,321
SSI Non-Dual	9,774	10,376	10,558	10,810	10,843	10,790	10,821	10,810	10,881	10,711	10,640	10,563
LTC Dual	7,913	8,518	8,664	8,834	8,841	8,838	8,789	8,780	8,760	8,786	8,740	8,691
LTC Non-Dual	3,654	3,961	4,048	4,144	4,167	4,171	4,164	4,183	4,211	4,216	4,201	4,179

Sunflower serves members in all Kansas counties. Since plan implementation on January 1, 2013, Sunflower has experienced an 11% increase in membership. Overall, the Sunflower membership by product line has remained stable over the timeframe. .

Languages Spoken by Sunflower Members

Sunflower reviewed census data to assess the linguistic needs of its members. The 2008-2012 American Community Survey and the U.S Census Bureau web site reported that 10.9% of the population of Kansas report speaking a language other than English at

home. Of those, 7.2% of Kansas residents report speaking Spanish at home, 1.5% report speaking other Indo-European languages, 1.7% report speaking Asian and Pacific Island languages, and 0.5% report speaking other languages at home.

Sunflower offers language assistance services to members who require translation services. Services are available for both telephonic and on-site interactions and can be arranged by Sunflower case management staff for member interactions with both Sunflower staff and network providers. The table below represents the top five languages for which members have requested translation services based on unique interactions. It should be noted that Sunflower has two Spanish-speaking Member Services Representatives on staff.

Language	Number of calls	Percentage of Total
Spanish	9799	94%
Burmese	159	1.5%
Russian	133	1.3%
Vietnamese	82	.79%
Somali	45	.43%
All other languages	199	1.9%
Total	10417	100%

Race/Ethnicity

The table noted below reflects race and ethnicity and is based on members who responded to the 2013 CAHPS survey and designated race/ethnicity on the survey.

Race / Ethnicity Category	2013 Adult CAHPS	2013 Child CAHPS
White	87.2%	77.3%
Black /African American	7.9%	16.0%
Hispanic / Latino**	8.3%	21.0%
Asian	2.0%	6.4%
Hawaiian / Pacific Islander	0.8%	3.4%
American Indian / Alaskan	7.9%	4.7%
Other	3.9%	8.6%

Sunflower determined the case 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 case management program at this time. Sunflower's protocol for complex case management will remain essentially the same in 2014 as no material changes in the membership relative to product line, age/gender, language, race and ethnicity were identified. However, there have been many changes made to the overall case management services provided by Sunflower as the health plan moves into the second year of operations. Some of the improvements made in 2013 include:

- Development of an Emergency Department Diversion program to assure members are connected with a primary care provider to manage their care and to provide any needed education and resources.

- Two new post-discharge nurse positions to contact all members not in case management after they have been discharged from the hospital.
- A dedicated Transplant Case Manager
- Sickle Cell Case Management Program to assess and educate all sickle cell members, assists with resources, coordinates care between providers, and any other functions necessary.
- Refocused efforts on TANF and CHIP members; Sunflower has instituted efforts to assist 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.
- 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.
- Community baby showers to connect with members in their community and present information about pregnancy, newborn care, and breastfeeding.
- Partner closely with Utilization Management staff to arrange safe discharges for NICU babies.
- Dedicated case managers for foster care children, to coordinate the special needs of this population.
- Initiated Integrated Case Management, a training program for staff conducted by the Case Management Society of America (CMSA). This program provides education and instruction for staff on how to work together to manage the member as a whole person. The program includes 40 hours of self-study, webinar sessions, 1.5 days of face-to-face training with CMSA instructors, and an exam with certificate upon successful completion of the course, earning case managers 59 CEUs. Sunflower case managers are completing this in three groups. The first of the three groups have completed the training.
- To improve coordination of care between departments, Sunflower has recently begun daily rounds on all inpatient members. Sunflower also has begun scheduling Complex Medical Rounds, Long-term Care Support Services (LTSS) rounds, and integrated rounds to discuss and coordinate care.
- Sunflower has a wide range of member materials, including a new diabetes handbook that is brightly colored and easy to read. Sunflower has also recently begun using the Krames Patient Education materials database which contains patient education materials for thousands of diagnoses, medications, and medical procedures.

Program Overview

Sunflower continues to be committed to the provision of a well-designed and well-implemented QAPI Program. Sunflower's culture, systems and processes are structured around its mission to improve the health of all enrolled members. 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, and 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 Sunflower's members including medical, behavioral health, dental and vision care. Sunflower 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. Sunflower's QAPI Program monitors the following:

- Acute and chronic care management
- Behavioral health care
- Care Management
- Compliance with member confidentiality laws and regulation
- 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 and prevention
- Home support service utilization for LTSS services
- Information Management
- Marketing practices
- Member enrollment and disenrollment
- Member Grievance System
- Member satisfaction
- Member 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
- Selection and retention of providers (credentialing and recredentialing)
- Utilization Management, including under and over utilization
- Polices to support the QAPI program

Goals

Sunflower's primary quality improvement goal is to assess, monitor, and measure improvement of the health care services provided to members served by the Plan. Sunflower will ensure quality medical care is provided to members, regardless of payer source, eligibility category or location of services whether provided in an acute setting or 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 Sunflower'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 guidelines. (Early Periodic Screening, Diagnosis and Treatment Program). Plan will measure compliance with clinical practice guidelines until 90% or more of relevant network providers are consistently in compliance;
- Compliance with all applicable regulatory requirements and accreditation standards will be maintained.

Objectives

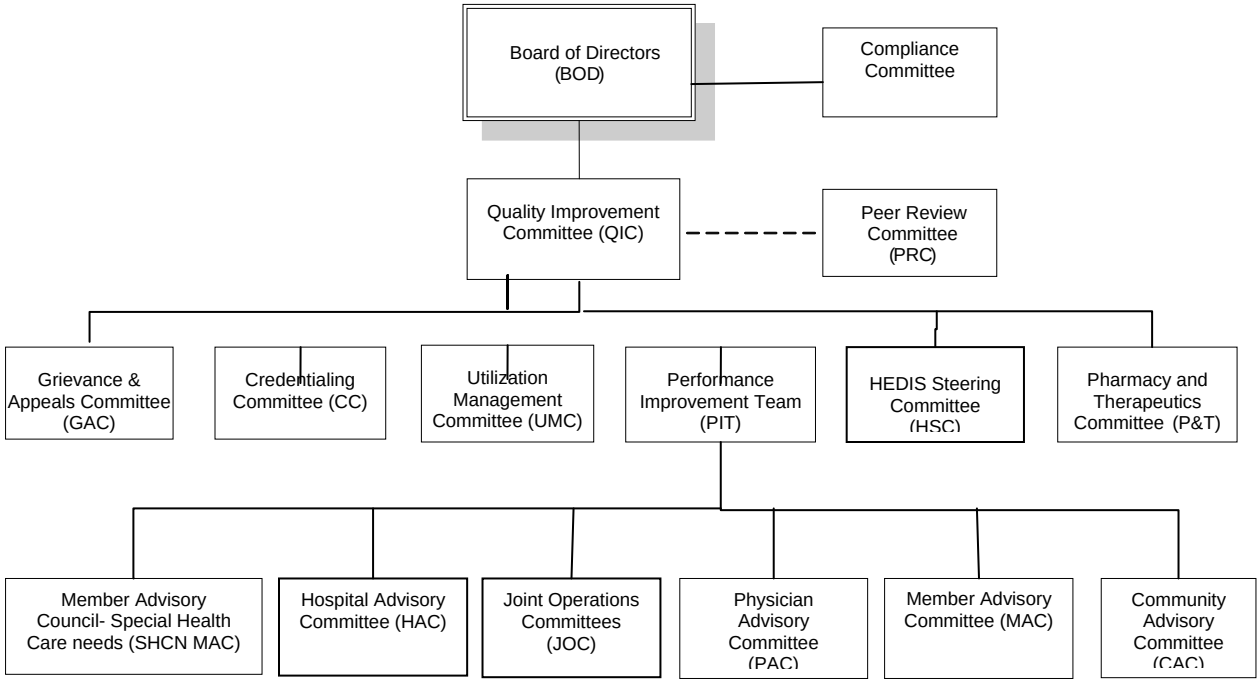
Sunflower's QAPI Program objectives include, but are not limited to, the following:

- 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 option;
- 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

Quality is integrated throughout Sunflower, and represents the strong commitment to the quality of care and services for members. To this end, Sunflower has established various committees, subcommittees, and ad-hoc committees to monitor and support the QAPI Program. Ultimate authority for the QAPI Program is held by the Board of Directors. The Quality Improvement Committee (QIC) is the senior management lead committee reporting to the Board of Directors, and is supported by various sub-committees as noted below.



Board of Directors

The Sunflower Board of Directors oversees development, implementation and evaluation of the QAPI Program. The Board of Directors has ultimate authority and accountability

for oversight of the quality of clinical and non-clinical care and services provided to members. Sunflower's Board of Directors reports to the Centene Board of Directors as Sunflower is a wholly-owned subsidiary of Centene Corporation. The Board of Directors delegates the authority of the QAPI Program to Sunflower's President and Chief Executive Officer (CEO) who delegates the daily operations of the QAPI Program to the Chief Medical Director.

Quality Improvement Committee (QIC)

The QIC is Sunflower's 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; and the education of members, providers and staff regarding the Quality Improvement (QI), Utilization Management (UM), and Credentialing programs.

The QIC is composed of Sunflower's CEO, Chief Medical Director, Associate Medical Director, and QI Director, along with other Sunflower executive staff representing the Medical Management (including Utilization Management and Case Management), Network Development/Contracting, Member and Provider Services, Compliance, and Pharmacy departments. Additional QIC attendees include staff responsible for clinical appeals and Fraud, Waste and Abuse. The first QIC meeting was held December 19, 2012 and has met three times in 2013 with the last meeting being held on December 18, 2013. Typically, the QIC meets quarterly.

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 are communicated to 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 Sunflower's network, and to oversee the credentialing process to ensure compliance with regulatory and accreditation requirements. The Credentialing Committee is facilitated through Centene's corporate office and is composed of Sunflower's Chief Medical Director and Associate Medical Director, Centene's Corporate Credentialing Director, network physicians, and other Sunflower QI staff. The Credentialing Committee met 17 times since January 1, 2013; meeting twice a month until July 2013. Typically the Credentialing Committee meets monthly and on an ad-hoc basis.

The Credentialing Department is responsible for ensuring all practitioners are appropriately licensed and experienced in their field. This is accomplished through applying rigorous standards that verifies practitioner's license, education, training, experience, certification, malpractice history, work history, and quality of care attributes.

To become a participating provider in the Sunflower 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 housed at Centene's corporate offices. The table below reflects credentialing application outcomes for 2013.

Month	Received	Complete and Non Excluded	Complete within 20 days	Complete within 30 days
January	197	127	119 – 94%	127 -100%
February	64	28	26 – 93%	28 - 100%
March	130	67	65 - 97%	67 - 100%
April	157	102	102 – 100%	102 - 100%
May	196	293	144 – 37%	231 - 59%
June	229	134	90 – 67%	100 - 75%
July	169	140	139 – 99%	139 - 99%
August	133	88	85 – 97%	88 - 100%
September	77	58	58 – 100%	58 - 100%
October	151	118	116 – 98%	118 - 100%
November	258	151	150 – 99%	151 - 100%
December	222	153	148 – 97%	151 - 99%

Pharmacy and Therapeutic Committee

The Pharmacy and Therapeutics (P&T) Committee is a standing subcommittee of the QIC and is responsible for administering the daily oversight and operating authority of the Pharmacy Program. The QIC is the vehicle through which pharmacy monitoring and reporting activities is communicated to the Board of Directors. The P&T Committee ensures Sunflower 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. The P&T Committee is a multidisciplinary team composed of Sunflower's Chief Medical Director, Associate Medical Director, Pharmacy Director, network physicians, and other executive staff. The first P & T Committee meeting was held on May 5, 2013 and has met three times in 2013. Typically, the P & T Committee meets quarterly.

Utilization Management Committee

Daily 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 Sunflower Board of Directors. The UMC is responsible for the review and appropriate approval of medical necessity criteria and 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 and appropriate use of services and resources as well as member and practitioner satisfaction with the UM process. The UMC is composed of Sunflower's Chief Medical Director, Associate Medical Director, Sunflower's Vice Presidents of Medical Management, and other operational staff as needed. The first UM Committee was held May 17, 2013 and since then met on two more occasions. Typically, the UM Committee meets quarterly.

HEDIS Steering Committee

The HEDIS Steering Committee oversees Sunflower's HEDIS process and performance measures. The Committee reports directly to the QIC and reviews monthly rate trending, identifies data concerns, and communicates corporate initiatives to Sunflower Senior Leadership. The Committee directs clinical, non-clinical, member and provider initiatives to improve selected HEDIS scores. 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 monthly, facilitated by the HEDIS Coordinator and includes the QI Director, the CEO, Chief Medical Director, Associate Medical Director, and Vice Presidents of Medical Management, with representation from Contracting/Network Management, Member/Provider Services, and Pharmacy. The HEDIS Steering Committee met five times in 2013.

Peer Review Committee

The Peer Review Committee (PRC) is an ad-hoc committee of the QIC and 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. The PRC is expected to use 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.

Performance Improvement Team

The Sunflower 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 reporting back to the designated committee.

The PIT meets monthly and includes representation from each functional area within Sunflower. Membership includes staff that conducts or directly supervises the day-to-day activities of the departments, i.e. Case Management, Compliance, Member Connections, Contracting, Member Services, Network Development, Prior Authorization, Provider Relations/Services, Quality Improvement or other members as determined by the topic under discussion.

Five subcommittees report to the PIT, as described below:

Member Advisory Committee

The goal of the Member Advisory Committee (MAC) is to solicit member input into the QAPI Program. Member feedback is obtained through committee participation, individual requests, and ongoing communications with members to engage them in performance improvement initiatives. The purpose of the MAC is to review member feedback and support Sunflower in remaining member-centric and in providing activities that improve member quality of care and satisfaction. The MAC met two times in 2013.

Community Advisory Committee

The Community Advisory Committee (CAC) is an advisory committee with local representation from key community stakeholders such as church leaders, representatives from advocacy groups, and other community-based organization representatives. The committee is responsible for providing Sunflower with feedback and making recommendations regarding health plan performance from a community and provider-based perspective. The CAC has not yet met but Sunflower is actively working to get this committee running in 2014.

Provider Advisory Committee

The Provider Advisory Committee (PAC) is an advisory committee composed of the Sunflower Medical Director, network practitioners, facilities, community-based providers and ancillary provider representatives from across the Sunflower service area, along with representation from the Sunflower Contracting and Provider Relations departments. The Committee provides input on provider profiling, incentive programs, and other administrative practices, and supports development of the physician scorecard indicators, useful analyses of the data, and effective means of aiding providers in improving their performance. The PAC has not yet met but Sunflower is actively working to get this committee running in 2014.

Hospital Advisory Committee

The Hospital Advisory Committee (HAC) is an advisory group made up of key administrative hospital leaders and Sunflower staff to address concerns of the hospital networks with regards to prior authorization, concurrent review, discharge planning and coordination of care and payment. The HAC has not yet met but Sunflower is actively working to get this committee running in 2014.

Joint Operations Committees

The Joint Operations Committees (JOCs) are active sub-committees of the PIT, whose primary function is 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 JOCs is to provide oversight and assess the appropriateness and quality of services provided on behalf of Sunflower to members. The JOCs includes representation from each Sunflower functional area as well as representation from the delegated vendors. The following table is reflective of the volume of vendor meetings in 2013.

Vendor	Number of meetings in 2013
National Imaging Association	6
US Scripts	4
Logisticare	6
NurseWise	3
DentaQuest	4
Nurtur	3
OptiCare	4
Cenpatico Behavioral Health	4

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 and timeliness of resolution, performing barrier and root cause analysis, and making recommendations regarding corrective actions as indicated. The GAC is composed of Sunflower's Chief Medical Director, Pharmacy Director, QI Director, Grievance Coordinator, Clinical Appeals Coordinator, QI Nurse and representatives from Member Services and Provider Relations. The GAC provides summary reports to the QIC at regular intervals, but no less than quarterly. The GAC met three (3) times between November 2012 and December 2013. Meetings typically are held quarterly or more frequently as needed.

New Committee Reporting Structure

The first year of Sunflower's operations presented a challenge in operationalizing committee activity. However, by the end of 2013 the committees were running smoothly with good representation. The QI Committee has strong network practitioner participation, with physician committee members providing robust feedback regarding QI activities. Sunflower followed established committee structure with the exception of the Grievance and Appeals Committee. Originally, it was planned for the Vice President of Compliance to chair the committee, but was later determined the QI Director would be a more appropriate chair. In addition, it was planned the Grievance and Appeal Committee would include at least one community advocate. This did not occur in 2013 and represents an opportunity for improvement in 2014. No other changes to the committee structure occurred in 2013 or are planned for 2014, other than recruitment of additional network practitioners for the Credentialing Committee.

Quality Improvement Department Structure and Resources

QI Department Staff

The QI Department resources were evaluated and determined to meet the needs of the QAPI Program during 2013. The QI Department is composed of the following members:

- Chief Medical Director, serving as the Senior Executive for Quality Initiatives (SEQI).
- Medical Director of Utilization Management.
- Director, Quality Improvement.

- Quality Improvement Coordinator (Nurse).
- EPSDT Coordinator.
- HEDIS Coordinator.
- Grievance Coordinator.
- Appeals Coordinator.
- Clinical Appeals Coordinator (Nurse).
- QI Analyst.
- Centene Corporate support.

Organizational Changes in 2013

Sunflower was without a local QI Director during September and October 2013. During this time the QI Director role was supported by the corporate office. The Corporate Office Senior Director of Quality Improvement served as the interim QI Director until the new Director was hired in November 2013. There have been no other changes to the QI staff since January 2013. Other than the QI Director, all staff members originally hired prior to the health plan implementation remains in the QI Department as of December 31st.

As noted previously in the Member Characteristics section of the report, membership in all of Sunflowers product lines have increased slightly since the KanCare contract began on January 1, 2013. In addition, on February 1, 2014, Sunflower assumed responsibility for approximately 4,000 members in the I/DD waiver program. In preparation for these additional members, Sunflower hired an additional 50 case managers. These case managers were trained and ready to assume their assignments on February 1, 2014.

Compliance Program

Sunflower's Compliance Department, in conjunction with Centene Corporate, is responsible for ongoing monitoring and investigation of potential fraud and abuse related to providers, members, and internal staff. Sunflower's 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).

In addition, the Compliance Department worked with the Kansas Foundation for Medical Care, the External Quality Review Organization (EQRO) in Kansas, to provide materials requested by the EQRO for their Balanced Budget Act (BBA) and KDHE audits. The majority of the document collection and submission occurred in 2013, but the results of these two evaluations have not yet been provided to Sunflower. The EQRO also conducted an Information System Capabilities Assessment (ISCA) which resulted in minor recommendations for improvement, most of which were corrected shortly after receipt of the EQRO's final report. The State also performed a Focused Review audit of Sunflower in July 2013 and found several areas for improvement which were acted upon by Sunflower.

Health Insurance Portability and Accountability Act of 1996 Compliance and Confidential Information

Sunflower is required to establish policies and procedures which address privacy and confidentiality of member information. Specific policies detail Magnolia's safeguards, collection, use and disclosure of protected health information (PHI) and how PHI is shared with the members based upon HIPAA. In accordance with Sunflower's policy, the following tasks are undertaken to ensure the protection of member information:

- Quarterly Desk Audits.
- Annual compliance training for all personnel.
- New Hire Compliance and HIPAA Training.
- Member complaints regarding management of health information are monitored.
- All member information will be maintained in secure systems and hard copies will be kept in locked locations.

All employee desk and work areas are audited to make sure that member PHI is secured, laptops are locked and PHI is disposed of properly. The Compliance Department conducted three quarterly desk audits in 2013 and the results revealed no infractions.

QAPI Program Effectiveness

Throughout 2013, the QI Department continued its collaboration with all organizational departments to facilitate continuous improvement in performance by empowering all stakeholders through education, communication, and evaluation. Sunflower has continued to improve the quality of care and services provided to the membership through continuous assessment of patterns and trends and identification of barriers to desired outcomes.

Sunflower continues to strive to include network physicians in the program through committee participation. Sunflower believes physician involvement ensures influencing network-wide safe clinical practices.

Quality Improvement Work Plan

The QI Department developed 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 QI Work Plan was approved by Sunflower's Board of Directors and QIC and is updated quarterly. The Sunflower QI Department collaborated with all organizational departments to develop a comprehensive program.

The 2013 QI Work Plan defines the activities, the person(s) responsible for the activity, the date of expected task completion and the monitoring techniques that will be used to ensure completion within the established timeframe. The QI Work Plan is presented to the QIC on an annual basis for approval, through the annual evaluation process and at regular intervals throughout the year. The 2014 QI Work plan is currently being updated and will be provided to the QIC for review and approval.

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 is then used to make modifications to the coming year's QI Program Description and to create the key metrics of the QI Work Plan.

Strengths and Accomplishments

- Development of the QI Work Plan.
- Committee membership and structure established.
- Quality improvement initiatives and focus studies identified.
- Established processes for HEDIS data collection and measurement. The Quality Improvement Department worked with the health data analysts to identify opportunities and interventions focused on improving HEDIS and EPSDT rates, including collaboration with all internal Sunflower departments and vendors as applicable.
- Partnered with The Meyers Group (TMG) to conduct an adult and child member satisfaction survey. The results of the survey were provided by the survey vendor in late 2013. The QI Department met with internal departments such as Member Services, Provider Relations and Pharmacy to identify suggested areas for improvement, which were presented to the QIC at the December 18, 2013 meeting.
- Partnered with The Meyers Group (TMG) to conduct a provider satisfaction survey. The results of the survey were provided by the survey vendor in Fall 2013. The QI Department met with internal departments such as Member Services, Provider Relations, Pharmacy and Claims to identify suggested areas for improvement, which were also presented to the QIC at the December 18, 2013 meeting.
- Two staff members passed the HEDIS training course allowing them to conduct the medical record review over-read of the cases abstracted by Outcomes, the medical record abstraction vendor, during the HEDIS data collection process.
- Established a quality control process involving audit of grievances to ensure timeliness and accuracy of acknowledgement and resolution letters.
- Began auditing appeals cases quarterly to ensure timeliness and accuracy of the acknowledgement and resolution letter.
- The Clinical Appeals Nurse has provided all requested documents for all State Fair Hearings within the timeframe given by the Office of Administrative Hearings.
- The Pay-for-Performance (P4P) incentive metrics were met for appeals. All appeals were processed in a timely manner for 2013.
- The P4P incentive metrics for grievances were nearly met for 2013 with only one case not being processed within the State-specified timeframe. Root cause analysis was conducted to determine the source of failure for this case; the problem was identified and corrective measures were put in place to ensure this situation will not occur in the future.

- Establishment of the process for investigation of quality of care concerns and peer review protocols for identified adverse events. Development of a process was initiated to track and trend results which will be reported to Credentialing Department.
- Member Connections Representatives conducted an average of 100 home and/or community visits per month.
- ConnectionsPlus cellular telephones were provided to 188 at risk members.
- Member Connections staff met with 149 new mothers in two Wichita hospitals during the first 9 weeks of 2014 to provide education related to well-child screenings.
- Case Management worked with 12,429 members in 2013.
- NurseWise responded to 16,995 calls from Sunflower members.
- Improved the grievance and appeals processes and collaborated with other Sunflower departments to improve workflow. Provided grievance and appeals training to new hires.
- Appeals staff completed AWD training.
- Participated in approximately twelve health fairs/community events.
- Established a solid network of providers. Sunflower's network contained 1,804 primary care providers in 556 locations at the start of the KanCare contract on January 1, 2013 and increased the number to 2,590 primary care providers at 747 locations by December 31, 2013.
- Partnered with Nurtur to provide disease management services for Sunflower members. Nurtur enrolled 1,732 members in their program in 2013 and reported conducting coaching session with 1,041 members.
- Developing and distributed member and provider newsletters.
- Exceeded performance metrics for the average speed of answer for member services (Goal is 30 seconds or less, actual was 9 seconds) and provider services (Goal is 30 seconds or less, actual was 8 seconds).
- The Sunflower Member Services/Provider Services call center provides education and referral services to members and providers. The call center received and responded to an average of 4,000 calls weekly regarding benefit inquiries, concerns, complaints, and request for arranging services.
- Since January 2013, the Marketing Department has reached approximately 114,000 persons through close to 300 events, conferences, and meetings.
- Obtained the immunization registry data from the State Immunization registry and merged it into the certified-HEDIS software.
- Met with KDHE representative regarding access to the KDHE supplemental lead screening data. Discussions are ongoing.

Opportunities for Improvements

- The Sunflower QI Department revised the work flows for some of the appeals and grievance processes. Additional opportunities for improvement have been identified regarding reporting.
- HEDIS rates are a focus of improvement; Sunflower continues to evaluate resources and opportunities for education and incentives to improve rates.
- Sunflower continues to work on P4P interventions for 2014. The baseline and targets have yet to be confirmed for all indicators.

- Sunflower continues to adjust to the needs of the I/DD population. Noted since February 1, 2014 is the increasing number of adverse incidents for this population. Sunflower staff have discussed this concern with the State and there is discussion of establish a mechanism for coordination among the three MCOs and involvement of the State's PERC Committee.
- Sunflower will partner with Televox, a call reminder vendor, for EPSDT reminder calls to allow Sunflower's EPSDT coordinator more time to work with providers and agencies in the community.
- Implement interventions to improve the result of the member and provider surveys.
- Develop State requested new interventions for the Collaborative diabetes performance improvement project, as the State believes the current interventions are too similar to what would occur upon implementation of Health Homes in July 2014.
- Continue to work with KDHE to obtain lead screening data to supplement HEDIS data.
- Continue to work with the other Kansas Medicaid MCOs on issues to improve care to Medicaid beneficiaries as necessary.

QUALITY PERFORMANCE MEASURES AND OUTCOMES

Performance Improvement Projects (PIPs)

17P

Sunflower adopted the use of 17P protocol to prevent premature deliveries. Sunflower's Start Smart for Baby program is initiated upon notification of pregnancy. Members identified as a "high risk" pregnancy are monitored for potential inclusion in the 17P protocol.

The performance goal is to increase the rate of 17P utilization by five (5) percentage points each year. The following reflects the numerator, denominator, and baseline rate.

Measurement Period	Numerator	Denominator	Rate	Goal	Goal Met?
1/1/2013 - 12/31/2013	20	62	32.3%	NA	Baseline

Diabetes Management

The state required all three Kansas Medicaid MCOs to participate in a collaborative diabetes performance improvement project (PIP). The MCOs meet with the state on a monthly basis to discuss issues related to the PIP. There has been much discussion related to the methodology and establishment of baselines and targets for improvement and all aspects of the project have yet to be finalized. One barrier common to all three MCOs is the lack of historical data since complete HEDIS data will not be available until June of 2014 which will be reflective of care provided in 2013. Currently, all that is available for Sunflower members are the administrative results which are based on claims data. Sunflower monitors this data each month following the updating of the certified-HEDIS software which contains the administrative data. The State did provide some claims history data (prior to 2013) to the three Medicaid MCOs.

Sunflower has tried various approaches to obtain information related to diabetic screening results that will only be available upon completion of the HEDIS medical record abstraction in June of 2014. In November, Sunflower attempted to contact all members covered by Medicaid behavioral health and disability waivers by phone to ask whether they had the following diabetic screening services in 2013 and if so, what their results were for the following:

- HbA1c testing.
- Retinal eye exam.
- LDL-C screening.
- Monitoring for nephropathy.

The results were analyzed and provided to the State, but the findings were viewed with caution since the data was self-reported and unable to be easily verified.

All three MCOs continue to utilize their member surveys for physical, Substance Use Disorder (SUD) and behavioral health; utilization and service penetration rates; and rates of critical incidents and complaints as ongoing sources of information for the PIP. Sunflower continues to work with the state and the other two MCOs to finalize the project and analytic plans as well as the interventions.

The following study indicators were selected for the PIP:

- Hemoglobin A1c testing.
- HbA1c control.
- Eye Exam (retinal) performed.
- LDL-C Screening.
- LDL-C control.
- BP Control.
- Medical Attention for Nephropathy.

Even though all aspects of the PIP have not been finalized with the state, Sunflower continues to intervene in an attempt to improve care, access to care and decrease the complication associated with diabetes. The following interventions were implemented during 2013:

- New members are encouraged to see their primary care providers on a regular basis.
- Healthy Reminder postcards are distributed to all diabetic members.
- Articles in both member and provider newsletters related to diabetes.
- Case management with referrals to Nurtur for high risk diabetics.
- Care gap reports available to providers through the web portal.
- Member Connections Representatives provide diabetic materials to diabetic members.
- Diabetes information available on the member website.
- Monitoring grievances related to access issues for diabetics.

In addition, considerations are being given to the following interventions.

- Automated reminders through the Televox vendor.

- Distributing hardcopy care gap reports to providers.
- Sending medication adherence reports to providers. The reports are generated by US Scripts each month showing members who are not refilling their medications on a regular basis.
- Involving the local pharmacist in the medication adherence intervention.

Initiation and Engagement for Alcohol and Other Drugs

Sunflower selected this PIP topic after meeting with the State and obtaining approval. The PIP is administered and monitored by Cenpatico, Sunflower's Behavioral Health affiliate, with oversight provided by Sunflower. Sunflower and Cenpatico provide monthly updates to the State regarding progress and barriers.

Initiation Phase – Member: Upon initiation of treatment, Sunflower begins care coordination to improve initiation of substance use disorder treatment. In follow-up, Sunflower sends each member a Welcome to Behavioral Health Services Information Packet. The packet contains references and information for members to access:

a. Transportation Assistance.
b. How to contact a mental health case manager/care coordinator.
c. Overview of behavioral health care coordination/disease management programs.
d. Substance Use Disorder (SUD) fact sheet.

In the event SUD is identified during an inpatient event, care coordination is triggered for the purpose of guiding the member towards engagement into treatment. This intervention is then documented in the clinical care management system, TruCare.

Engagement Phase – Member: At weeks two and three of member SUD treatment, the Sunflower care management teams conduct outreach and follow up calls with members in SUD treatment for members receiving Case Management services. The calls will be documented in the case management note section in TruCare. The calls are designed to:

a. Engage members in continued treatment.
b. Ensure members are scheduled for their continued SUD follow up services and schedule the service if needed.
c. Assess for treatment compliance barriers and identify resources for the members to improve access.

Initiation – Providers: Sunflower continuously provides technical assistance and training to its SUD providers. Sunflower distributes the Sunflower behavioral health provider newsletter biannually, which contains:

a. Names, contact numbers and overview of all Sunflower behavioral health/co-occurring programs.
b. Information to access transportation assistance.
c. Training for MCO/Provider staff on motivational interviewing is available for all Sunflower behavioral health providers through our E-learning module. Sunflower tracks provider participation in trainings completed through E-Learning, and is exploring additional provider incentives for their staff to participate in ongoing professional development.

Continuation – Providers:

a. Deliver member access and provider performance reports each quarter to all SUD providers.
b. Establish provider mental health access line that connects providers with Sunflower behavioral health clinicians for assistance with SUD screening and treatment referral.

The interventions identified above were selected to support member and provider education regarding available resources for improved access to SUD services; serve to support member engagement in the critical pathway measured by the HEDIS indicators; support member adherence to SUD treatment protocols; and support clinician adherence to best practices in SUD treatment.

Technical assistance and provider trainings are expanded as needed based on analysis of interim monitoring and annual measurement findings. All intervention data is collected at the point of delivery of the intervention; documented member outreach efforts are included in the Sunflower electronic care management system, TruCare. Intervention data is analyzed and presented in conjunction with interim monitoring study indicator data at the following frequencies: monthly, quarterly, and annually. Statistical testing for impact/correlation of effectiveness of interventions to the study indicators is conducted at least annually to support barrier analyses and identification of additional intervention opportunities. All interventions are culturally and linguistically appropriate.

The analysis was performed according to the data analysis plan. The results and findings present numerical data in a way that provides accurate, clear and easily understood information. The analysis identifies initial and repeated measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity. The analysis includes an interpretation of the extent to which the PIP was successful and follow-up activities.

NCQA Accreditation

Sunflower is actively seeking full NCQA accreditation from the National Committee for Quality Assurance (NCQA). The NCQA survey date is March 11, 2014 and the onsite audit is scheduled for April 28, 2014. In preparation for the audit, Sunflower has aligned all quality improvement processes to be consistent with NCQA standards.

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. In 2014, Sunflower will submit HEDIS data in accordance with the performance measure specifications and design and implement key interventions to increase the Plan's HEDIS rates reported each calendar year.

Sunflower has been collecting HEDIS data since plan implementation in January 2013 and loading the information into its certified-HEDIS software. Monthly data reports allow for ongoing monitoring of rate activity. While HEDIS is collected for all measures, Sunflower will focus interventions specifically on those identified by the State as pay for performance indicators in 2014. The following listing represents the 2014 pay for performance HEDIS measures:

- Comprehensive Diabetes Care
- Well Child Visits in First 15 Months of Life
- Annual Monitor of Members on Persistent Medications
- Follow-up After Hospitalization for Mental Illness
- Cholesterol Management
- Breast Cancer Screening
- Cervical Cancer Screening

Sunflower is tracking progress on these measures on a monthly basis. The determination as to whether the measures were met will not be able to be determined until the HEDIS 2015 results are available.

Patient Safety

Quality of Care and Adverse Events

Sunflower monitors the safety of its members by the identification of potential and/or actual quality of care (QOC) events and adverse incidents (AI). Sunflower's Quality Improvement Department monitors member and provider issues related to quality of care and adverse incidents on an ongoing basis. A QOC Severity Level table is used to classify issues into the four levels (Low, Medium, High and Critical) based on the potential or actual serious effects. These issues are tracked and trended for patterns and any applicable corrective action plans put into place when issues need further action. All cases are entered into a database and reviewed quarterly. Practitioners or providers with multiple potential quality of care issue referrals per quarter may be subject to additional review/investigation. Providers will be reported to the Credentialing Committee at the discretion of the Peer Review Committee. Reports are provided to the QIC and Credentialing departments for consideration at the time of re-credentialing.

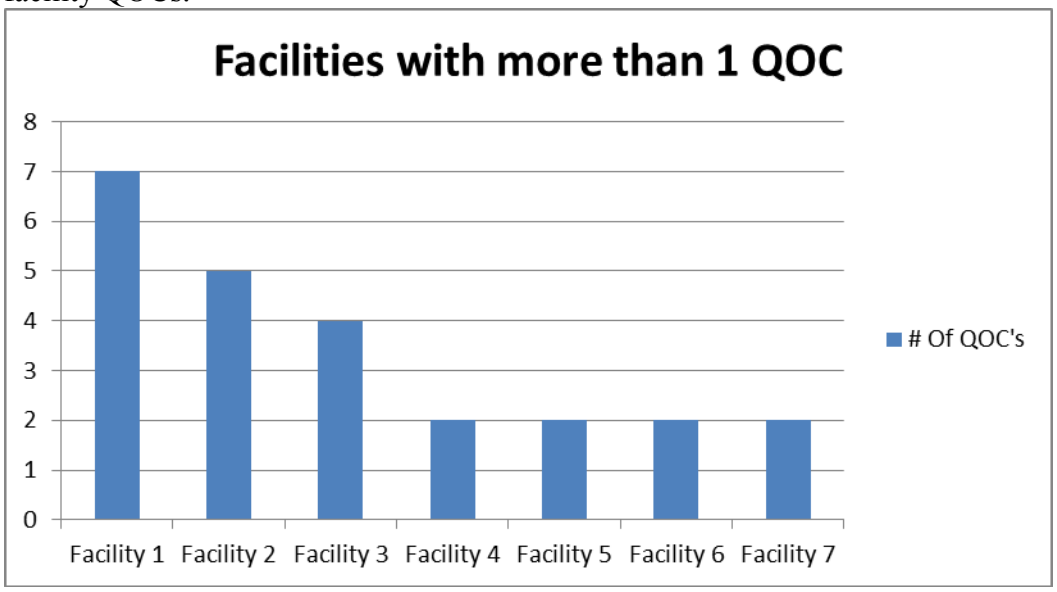
Potential quality of care issues are defined as any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care, or that signals a potential sentinel event.

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

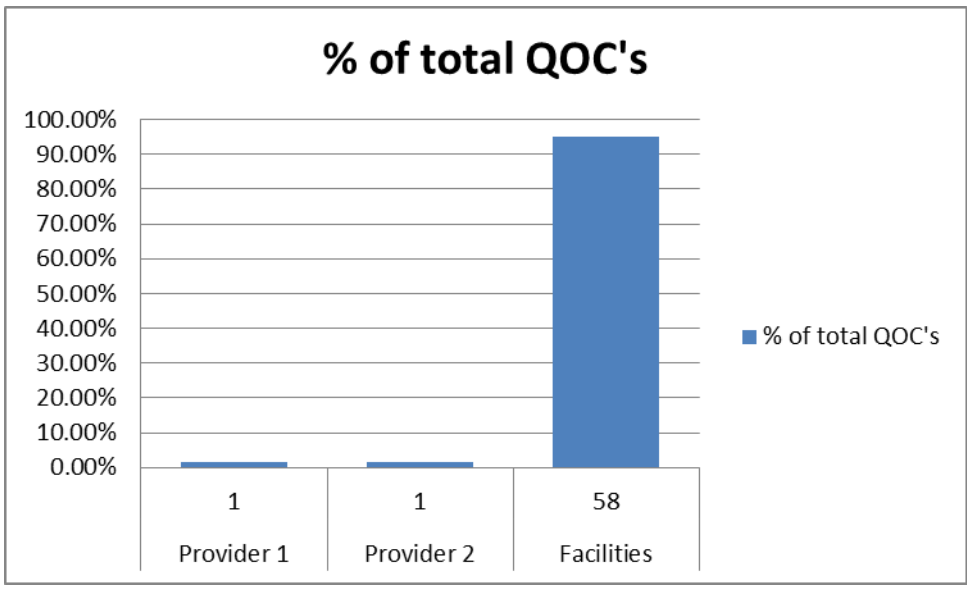
- Admit following outpatient surgery.
- Altercations requiring medical intervention.
- CMS Never Events.
- Decubitus Ulcers in LTC.
- Enrollee elopement/escape from facility.
- Enrollee Injury or Illness during BH Admission.
- Enrollee suicide attempt.
- Falls/Trauma.
- Fetal Demise.
- Hospital Acquired 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 table below reflects the 2013 confirmed quality of care (QOC) issues involving facilities with more than one issue. These facilities with multiple issues represent 41% of facility QOCs.



The table below reflects the total number of confirmed QOCs by facility (97%) and individual practitioner (3%).

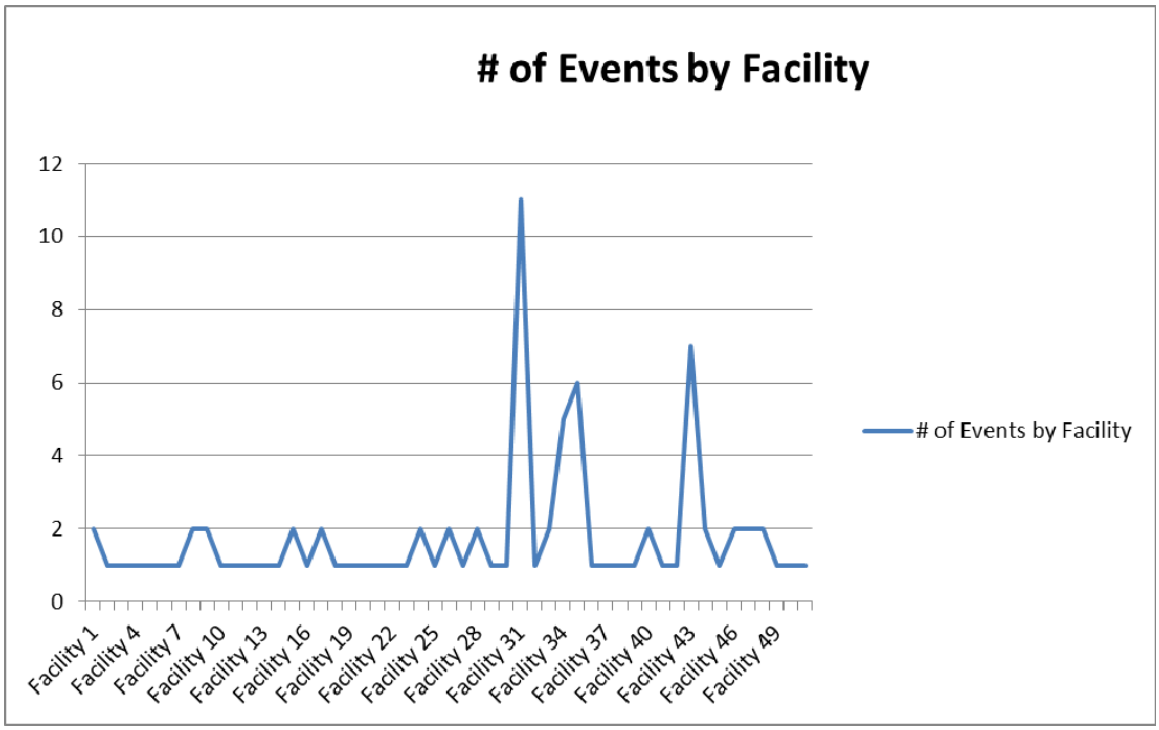


Adverse incidents are defined as an event over which health care personnel could exercise control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred.

Adverse Incidents include potentially serious events or outcomes, as defined:

1. Preventable death- Any death that occurs as a direct result of the actions (or lack thereof) of any CSP provider that can be reasonably confirmed by the providers or upon medical examination.
2. Physical abuse - Any allegation of intentionally or recklessly causing physical harm to a consumer by any other person, while receiving a CSP service.
3. Inappropriate sexual contact - Any allegation of intentional touching of a sexual nature, of any consumer, who does not give consent or is incapable of resisting or declining consent due to mental deficiency, or disease, or fear of retribution or hardship. In addition:
    a. Consumers receiving services in any KDADS CSP licensed or certified program who are under the age of 18 years of age cannot give consent
    b. Any allegation of intentional touching of a sexual nature, by a provider, towards a consumer is inappropriate sexual contact
4. Misuse of medications - The incorrect administration or mismanagement of medication, by someone providing a CSP service which result in or could result in serious injury or illness to a consumer.
5. Psychological abuse - A threat or menacing conduct directed toward an individual that result in or might reasonably be expected to cause emotional distress, mental distress or fear to an individual.
6. Neglect - The failure or omission by one's self, caretaker or another person with a duty to supply or to provide goods or services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.
7. Suicide - Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.
8. Suicide attempt - A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.
9. Serious injury – An unexpected occurrence involving the significant impairment of the physical condition of a consumer. Serious injury specifically includes loss of limb or function.
10. Elopement – The unplanned departure from an inpatient unit or facility where a consumer leaves without prior notification or permission or staff escort.
11. High profile event - Any situation which is likely to result in negative media coverage or involvement of the Kansas Legislators or complaints to the Governor's office.
12. Natural disaster – Any closure or evacuation of a facility due to fire, storm damage or mechanical system failure that may result in major expenditures or work stoppage or any significant event affecting consumers.

The table below reflects the 2013 confirmed adverse incident issues involving facilities. None of the incidences were attributable to individual providers.



Practice Guidelines

Sunflower adopted the following clinical and preventive health practice guidelines in 2013. Sunflower made providers aware of the guidelines and their expected use through the provider newsletters, inclusion in the provider manual, targeted mailings and on the Sunflower website. At the time of their adoption in July 2013 the below noted guidelines were the most current versions.

- ADHD.
- Adult Preventive.
- Atypical Antipsychotic use in patients with Schizophrenia.
- Asthma.
- Diabetes.
- CHF / Heart Failure.
- CAD.
- COPD.
- Hypertension.
- Hypertension in Children.
- Immunizations.
- Pediatric Preventive.
- Sickle Cell.
- Major Depressive Disorder.
- Substance Use Disorders.

All Clinical Practice Guidelines (CPGs) and Preventive Health Guidelines (PHGs) were reviewed and/or updated on schedule during 2013.

Recommended 2013 Interventions:

- Continue annual review of CPGs and PHGs, review and update as needed based on the policy and procedure requirements.
- 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 2013.

Sunflower maintains preventative care guidelines as a reference on the Sunflower web site and updates them annually or as the guidelines change. These guidelines include adult preventive, immunizations; lead screening, pediatric preventive and perinatal care. These guidelines are available in hard copy upon request.

Preventive Health Guidelines

In accordance with the Kansas Medicaid contract, Sunflower has adopted evidence-based preventive guidelines. These guidelines represent various aspects of Sunflower membership, and are based on utilization of services, prevalence of disease and the age segments of the overall membership represented. Preventive health guidelines performance is assessed using population-based HEDIS measures. The preventive health guidelines chosen for performance assessment were:

1. Adult preventive.
    - Chlamydia Screening.
    - Cervical Cancer Screening.
2. Child preventive.
    - Well-child check for the 3-6 year old.
    - Well-child check for the adolescent (age 12-21).
    - Lead Screening.

<u>Adult Preventive Health Guideline Performance Measurement</u>

Chlamydia Screenings: According to the 2011 NCQA State of Health Care Quality Report, chlamydia is the most common sexually transmitted disease reported in the United States. More than 1.4 million infections throughout the United States were reported to the CDC in 2011. Although chlamydia is known as a "silent" disease, causing no symptoms in 75% of infected women, it can cause extensive and irreversible damage to reproductive organs.

Chlamydia Screening Metrics

- Denominator: Women 16-24 years of age as of December 31st of the measurement year identified as sexually active.
- Numerator: The percentage of women 16-24 years of age identified as sexually active who had at least one screening for chlamydia in the measurement year.
- Data Source: Claims, encounter, and administrative data.

	HEDIS 2014*	NCQA Quality Compass Benchmark	Goal Met?
Chlamydia Screening	44.7% (1817/4065)	57.30%	No

*Rates not final; results complied by Centene Corporate – Data Source QSI as of 1/18/2014

Cervical Cancer Screenings: Cervical cancer is nearly 100% preventable, yet it is the second most common cancer among women worldwide. In the United States, approximately 12,000 women are diagnosed with cervical cancer each year, resulting in more than 4,000 deaths. Cervical cancer incidence and mortality rates have decreased 67% over the past three decades. Most of the reduction is attributed to the Pap test, which detects both cervical cancer and precancerous lesions.

Cervical Cancer Screenings Metrics

- Denominator: Women 21-64 years of age as of December 31st of the measurement year.
- Numerator: The percentage of women 24-64 years of age who received one or more Pap tests to screen for cervical cancer during the measurement year or two years prior to the measurement year. For the women who did not meet this requirement, women 35-64 who received a Pap test and a HPV test during the measurement year or four years prior to the measurement year.
- Data Source: Claims, encounter, and administrative data.

		NCQA Quality Compass Benchmark	Goal Met?
Cervical Cancer Screening	45.65% (5048/11059)	66.42%	No

*Rates not final; results complied by Centene Corporate – Data Source QSI as of 1/18/2014

Both the chlamydia and cervical screening rates fall short of the NCQA Quality Compass benchmark, not meeting Sunflower's goal of reaching the NCQA Quality Compass Benchmark 50th Percentile. Administrative data is not considered complete at this time due to claims lag, and the cervical cancer screening results for HEDIS 2014 require a hybrid review of practitioner medical records and medical record review is currently underway. The results for these measures will be final in June 2014 and re-evaluated against Sunflower's goal once available. An average of a 4.71 percentage point increase in cervical cancer screening rates was seen with hybrid data collection for HEDIS 2013, across all Centene Medicaid health plans.

Some of the barriers Sunflower identified are:

- Members not aware of the importance of preventive screenings.
- Practitioners may not be familiar with the Plan's Preventive Health Guidelines.
- Members may not have an established relationship with a PCP or OB/GYN.
- Members not aware of the importance of preventive screenings.
- Member lack of understanding for the need of routine Pap tests and chlamydia

screenings.
- Practitioners may not promote importance of women's health preventive screenings.
- Practitioners may be billing with incorrect CPT codes.

Some of the implemented or planned actions Sunflower identified to improve these rates:
- CentAccount program incentive, for adult members who complete an annual well visit.
- Distribute PHGs to practitioners via the Plan web site.
- Member welcome calls to assure all members have an assigned PCP and promote establishment of a relationship with a PCP.
- Publish article on the importance of preventive screenings in the member and provider newsletters.
- Inform providers of Sunflower's PHGs through the provider newsletter.
- Create or identify educational materials to promote women's health screenings.
- Publish article on HEDIS measures, including women's health screenings, in the provider newsletter.
- Create and disseminate HEDIS Quick Reference Guides to educate practitioners on measures, including women's health screenings, and correct billing codes.
- Develop Care Gap report made available to providers through the provider portal, related to gaps in care, including women's health screenings.

Child Preventive Health Guideline Performance Measurement

Well-Child Visits: Preventive health is a core feature of managed care. Wellness visits include preventative services such as vaccinations and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) components. Sunflower has established preventive health programs founded on evidence-based clinical practice guidelines and promotes healthy living and other strategies to reduce incidence of chronic medical conditions. Additionally, having a child's immunizations up-to-date has found to be highly effective in reducing vaccine-preventable disease.

Well-Child Metrics
- Denominator: Members 3-6 years of age as of December 31st of the measurement year.
- Numerator: The number of eligible members, age 3-6 years as of December 31st of the measurement year, who had at least one well-child visit with their provider during the measurement year.
- Data Source: Claims, encounters and administrative data.

		NCQA Quality Compass Benchmark 50th Percentile	Goal Met?
Well-Child Visits Age 3-6	65.04% (14374/22099)	72.26%	No

*Rates not final; results complied by Centene Corporate – Data Source QSI as of 1/18/2014

Adolescent Well Care: Adolescents are generally healthy, however adolescence is a time when significant health risk behaviors (e.g. drug use, unprotected sex, unhealthy eating patterns, physically dangerous behavior) become more common, especially among low-income adolescents. Many chronic health conditions may begin at this time as well (e.g. diabetes, mood disorders). Left unidentified and without appropriate management and intervention, health conditions are likely to become serious, and risk-taking behaviors are likely to persist into adulthood. It is estimated that 65% of adolescents receive no preventive health care.

Adolescent Metrics

- Denominator: Members age 12-21 years as of December 31 of the measurement year.
- Numerator: Members, age 12-21 years as of December 31 of the measurement year, who had at least one comprehensive well-care visit with a PCP/practitioner during the measurement year.
- Data Source: Claims, encounter, and administrative data.

		NCQA Quality Compass Benchmark 50th Percentile	Goal Met?
Adolescent Well Care	44.56% (11502/25812)	48.18%	No

*Rates not final; results complied by Centene Corporate – Data Source QSI as of 1/18/2014

Lead Screening in Children: Protecting children from exposure to lead is important to lifelong good health. Even low levels of lead in blood have been shown to affect IQ, ability to pay attention, and academic achievement, and effects of lead exposure cannot be corrected, thus prevention is critical.

Lead Screening Metrics

- Denominator: Members who turn 2 years old during the measurement year.
- Numerator: At least one lead capillary or venous blood test on or before the child's second birthday.
- Data Source: Claims, encounter, and administrative data.

		NCQA Quality Compass Benchmark 50th Percentile	Goal Met?
Lead Screening	33.95% (219/645)	72.26%	No

*Rates not final; results complied by Centene Corporate – Data Source QSI as of 1/18/2014

The Well-Child Visits Age 3-6, Adolescent Well Care, and the Lead Screening results fell short of the NCQA Quality Compass benchmark, not meeting Sunflower's goal of reaching the NCQA Quality Compass Benchmark 50th Percentile. Administrative data is not considered complete at this time due to claims lag. Results will be final in June 2014 and re-evaluated against Sunflower's goal once available. In addition, Sunflower has not

been successful in obtaining supplemental lead screening data from KDHE, thus Sunflower believes the rates reflect under-reporting.

Some of the barriers Sunflower identified are:

- Parents not aware of the importance of EPSDT/well-child preventive screenings, including screening for lead.
- Practitioners may not be familiar with the Plan's Preventive Health Guidelines.
- Members unaware of the availability of the CentAccount incentive for well-child/adolescent visits.
- Members unaware of covered benefits/recommendations (all the way up to age 21).
- Practitioners may not promote importance of well-child/adolescent preventive visits, including screening for lead.
- Members may not have an established relationship with a PCP or OB/GYN.
- Practitioners may be billing with incorrect CPT codes.
- Practitioners may not be aware of those members needing a well-child/adolescent visit and/or a lead screening.

Some of the implemented or planned actions Sunflower identified to improve these rates:

- CentAccount program incentive, for members who complete an annual well-child and adolescent well care visit.
- Distribute PHGs to practitioners via the Plan web site.
- Birthday postcards sent to all members turning 2-20 years old, reminding of the importance of scheduling a well-child/adolescent visit and of the CentAccount incentive for preventive visits.
- Publish article on the importance of scheduling an annual well-child/adolescent visit and lead screening in the member and provider newsletters.
- Inform providers of Sunflower's PHGs through the provider newsletter.
- Member welcome calls to assure all members have an assigned PCP and promote establishment of a relationship with a PCP.
- Create and disseminate HEDIS Quick Reference Guide to educate practitioners on measures, including well-child/adolescent visits and lead screening, and correct billing codes.
- Develop Care Gap report made available to providers through the provider portal, related to gaps in care, including well-child/adolescent visits and lead screening.

Healthcare Effectiveness Data Information Set (HEDIS®)

HEDIS is one of the most widely used data sets used in performance measurement in the United States. The measures include 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. Sunflower uses HEDIS criteria for all applicable clinical studies as part of the NCQA process. Preliminary reports are provided by Centene's corporate office for monthly review.

Member Satisfaction

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

- Member grievances.
- Member appeals.
- Member satisfaction surveys.

The Sunflower Grievance & Appeal Committee and Quality Improvement Committee review grievance and appeal data on a quarterly basis. Analysis performed by the Quality Improvement Committee, which is composed of departmental leaders and network physicians, enables Sunflower to initiate quality improvement efforts to improve member satisfaction as needed. The following is a summary of the results and analysis for January 1, 2013 through December 31, 2013.

The table below displays grievance data by category and represents all member grievances received. All grievances are reviewed and analyzed; no sampling is used.

Grievance Category	Jan. 1 – Dec. 31, 2013	Per 1000
Access to Care & Services	388	2.87
Billing & Financial	34	0.25
Quality of Care	26	0.19
Attitude/Service	110	0.81
Quality of Practitioner Office Site	0	NA
Benefit	13	0.09
Cultural/Linguistic	3	0.02
Total	574	4.25

The grievance category with the highest volume in 2013 was Access to Care & Services, representing 68% (388/574) of total grievances. Grievances related to Attitude/Service, which included grievances against both the health plan and Sunflower network providers, was the second highest category, at 19% 110/674) of all member grievances received in 2013. All other categories represented a minimal number of overall grievances, from 6% of grievances related to Billing & Financial issues, 5% related to Quality of Care, 2% related to Benefit issues, and <1% related to Cultural/Linguistic issues. Sunflower has established a goal for total grievances to remain less than 5.00/1000 members annually. With a rate of 4.25/1000 for all grievances, the goal was met for 2013. Despite meeting the goal, Sunflower conducted barrier analysis and continues to analyze grievance trends to identify ways to increase member satisfaction.

Sunflower assigns each grievance a sub-category code. A drill down analysis was performed on the two highest categories to understand the key issues driving these grievances. The two tables below display the results by sub-category for the two categories having the largest number of grievances.

Access to Care & Services Grievances

Access Sub-category	Jan. 1 – Dec. 31, 2013	Per 1000
Transportation	314	2.32
Pharmacy	22	0.16
Vendor issue (e.g. dental, vision)	14	0.10
PCP – Appointment Availability	6	0.04
Facility Services	5	0.03
After-hours access	5	0.03
Specialist – Appointment Availability	2	0.01
Provider Refused to Treat Member	2	0.01
Miscellaneous	18	0.13
Total	388	2.87

Attitude/Service Grievances

Attitude/Service Sub-category	Jan. 1 – Dec. 31, 2013	Per 1000
Attitude/Service (Provider): Rude/unprofessional provider or clinical staff	48	0.36
Attitude/Service (Provider): Rude/unprofessional office staff	19	0.14
Attitude/Service (Health Plan): Service/benefit limitations or exclusions	8	0.06
Attitude/Service (Health Plan): Case Management	8	0.06
Transportation Vendor	7	0.05
Attitude/Service (Provider): Excessive telephone wait time	3	0.02
Attitude/Service (Health Plan): Incorrect PCP assignment	2	0.01
Attitude/Service (Health Plan): Rude/unprofessional Plan staff	2	0.01
Attitude/Service (Health Plan): UM Process	2	0.01
Miscellaneous	11	0.08
Total	110	0.81

The most common grievance within the Access to Care & Services category was complaints related to transportation, comprising 81% (314/388) of the grievances in this category, and representing 56% (314/574) of grievances overall. Pharmacy complaints were the next most common grievance in the Access to Care & Services category, but

with a much lower volume than complaints regarding transportation (6% for pharmacy versus 81% for transportation).

The most common areas within the Attitude/Service category were related to Sunflower providers: "Rude/unprofessional provider or clinical staff" (44% or 48/110) and "Rude/unprofessional office staff" (17% or 19/110). Overall, all complaints regarding providers represented 70% of the Attitude/Service grievances, when including complaints against the transportation vendor.

Complaints regarding transportation are clearly the most significant issue impacting member satisfaction in looking at member grievance data. When including complaints against the transportation vendor from the Attitude/Service category, all complaints regarding transportation comprise 56% of total member grievances received in 2013.

Due to a significant number of complaints and issues with the original transportation vendor, Sunflower transitioned to a new vendor in April 2013. It was believed that the problems with the original vendor, and transition to another vendor when the health plan was still new following implementation in January 2013, was a substantial driver of member grievances related to transportation in 2013. However, as stated previously, since the change in transportation was made, the average number of transportation grievances per quarter decreased by 9%.

Sunflower has also determined that complaints related to transportation are a common member complaint in other Centene health plans that have a transportation benefit.

Member Appeals

Appeal Category	Jan. 1 – Dec. 31, 2013	Per 1000
Access	0	NA
Billing & Financial	5	0.04
Quality of Care	325	2.40
Attitude/Service	0	NA
Quality of Practitioner Office Site	0	NA
Other	6	0.04
Total	336	2.49

The appeal category with the highest volume of appeals is Quality of Care, which includes medical necessity appeals, the majority of the type of appeals Sunflower receives. Quality of Care/medical necessity appeals comprise 97% (325/336) of all appeals received in 2013. The only other categories of appeals received were those related to Billing & Financial issues and appeals included in an "Other" category, with both categories representing less than 2% of all appeals received. Sunflower has established a goal for total appeals to remain less than 2.50/1000 members annually. With a rate of 2.49 /1000 members for all appeals, the goal was met for 2013. Despite meeting the goal, Sunflower conducted barrier analysis and continues to analyze grievance trends to identify ways to increase member satisfaction.

Sunflower also assigns a sub-category to each appeal received. A drill down analysis was performed to understand the key issues driving appeals; analysis was completed for the Quality of Care category only as this category represents 97% of appeals.

The table below reflects the sub-categories for the Quality of Care category.

Quality of Care Sub-category	Jan. 1 – Dec. 31, 2013	Per 1000
Pharmacy	121	0.89
Criteria Not Met – Medical Procedure	77	0.57
Lack of Information from Provider	50	0.37
Criteria Not Met – Inpatient Admissions	34	0.25
Criteria Not Met – Durable Medical Equipment	26	0.19
Home & Community Based Services (HCBS)	12	0.09
Prior or Post Authorization	4	0.03
Sleep Studies	1	0.01
Level of Care Dispute	0	NA
Sterilization	0	NA
Total	325	2.40

The largest number of appeals within the Quality of Care category were appeals related to pharmacy, comprising 37% (121/325) of the appeals in this category, and representing 36% (121/336) of appeals overall. Appeals related to "Criteria Not Met – Medical Procedure" were the next most common appeal in the Quality of Care category, at 24% (77/325), followed by "Lack of Information from Provider" appeals at 15% (50/325). When looking at all appeals related to "Criteria Not Met" (i.e. for medical procedures, inpatient admissions and durable medical equipment), these sub-categories account for 42% (137/325) of Quality of Care appeals.

The high volume of pharmacy appeals is believed to be related to the transition to the KanCare program in January 2013. KanCare covers all Medicaid members including those on waivers such as I/DD, SED and LTC. These populations were "carved out" of previous Kansas Medicaid managed care contracts which were previously fee-for-service.

Similarly, the volume of appeals related to "Criteria Not Met" and "Lack of Information from Provider" are believed to be associated with the transition of member populations into managed care and providers and members not being familiar with Sunflower's medical necessity criteria and utilization management processes. Sunflower will focus on educating providers and members with the criteria and need for sufficient clinical information in order to process requests in a timely and appropriate manner.

Member Satisfaction Survey

Sunflower conducts member satisfaction surveys utilizing the Consumer Assessment of HealthCare Providers and Systems (CAHPS®) 5.0H Medicaid Adult and Child Member Satisfaction Surveys to evaluate and compare health plan ratings by members. An annual

survey of member satisfaction is required to comply with Sunflower's contract with the State of Kansas and to support Sunflower's efforts to obtain accreditation status with the National Committee for Quality Assurance (NCQA).

The population consists of:

- Child Survey - all members 17 years or younger.
- Adult Survey - all members 18 years or older.
- Members may not have a gap more than 1 month in coverage and must be enrolled for 5 of the last 6 months of the reporting timeframe.

For the Medicaid Adult survey, the sample size for CAHPS 2013 consisted of 1,350 members. The Medicaid Adult survey response rate for 2013 was 41.6%. The sample size for the 2013 Medicaid Child Survey (MCS) consisted of 1,650 members, The Medicaid Child response rate was 36.63%.

The tables below reflect Sunflower's results of the Adult and Child surveys compared to the 2013 Quality Compass All Plans means and percentiles.

	2013 Rate	2013 Quality Compass All Plans	2013 Quality Compass All Plans Percentile
Getting Needed Care	**84.2%**	**80.6%**	**75th**
• Ease of getting care, tests, or treatment needed	84.7%	82.5%	50th
• Obtaining appointment with specialist as soon as needed	83.8%	79.0%	75th
Getting Care Quickly	**84.5%**	**81.2%**	**75th**
• Obtaining needed care right away	86.4%	83.1%	75th
• Obtaining appointment for care as soon as needed	82.6%	79.3%	75th
How Well Doctors Communicate	**90.4%**	**89.3%**	**50th**
• Doctors explaining things in an understandable way	90.3%	89.5%	50th
• Doctors listening carefully to you	91.0%	89.9%	50th
• Doctors showing respect for what you had to say	92.2%	91.2%	50th
• Doctors spending enough time with you	88.2%	86.5%	50th
Customer Service	**79.1%**	**86.2%**	**<25th**
• Getting information/help from customer service	70.8%	79.8%	<25th
• Treated with courtesy and respect by customer service	87.4%	92.5%	<25th
Shared Decision Making	**51.1%**	**NA**	**Not available**
• Doctor/health provider talked about reasons you might want to take a medicine	47.1%	NA	Not available
• Doctor/health provider talked about reasons you might not want to take a medicine	27.4%	NA	Not available

	2013 Rate	2013 Quality Compass All Plans	2013 Quality Compass All Plans Percentile
• Doctor/health provider asked you what you thought was best when talking about starting or stopping a prescription medicine	78.8%	NA	Not available
• **Health Promotion and Education**	67.7%	NA	Not available
• **Coordination of Care**	87.7%	78.7%	90th
• **Providing Needed Information**	60.8%	66.6%	<25th
• **Ease of Filling Out Forms**	92.5%	94.5%	<25th
Ratings Items			
Rating of Health Care	71.6%	70.8%	50th
Rating of Personal Doctor	79.5%	78.4%	50th
Rating of Specialist	79.2%	79.4%	25th
Rating of Health Plan	67.6%	73.5%	<25th

	2013 Rate	2012 Quality Compass All Plans	2012 Quality Compass All Plans Percentile
Getting Needed Care	**79.8%**	**79.3%**	**50th**
• Ease of getting care, tests, or treatment child needed	90.0%	82.9%	75th
• Obtaining child's appointment with specialist as soon as needed	69.5%	75.7%	<25th
Getting Care Quickly	**90.1%**	**87.3%**	**50th**
• Obtaining needed care right away	91.1%	90.3%	25th
• Obtaining appointment for care as soon as needed	89.0%	84.2%	75th
How Well Doctors Communicate	**93.9%**	**91.8%**	**75th**
• Doctors explaining things in an understandable way	92.9%	92.5%	25th
• Doctors listening carefully to you	94.7%	93.5%	50th
• Doctors showing respect for what you had to say	95.0%	94.7%	50th
• Doctors spending enough time with your child	92.9%	86.4%	90th
Customer Service	**86.8%**	**83.0%**	**75th**
• Getting information/help from customer service	79.3%	76.9%	50th
• Treated with courtesy and respect by customer service staff	94.2%	88.9%	90th
Shared Decision Making	**52.1%**	**NA**	**NA**

	2013 Rate	2012 Quality Compass All Plans	2012 Quality Compass All Plans Percentile
• Doctor/health provider talked about reasons you might want your child to take a medicine	56.3%	NA	NA
• Doctor/health provider talked about reasons you might not want your child to take a medicine	23.8%	NA	NA
• Doctor/health provider asked you what you thought was best for your child when starting or stopping a prescription medicine	76.2%	NA	NA
• **Health Promotion and Education**	67.7%	NA	NA
• **Coordination of Care**	75.7%	79.6%	<25th
• **Ease of Filling Out Forms**	94.2%	95.8%	<25th
Rating Items			
Rating of Health Care	84.9%	83.0%	50th
Rating of Personal Doctor	87.1%	86.4%	50th
Rating of Specialist seen most often	78.7%	82.4%	25th
Rating of Health Plan	80.7%	83.7%	<25th

Sunflower's KanCare contract was implemented on January 1, 2013. Sunflower's goal for the first year of the contract was to meet or exceed the NCQA Quality Compass 50th percentile for both the Adult and Child surveys. New goals will be determined for 2014 CAHPS. Sunflower met the goal for most areas on the 2013 Adult and on the Child surveys. The areas not meeting Sunflower's goal of meeting the 50th percentile or above are the areas Sunflower is focusing improvement efforts on.

Some composites impact the members' responses to the rating questions more than others and are considered Key Drivers. Key Drivers are determined using multiple linear regression analyses on the results.

The analysis of key drivers allowed Sunflower to drive actions based on plan strengths (summary rates at or above 75th percentile), opportunities (summary rates below 50th percentile) and areas to monitor (summary rates between 50th and 75th percentile). The tables below reflect the Key Drivers, percentile rankings and recommendations for action.

	2013 Percentile Ranking	2013 Opportunity Analysis
Customer Service	<10th	Opportunity
Key Driver of Health Care Rating		
Customer Service	<10th	Opportunity

	2013 Percentile Ranking	2013 Opportunity Analysis
Customer Service	41st	Opportunity
Getting Needed Care	10th	Opportunity
Key Driver of Health Care Rating		
How Well Doctors Communicate	59th	Monitor
Getting Needed Care	10th	Opportunity
Key Driver of Personal Doctor Rating		
How Well Doctors Communicate	59th	Monitor
Coordination of Care	14rd	Opportunity

To identify opportunities to improve performance, Sunflower examined all sources of member satisfaction data to identify common issues across the various data sources. The grievance and appeal data and CAHPS survey results, including the key driver analysis, were reviewed by representatives from key Sunflower departments. The Sunflower workgroup met and discussed barriers, opportunities to address these barriers to increase member satisfaction, and potential interventions.

The table below reflects the barriers identified, the opportunities for improvement, and whether the intervention was targeted for implementation.

Barrier	Opportunity	Selected for Improvement?
Member Services staff have limited experience and proficiency.	Ongoing training of Member Services Representatives.	Y
Members unaware of access standards, i.e. typical timeframe for obtaining appointments.	Member education regarding access standards.	Y
Providers unaware of the contractual requirements regarding accessibility of appointments.	Provider education regarding access standards. Enhance the provider orientation experience.	Y
Limited number of child specialists available in some geographic areas.	Determine specific geographic areas regarding practitioner network gaps and increase recruiting efforts in these areas for identified specialists.	Y
Members unaware of covered services, including covered medications, and the UM/prior authorization process.	Member education regarding covered services and UM requirements	Y

Providers unaware of prior authorization requirements and need for adequate clinical information/medical records to determine medical necessity of services requiring authorization.	Provider education regarding covered services, prior authorization requirements and the utilization management process. Enhance the provider orientation experience.	Y Y
Members unaware of support the health plan can provide in communication with their provider and with providing health information.	Member education and outreach regarding the availability of assistance from health plan staff, including care coordination and case management services.	Y
Pharmacy edits and prior authorization requirements first put into place in April 2013; members and providers unaware of the formulary and authorization processes.	Member and provider education regarding the formulary and prior authorization requirements.	Y
Members and providers unfamiliar with the process for transportation; transition to new vendor in April 2013 caused additional confusion.	Member and provider education regarding transportation benefits.	Y

Access & Availability

Member Services Call statistics

Sunflower monitored customer telephone access in 2013 to assure members can access assistance from the health plan when needed. The table below reflects the goals and metrics used to measure them.

Goals for Performance Metrics	
Average Speed of Answer	**Abandonment Rate**
80% within 30 seconds or less	Less than 4%

The table below reflects the results of the call metrics for 2013.

Month	Calls Volume	Average Speed of Answer	Abandonment %
Jan-2013	15023	:00:22	1.87
Feb-2013	25554	:00:11	0.95
Mar-2013	23012	:00:08	0.69
Apr-2013	25310	:00:07	0.86

May-2013	19353	:00:06	0.59
Jun-2013	16623	:00:08	0.98
Jul-2013	17584	:00:09	1.26
Aug-2013	18877	:00:09	0.77
Sep-2013	17270	:00:07	0.8
Oct-2013	19012	:00:10	1.1
Nov-2013	16140	:00:11	1.13
Dec-2013	15526	:00:11	1.17

The Member Services Department consistently met Sunflower's performance goals in 2013. As all results met the performance goals, there are no opportunities to improve Sunflower's telephone access at this time. Sunflower will continue monitoring telephone access on a monthly basis.

Member's Rights and Responsibilities are given to the member on enrollment by the State and also upon enrollment with Sunflower in the Member Handbook. The handbook provides a description of both the Case Management and Disease Management programs, the types of diseases they manage and the telephone number to obtain more specific information.

Accessibility of Primary Care Services

Sunflower State Health Plan (Sunflower) monitors primary care provider appointment accessibility against its standards, identifies opportunities for improvement and initiates actions as needed to improve results. Sunflower incorporates data and results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys, practitioner office surveys, member complaints/grievances, and 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. Access to behavioral healthcare practitioner and behavioral healthcare telephone access is monitored on a regular basis and actions are initiated when needed to improve performance by Cenpatico, Sunflower's NCQA-accredited behavioral healthcare vendor.

CAHPS Survey

Sunflower monitors practitioner appointment accessibility through analysis of relevant CAHPS® survey question results. Sunflower reviews results from CAHPS Question 4 "Obtaining needed care right away" and Question 6 "Obtaining care when needed, not when needed right away" in both the Adult and Child Medicaid surveys. Survey responses reported reflect the percent of members who report "Always" or "Usually" to the survey questions.

Practitioner Office Survey

Sunflower conducted a web-based survey of appointment access, per the standards required by Sunflower's contract with the state of Kansas. Primary care and OB/GYN

provider offices were identified by determining those office sites with a large number of members assigned to that practice, and emailed an electronic survey.

After-hours Care
Access to after-hours care was assessed per the web-based survey noted above, and through calls placed directly to practitioner offices after business hours by Sunflower staff. Provider offices were then called after regular business hours by Sunflower staff to verify their responses regarding after-hours coverage and the results documented.

Member Grievances
Sunflower incorporates member complaints/grievances related to accessibility of appointments into the review and analysis of primary care access.

The table below displays the standards, performance goal, measurement methods and measurement frequency for each area of accessibility.

Accessibility Type	Standard and Performance Goal	Measurement Method	Measurement Frequency
Primary care: Routine, Non-Symptomatic	90% within 21 calendar days of request	Web Survey	Annually
Primary care: Urgent, Symptomatic	90% within 48 hours of request	Web Survey	Annually
Primary care: Emergent	90% within 24 hours of request	Web Survey	Annually
OB: First Trimester	90% within 14 calendar days of request	Web Survey	Annually
OB: Second Trimester	90% within 7 calendar days of request	Web Survey	Annually
OB: Third Trimester	90% within 3 calendar days of request	Web Survey	Annually
OB: High Risk Pregnancy	90% within 3 calendar days of request	Web Survey	Annually
Wait Time in Office	Patients seen in less than 45 min. of appointment time	Web Survey	Annually
After-hours Care	90% have acceptable after-hours coverage	Web Survey & Telephonic	Annually
Q4 Adult Survey: Percent of members who responded always or usually to "Obtaining needed care right away"	83.3% (2013 Quality Compass 50th percentile)	CAHPS Survey	Annually
Q6 Adult Survey: Percent of members who responded always or usually to "Obtaining	79.7% (2013 Quality Compass 50th percentile)	CAHPS Survey	Annually

Accessibility Type	Standard and Performance Goal	Measurement Method	Measurement Frequency
appointment for care as soon as needed"			
Q4 Child Survey: Percent of members who responded always or usually to "Child obtaining needed care right away"	91.8% (2013 Quality Compass 50th percentile)	CAHPS Survey	Annually
Q6 Child Survey: Percent of members who responded always or usually to "Child obtaining appointment for care as soon as needed"	84.8% (2013 Quality Compass 50th percentile)	CAHPS Survey	Annually
Member Grievances related to Appointment Access	< 5.0/1000 members	Grievance Database	Annually

The table below reflects whether the goals were met for the Adult CAHPS survey.

	2013 Rate	2013 Quality Compass 50th Percentile	Goal Met?
Getting Care Quickly	**84.5%**	**81.5%**	**Yes**
Q4: Obtaining needed care right away	86.4%	83.3%	Yes
Q6: Obtaining appointment for care as soon as needed	82.6%	79.7%	Yes

The table below reflects whether the goals were met for the Child CAHPS survey.

	2013 Rate	2013 Quality Compass 50th Percentile	Goal Met?
Getting Care Quickly	**90.1%**	**88.4%**	**Yes**
Q4: Obtaining needed care right away	91.1%	91.8%	No
Q6: Obtaining appointment for care as soon as needed	89.0%	84.8%	Yes

The table below reflects whether the appointment access goals were met**.**

Appointment Type	Goal	N	D	No Response	Rate	Goal Met?
Primary care: Routine, Non-Symptomatic	90% within 21 calendar days of request	150	246	86	70%	No
Primary care: Urgent, Symptomatic	90% within 48 hours of request	157	246	88	63.8%	No
Primary care: Emergent	90% within 24 hours of request	148	246	96	60.16%	No
OB: First Trimester	90% within 14 calendar days of request	40	52	9	76.9%	No
OB: Second Trimester	90% within 7 calendar days of request	31	52	11	56.6%	No
OB: Third Trimester	90% within 3 calendar days of request	22	52	12	42.3%	No
OB: High Risk Pregnancy	90% within 3 calendar days of request	26	52	19	50%	No
Wait Time in Office	Patients seen in less than 45 min. of appointment time	170	246	68	69.1%	No

The table below reflects whether the after-hours access goals were met.

After-hours Care	Goal	N	D	No Response	Rate	Goal Met?
After-hours Care (web survey)	90% have acceptable after-hours coverage	202	246	0	82.11%	No

The table below reflects the access sub-categories, the number of grievances for each category and the grievances per thousand for each sub-category.

Access Sub-category	Jan. 1 – Dec. 31, 2013	Per 1000
Transportation	314	2.32
Pharmacy	22	0.16
Vendor issue (e.g. dental, vision)	14	0.10
PCP – Appointment Availability	6	0.04
Facility Services	5	0.03
After-hours access	5	0.03
Specialist – Appointment Availability	2	0.01
Provider Refused to Treat Member	2	0.01
Miscellaneous	18	0.13
Total	388	2.87

Sunflower's goal for 2013 was to meet or exceed the NCQA Quality Compass 50th percentile. Sunflower met the goal for the relevant CAHPS questions on the 2013 Adult survey, and most areas on the Child survey. The rate of 91.1% for the question "Obtaining needed care right away" on the Child survey fell slight below the 50th percentile (91.8%).

The results of the appointment access web survey did not meet Sunflower's goal of at least 90% in each area, with rates by appointment type falling between a high of 79.6% and a low of 42.3%. A significant contributor to the low compliance rates is believed to be the high number of questions in which no response was provided by the office. 2013 was the first year of operations for Sunflower; therefore this was the first time an appointment accessibility survey was conducted. The intent of the web survey was to primarily satisfy state requirements, and a web-based survey was chosen as a means to reduce the burden on practitioner offices (versus Sunflower calling the office during business hours to conduct the survey). However, this method led to incomplete data since respondents were able to not respond to questions, even though all questions were applicable for every office (other than the OB questions not being applicable for primary care offices). Sunflower will re-evaluate the survey methodology for future surveys.

Offices which did not pass all elements of the survey will be re-educated onsite during an office visit conducted by the practitioner's Provider Relations Representative and will be re-surveyed at a later time. Practitioners who fail the second survey will be required to submit a written corrective action plan.

82.1% of offices responded positively to having a process for after-hours coverage, but not meeting Sunflower's goal of at least 90% of offices meeting the standard for adequate after-hours access. Follow-up calls were also made to verify the presence of adequate after-hours coverage; that data is still being analyzed.

Sunflower established a goal in 2013 for total grievances, and grievances per sub-category, to remain less than 5.00/1000 members annually. With a rate of 2.87/1000 for access to care grievances, the goal was met for 2013. Despite meeting the goal, Sunflower conducted barrier analysis and continues to analyze grievance trends to identify ways to increase member satisfaction. Each grievance was investigated and follow up was conducted in accordance with Sunflower policy. Sunflower will continue to monitor grievances as they relate to appointment access to ensure standards are met and member satisfaction increases with respect to access to care.

Practitioner availability is monitored by a collaborative workgroup including members of Provider Relations, Contracting, and Quality Improvement. The group identified barriers and opportunities for improvement:

The table below reflects the barriers identified, the opportunities for improvement, and whether the intervention was targeted for implementation.

Barrier	Opportunity	Selected for Improvement?
Provider lack of knowledge of the state contact appointment timeliness standards.	Re-educate at a network-wide level as well as with individual offices that did not pass all standards.	Yes
Provider lack of knowledge of member satisfaction survey results.	Educate providers on member satisfaction level with appointment access per CAHPS results.	Yes
Member lack of knowledge of appointment access standards.	Educate members on appointment accessibility standards.	Yes
Web-based survey allowed for offices to not provide responses to questions, leading to a high number of no responses and incomplete data.	Re-evaluate survey methodology for future surveys.	Yes

Network Access

Cultural and Linguistic Capabilities

Sunflower 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. The available data demonstrates that the current Spanish speaking capabilities among practitioners, together with the language assistance services available to members and the availability of Spanish speaking call center staff, adequately meets the cultural and linguistic needs of Sunflower's Spanish speaking members. There were no other significant cultural or linguistic needs identified for Sunflower residents, however, interpreter services and translation of written materials is available to any Sunflower member as needed.

Practitioner Availability

Practitioner availability monitoring is completed for primary care practitioners (PCPs), high volume specialty care practitioners, and high volume behavioral health practitioners. As noted above, Cenpatico, the Plan's behavioral health delegate, monitors and analyzes behavioral health practitioner availability on behalf of Sunflower State Health Plan.

The table below reflects the practitioner type, access standard, method of measurement and measurement frequency.

Practitioner Type	Standard	Measurement Method	Measurement Frequency
PCPs: All Types	95% of urban members have at least 1 PCP within 20 miles. 95% of rural members have at least 1 PCP within 30 miles. At least 1 PCP per 2000 members	GeoAccess GeoAccess Ratio of PCPs to members	Annually

The table below reflects the practitioner type, access standard, method of measurement and measurement frequency.

Practitioner Type	Standard	Measurement Method	Measurement Frequency
PCPs: Family Practitioners / General Practitioners	95% of urban members have at least 1 FP or GP within 20 miles 95% of rural members have at least 1 FP or GP within 30 miles. At least 1 FP or GP per 2000 members	GeoAccess GeoAccess Ratio of FPs or GPs to members	Annually
PCPs: Internal Medicine	95% of urban members ≥19 years have at least 1 internist within 20 miles 95% of rural members ≥19 years have at least 1internist within 30 miles. At least 1 internist per 2000 adult members	GeoAccess GeoAccess Ratio of internists to members	Annually
PCPs: Pediatrics	95% of urban members ≤18 years have at least 1 pediatrician within 20 miles 95% of rural members ≤18 years have at least 1 pediatrician within 30 miles. At least 1 pediatrician per 2000 members ≤18	GeoAccess GeoAccess Ratio of pediatricians to members	Annually
PCP Extenders: Nurse Practitioners	95% of urban members have at least 1 NP within 20 miles 95% of rural members have at least 1 NP within 30 miles. At least 1 NP per 2000 members	GeoAccess GeoAccess Ratio of NPs to members	Annually
PCP Extenders: Physician Assistants	95% of urban members have at least 1 PA within 20 miles 95% of rural members have at least 1 PA within 30 miles. At least 1 PA per 2000 members	GeoAccess GeoAccess Ratio of PAs to members	Annually
Obstetrics and Gynecology	95% of urban female members have at least 1 OB/GYN within 15 miles. 95% of rural female members have at least 1 OB/GYN within 60 miles. At least 1 OB/GYN per 2000 members	GeoAccess GeoAccess Ratio of OB/Gyn practitioners to members	Annually

The table below reflects the practitioner type, access standard, method of measurement and measurement frequency.

Practitioner Type	Standard	Measurement Method	Measurement Frequency
Cardiology	95% of urban members have at least 1 cardiologist within 25 miles. 95% of rural members have at least 1 cardiologist within 100 miles. At least 1 cardiologist per 5000 members	GeoAccess GeoAccess Ratio of cardiology practitioners to members	Annually
Orthopedics	95% of urban members have at least 1 orthopedist within 25 miles. 95% of rural members have at least 1 orthopedist within 100 miles. At least 1 orthopedist per 5000 members	GeoAccess GeoAccess Ratio of orthopedic practitioners to members	Annually
Otolaryngology	95% of urban members have at least 1 otolaryngology practitioner within 25 miles. 95% of rural members have at least 1 otolaryngology practitioner within 100 miles. At least 1 otolaryngology practitioner per 5000 members	GeoAccess GeoAccess Ratio of otolaryngology practitioners to members	Annually
Urology	95% of urban members have at least 1 urologist within 25 miles. 95% of rural members have at least 1 urologist within 100 miles. At least 1 urologist per 5000 members	GeoAccess GeoAccess Ratio of urology practitioners to members	Annually
Dermatology	95% of urban members have at least 1 dermatologist within 25 miles. 95% of rural members have at least 1 dermatologist within 100 miles. At least 1 dermatologist per 5000 members	GeoAccess GeoAccess Ratio of dermatology practitioners to members	Annually

The table below reflects whether the access standards were met for each provider type.

Practitioner Type	Standard	Results	Goal Met?

The table below reflects the practitioner type, access standard, method of measurement and measurement frequency.

Practitioner Type	Standard	Measurement Method	Measurement Frequency
PCPs: All Types	95% of urban members have at least 1 PCP within 20 miles.	100%	Yes
	95% of rural members have at least 1 PCP within 30 miles.	100%	Yes
	At least 1 PCP per 2000 members	1:54	Yes
PCPs: Family Practitioners / General Practitioners	95% of urban members have at least 1 FP or GP within 20 miles	100%	Yes
	95% of rural members have at least 1 FP or GP within 30 miles.	100%	Yes
	At least 1 FP or GP per 2000 members	1:128	Yes
PCPs: Internal Medicine	95% of urban members ≥19 have at least 1 internist within 20 miles	99.8%	Yes
	95% of rural members ≥19 have at least 1internist within 30 miles.	87.1%	**No**
	At least 1 IM per 2000 adult members	1:101	Yes
PCPs: Pediatrics	95% of urban members ≤18 years of age have at least 1 pediatrician within 20 miles	98.7%	Yes
	95% of rural members ≤18 years of age have at least 1 pediatrician within 30 miles.	75.1%	**No**
	At least 1 Pediatrician per 2000 members under age 19	1:360	Yes
PCP Extenders: Nurse Practitioners	95% of members have at least 1 NP within 20 miles	98.3%	Yes
	95% of rural members have at least 1 NP within 30 miles.	94.4%	**No**
	At least 1 NP per 2000 members	1:395	Yes
PCP Extenders: Physician Assistants	95% of members have at least 1 PA within 20 miles	99.9%	Yes
	95% of rural members have at least 1 PA within 30 miles.	95.4%	Yes
	At least 1 PA per 2000 members	1:508	Yes

The table below reflects the practitioner type, access standard, method of measurement and measurement frequency.

Practitioner Type	Standard	Measurement Method	Measurement Frequency
Obstetrics and Gynecology	95% of urban female members have at least 1 OB/GYN within 15 miles.	98.4%	Yes
	95% of rural female members have at least 1 OB/GYN within 60 miles.	95.1%	Yes
	At least 1 OB/GYN per 2000 members	1:233	Yes
Cardiology	95% of urban members have at least 1 cardiologist within 25 miles.	96.9%	Yes
	95% of rural members have at least 1 cardiologist within 100 miles.	98.2%	Yes
	At least 1 cardiologist per 5000 members	1:499	Yes
Orthopedics	95% of urban members have at least 1 orthopedist within 25 miles.	99.9%	Yes
	95% of rural members have at least 1 orthopedist within 100 miles.	98.1%	Yes
	At least 1 orthopedist per 5000 members	1:744	Yes
Otolaryngology	95% of urban members have at least 1 otolaryngology practitioner within 25 miles.	99.8%	Yes
	95% of rural members have at least 1 otolaryngology practitioner within 100 miles.	98.6%	Yes
	At least 1 otolaryngology practitioner per 5000 members	1:1697	Yes
Urology	95% of urban members have at least 1 urologist within 25 miles.	97.9%	Yes
	95% of rural members have at least 1 urologist within 100 miles.	98.1%	Yes
	At least 1 urologist per 5000 members	1:1784	
Dermatology	95% of urban members have at least 1 dermatologist within 25 miles.	84.8%	No
	95% of rural members have at least 1 dermatologist within 100 miles.	87.8%	No
	At least 1 dermatologist per 5000 members	1:4489	Yes

Geographic analysis entails comparing results to the standards for primary care for members residing in urban areas (95% of members having at least 1 PCP within 20 miles) and rural areas (95% of members have at least 1 PCP within 30 miles). Availability for all PCP types combined and by specific type, i.e. family/general practitioners, pediatricians, and internists, met Sunflower's standards for members residing in urban areas. Two standards were not met for Sunflower members residing in rural areas: PCP access for internists at 87.1%, and access to pediatricians at 75.1%. Sunflower also measures availability for PCP-Extenders, i.e. Nurse Practitioners and Physician Assistants, which both met the standards for urban members. Availability of Nurse Practitioners for members residing in rural areas did not meet the standard, falling slightly below the standard at 94.4%.

All PCP types exceeded the numeric/ratio standards established by the Sunflower: 1:2000 for all types of PCPs.

Sunflower's rural standards include both rural areas and "frontier" areas. Much of the state of Kansas is considered rural or frontier. Definitions of "frontier" vary; estimates based on the definition of frontier as counties having a population density of six or fewer people per square mile show that approximately three-fourths of the state is considered frontier. Per the US Department of Agriculture, the term "frontier and remote" describes territory characterized by a combination of low population size and a high degree of geographic remoteness, and are defined in relation to the time it takes to travel by car to the edges of nearby Urban Areas (UAs). Based on this definition, over 58% of the Kansas population is considered living in "frontier and remote" areas. The large percentage of the state is considered as rural or frontier/remote creates a challenge for the availability of healthcare services. Many of these counties in Kansas are considered Medically Underserved Area (MUA) or a Health Professional Shortage Area (HPSA) by the U.S. Department of Health and Human Services (DHHS).

In many rural areas in Kansas, hospitals are considered "critical access" and provide a variety of healthcare services, including primary care. Many rural hospitals have Rural Health Clinics (RHCs), Federally Qualified Healthcare Clinics (FQHCs) or health departments located in or near the acute care hospital that provide services to the entire county, and often to several surrounding counties as well. These arrangements, unique to rural and frontier/remote areas, may not accurately reflect the availability of primary care services through GeoAccess reporting. Sunflower believes that despite not meeting the geographic standards for internists and pediatricians per GeoAccess reporting, members in rural and frontier areas of the state do have adequate access to primary care when considering the overall availability of all PCPs, including PCP-Extenders and known primary care services available through hospitals, as Sunflower is contracted with all available hospitals in the rural and frontier areas.

Sunflower's standards for OB/GYN practitioners are that 95% of female members have access to at least one (1) OB/GYN within 15 miles for urban areas and within 60 miles for rural areas. The standard for all other high-volume specialty care providers are that 95% of members have access to at least one (1) specialist within

25 miles for urban areas and within 100 miles for rural areas. The urban and rural standards were met for all specialty types other than Dermatology, which did not meet the standard for either urban members (results = 84.8%) or members residing in rural areas (results = 87.8%). Sunflower's first year of operations was 2013; initial contracting efforts focused on recruiting practitioners from the state Medicaid provider list and were successful. Sunflower has confirmed that many clinics located in rural and frontier areas have specialists, including dermatologists that come into the clinics on a monthly basis to see patients in those areas; as with primary care services, these types of arrangements may not be accurately represented in GeoAccess reports. Increased contracting efforts for dermatologists are planned for 2014.

All specialty practitioner types exceeded the ratio standards established by Sunflower: 1:2000 for OB/GYNs and 1:5,000 for other high-volume specialists.

In addition to the above results, Sunflower also monitors member grievances for access to care. Of the grievances received during the time period, none were documented for lack of availability of a PCP or dermatologist.

Practitioner availability is monitored by a collaborative workgroup including members of the Sunflower Provider Relations, Contracting, Member Services, and Quality Improvement departments. The workgroup brainstormed potential barriers and opportunities for improvement related to practitioner availability.

Continuity and Coordination of Care between Medical and Behavioral Healthcare
Cenpatico is the delegated behavioral health service vendor for Sunflower. Cenpatico supports Sunflower in meeting the NCQA standard for managed care organizations. . The areas assessed for collaboration between medical and behavioral health care include:

- Exchange of information between behavioral health care and primary care practitioners (PCPs) 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 psychopharmacological medications;
- Screening and the management of patients with coexisting disorders; and
- Implementation of a primary or secondary behavioral health program.

The table below reflects the results of the assessment.

2013 NCQA Health Plan Standards and Guidelines QI 11 Element A Monitoring and Evaluation Plan			
Specific Area Monitored	**Description of Monitor**	**Frequency**	**Time Period Monitored**
Exchange of Information	Communication of discharge assessment to the assigned primary care practitioner (PCP) and assigned behavioral health	Annually	January-December 2013

2013 NCQA Health Plan Standards and Guidelines QI 11 Element A Monitoring and Evaluation Plan			
Specific Area Monitored	**Description of Monitor**	**Frequency**	**Time Period Monitored**
	providers for members who are discharged from an inpatient facility for a behavioral health admission. Rate of practitioner satisfaction with behavioral health practitioner communication as reported through the annual provider satisfaction survey.	Annually	January - August 2013
Appropriate Diagnosis, Treatment and Referral and **Appropriate Use of Psychopharmacological Medications**	The percentage of members 18 years of age or older diagnosed with a new episode of major depression and treated with antidepressant medication(s) who remained on antidepressant medication treatment. Two rates monitored: Acute Phase and Continuation Phase. The percentage of children newly prescribed Attention Deficit Hyperactivity Disorder (ADHD) medication with at least 3 follow-up care visits within a 10-month period, one of which is within 30 days of when the ADHD medication was first dispensed.	Annually Annually	January-December 2013 Pending Data
Screening and Management of Coexisting Disorders	Percent of post-partum women scoring moderate or high on the Edinburgh Depression Screening tool, with a claim for a behavioral health care service within 6 weeks of survey return.	Annually	January - December 2013
Preventive Behavioral Program	Screening and referral of pregnant women scoring moderate or high on the Edinburg Depression Screening tool.	Annually	January - December 2013

Cenpatico completes a discharge assessment for each member upon discharge from an inpatient level of care. Discharge summaries containing protected health information related to HIV/AIDS or substance abuse treatment are not eligible for re-disclosure unless

the member consents to release information obtained by Cenpatico. PCPs are contacted telephonically prior to faxing the discharge assessment, to assure the PCP information is correct and to obtain agreement to accept the information. The table below captures the results of this monitoring.

Cenpatico Communication with Sunflower PCP January 1, 2013 thru December 31, 2013 Goal: 65%	
Total Discharge Assessments	3214
Assessments with substance abuse documentation	450
Assessments with HIV/AIDS documentation	68
PCP Unknown	118
PCP Declined	625
Total Eligible Discharge Assessments	1953
Total Discharge Assessments faxed	617
% of Discharge Assessments faxed	32%
% of Discharge Assessments excluded	39%

Cenpatico faxed 32% of eligible discharge assessments to the PCPs assigned to members discharged from a behavioral health inpatient event. As this is the baseline year for this performance activity, no historical data is available for comparison. The majority of faxes were not sent due to PCP refusal in 2013. This category comprised close to 20% of the eligible faxes. Cenpatico did not meet its goal of at least 65% of eligible discharge assessments faxed to members' PCPs.

Performance in 2013 indicates areas for improvement. Cenpatico and Sunflower began management of physical and behavioral health services in January, 2013. Onboarding of new clinical staff and changes in clinical management within the Kansas market increased the variability in staff consistently following the established discharge assessment protocol. In order to improve the rate of discharge assessments which are faxed to PCPs and behavioral health providers, training all new and existing staff on the expanded case management assessments was conducted to include a comprehensive medical history assessment. Additionally, Cenpatico's clinical supervisors audited each clinical team member's documentation to provide feedback and coaching on improved coordination of care. The Cenpatico QI department will commence monthly audits of the Cenpatico clinical staff to ensure consistent and reliable application of the discharge assessment/care coordination protocol. To address the issue of lack of PCP identification, the audits and training will continue to focus on comprehensive collection of medical histories and member demographics to ensure members' PCPs are identified and documented. In addition, Cenpatico will continue to provide resources and trainings to its providers related to motivational interviewing and member engagement to improve PCP communication rate and improve continuity and coordination of care. Sunflower also wants to promote that members establish a medical home and receive preventive care. This should increase the amount of PCP's that recognize the member and accept receipt of the behavioral health information.

Provider Satisfaction Survey

This is the first Provider Satisfaction Survey conducted for Sunflower. The transition of most behavioral health within the Medicaid market was carved out by the state prior to the change in structure that coincided with the implementation of Sunflower. Also, the management of all of the waiver population by the health plans began in 2013. These members have severe mental, physical and/or developmental disabilities and can be perceived by both behavioral and physical practitioners to be difficult to manage. The results of the survey are shared with Cenpatico.

The following tables reflect the results of the Provider Survey related to behavioral health providers.

Composite/Attribute	Sunflower Summary Rate Score	Responses by Category				
Q4E: Rate the timeliness of exchange of information/ communication/reports from the behavioral health providers.	**5.9%**	Excellent	Very Good	Good	Fair	Poor
		1	5	46	32	16
Q4F: How often do you receive verbal and/or written communication from behavioral health providers regarding your patients?	**21.4%**	Always	Usually	Some-times	Rarely	Never
		5	19	28	40	20

The following table reflects the results of the barrier analysis and the interventions selected for implementation.

Root Cause/ Barrier	Solution Description Action Step/ Intervention	Selected for Implementation (Yes, No)
Behavioral health clinicians do not know members' current PCPs	Cenpatico retrained its Utilization and Case Management teams to capture full demographic and medical histories in assessments to improve identification of members' PCPs. Cenpatico's QI auditors will audit the clinical documentation monthly.	Yes. All new and Existing staff trained in 2013. QI audits scheduled to begin in March, 2014 and will recur monthly.

Root Cause/ Barrier	Solution Description Action Step/ Intervention	Selected for Implementation (Yes, No)
Primary Care Physicians do not have a relationship with the member and refuse the information.	Cenpatico and Sunflower to encourage wellness and preventive care with the Primary Care Physician in order to establish a medical home. Encourage CentAccount incentive for preventive care in welcome calls and member outreach.	Yes, Member Newsletter (Fall/ Winter) 2014 Yes
Limited staff resources at behavioral health offices do not allow providers to forward information to members' PCPs.	Provide training and resources for providers regarding motivational interviewing and member engagement.	Yes; Cenpatico providers – Ongoing.
Lack of provider awareness of the importance of exchanging information with PCPs.	Cenpatico QI will develop a provider resource packet for all Cenpatico providers which will include the Cenpatico PCP communication form and community resource list for which can be provided to members.	Yes, Nov 2012. Distribution is ongoing

HEDIS Measure: Antidepressant Medication Management (AMM)
Sunflower and Cenpatico collaborated on this measure as practitioners from both primary health and behavioral health treat Sunflower members who have a diagnosis of Depressive Disorders and prescribe antidepressant medications. Sunflower collects and analyzes appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care through this HEDIS Measure.

Effective Acute Phase Treatment: The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks).

Effective Continuation Phase Treatment: The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days.

Sunflower HEDIS Rates: Antidepressant Medication Management (AMM) Goal: NCQA 75th Percentile: Effective Acute 56.05%- Effective Continuation 40.06%			
AMM Indicator	2013		
	Numerator	Denominator	Rate
Acute Phase	116	203	57.14%
Cont. Phase	76	203	37.44%

This data note above represents a HEDIS measure and the final results will not be available until June, 2014. The results are based on the administrative data through

January 18, 2014. It is expected for the results to increase slightly as additional claims are received.

HEDIS Measure: Attention Deficit Disorder Medication Management (ADD)
Sunflower and Cenpatico collaborated on this measure as practitioners from both primary healthcare and behavioral health treat Sunflower members who have a diagnosis of Attention Deficit Disorder (ADD). Sunflower collects and analyzes appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care through this HEDIS measure.

The ADD HEDIS measure has two indicators:
Initiation Phase: The percentage of members 6-12 years of age as of the index prescription start date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30 day Initiation Phase.

Continuation and Maintenance Phase: The percentage of members 6-12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, which remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ends.

Due to the enrollment requirements and length of the measure, the January QSI run indicates no members meet the requirements for the population in 2013. The plan will report this measure when data is available. Regardless of the lack of data, Coordinated Care has identified root causes and interventions to target compliance with both HEDIS measures. The table below reflects the results of the barrier analysis and the interventions selected for implementation.

Root Cause/ Barrier	**Solution Description Action Step/Intervention**	**Selected for Implementati (Yes, No)**
Members/families not following their medication treatment plans	Conduct clinical outreach calls to assess for medication compliance and treatment needs to members receiving treatment for Depressive Disorders.	Yes. Initiated December, 2013
Practitioners may not be familiar with Sunflower's Depression Practice Guidelines. Practitioners may not be aware of the Depression Toolkits that are available on the Sunflower Web Portal.	Sunflower to educate providers via the Provider Newsletter announcing the toolkits and providing information on how to obtain from the website. Propose joint webinar or educational outreach in 2014 to promote awareness and use of the toolkits and	Yes, January (Fall/Winter) 2014 TBD

Root Cause/ Barrier	Solution Description Action Step/Intervention	Selected for Implementati (Yes, No)
	resources available through Cenpatico.	
Members and families are not compliant with medication treatment plans.	Provide members and families with Depression Education Brochure at onset of diagnosis and throughout episode Depression treatment. Expand the number of members with co-morbidities in the Cenpatico Depression Disease Management program to provide members and families with self-management tools and action plans.	Yes. Initiated December, 2013 Yes. Initiated January, 2013. Ongoing.

Screening and Management of Coexisting Disorders/ Preventative Behavioral Program
Sunflower partners with Cenpatico to provide Perinatal Depression Screening Program which is a preventative behavioral health program. The Perinatal Depression Screening Program begins with Sunflower identifying all pregnant members and newly delivered members. Members identified in their prenatal period receive a Start Smart for Your Baby member mailing which allows for Sunflower and Cenpatico the opportunity to co-manage perinatal cases where a member may be experiencing depression along with their pregnancy. The program also identifies those who have delivered, which allows for a preventive screening program to assess for post-partum depression. Both the prenatal and the post-partum activities provide members with information regarding depression in pregnancy, an Edinburgh Depression Scale and a self-addressed stamped envelope for mailing the completed Edinburgh Depression Scale survey to Cenpatico. Practitioners are advised of the program through the Provider Newsletter, on the Cenpatico website and through the Provider Manual.

When surveys are returned to Cenpatico, they are scored as listed below:

- Low Risk - Score is less than 13 (1-12).
- Moderate Risk - Score is equal to or greater than 13, less than 20 (13-19).
- High Risk –Score is equal to or greater than 20 (20 – 30).

	# Sent	# Received	Return Rate	Low	Percent	Moderate	Percent	High	Percent
Pregnant	4662	129	2.8%	106	82.2%	20	15.5%	3	2.3%
Delivered	3055	64	2.1%	54	84.4%	5	7.8%	5	7.8%
Total	7717	193	2.5%	160	82.9%	25	13.0%	8	4.1%

As evidenced above, the response rates for both Prenatal and Post-Partum respondents are 2.8% and 2.1%, respectively, with a total response rate of 2.5%. This marks the baseline year for this activity and there is no historical data for comparison. However, the response rates for Sunflower members is commensurate with the response rates received from other Centene health plans working with Cenpatico on this preventative activity. While Sunflower and Cenpatico have not set a target response rate for this preventative activity, the data indicates barriers to receipt and completion of the depression surveys. Cenpatico identified the need to ensure that all high volume obstetricians and gynecologists have the survey to distribute directly to prenatal and post-partum members. Cenpatico ordered tablets of the surveys for distribution by Sunflower in order to ensure doctors and members have easy access to the survey. Sunflower's OB case managers also assist in engaging members in completion of the survey during case management outreach calls and other contact with members.

As noted in a position paper published in 2004 by The Commonwealth Fund titled *State Medicaid Policy for Reimbursement of Maternal Depression Screening,* women whose funding source is Medicaid have a higher incidence of depression. When a woman who has delivered experiences depression, she is more likely to experience difficulty with nurturing behaviors which translates to infants and children with an increased risk for problem behaviors. Children of woman with depression have more difficulty in achieving age-appropriate developmental and cognitive milestones. This program attempts to encourage the newly delivered woman to identify the signs and symptoms of depression and seek help for depression so that complications can be minimized. The purpose of this survey process is to identify members at moderate or high risk for depression and engage them in preventative care to avoid adverse outcomes for members and their newborn children.

To assess the impact of the perinatal depression screening process on moderate or high risk members, Sunflower and Cenpatico measured the number of member who accessed behavioral health care services in the 45 days following the completion of the survey. Cenpatico clinicians were able to successfully outreach to 29% of the members screened as moderate or high risk for depression. Cenpatico saw the most success in outreach attempts with newly delivered members, who responded to clinical engagement at a rate of 50%, as compared to a rate of 35% engagement for pregnant members. Of the members that engaged in outreach from a Cenpatico clinician, 100% of the members engaged in behavioral health services within 45 days of survey completion. Please note that the data below is inclusive of only the claims that are submitted to and paid by Cenpatico for behavioral health services and does not include those members receiving behavioral health medications only from their physical health providers.

	Number Moderate / High	**Number Successful Outreach**	**Rate Successful Outreach**	**Number with successful outreach and BH paid claim**	**Rate with successful outreach and BH paid claim**
Prenatal	23	8	35%	8	100%
Post-	10	5	50%	5	100%

partum					
Total	33	13	39%	13	100%

The table below reflects the results of the barrier analysis and the interventions selected for implementation.

Root Cause/ Barrier	**Solution Description Action Step/ Intervention**	**Selected for Implementatio (Yes, No)**
Low member response rate/low number of completed survey.	Sunflower care managers to work with members during post-partum contacts to complete the Edinburgh survey.	Yes, 2nd Quarter 2014
	Sunflower to educate PCPs and OB providers on the need to assess the pregnant member for depression during the prenatal and post-partum periods.	Yes
	Review member materials to determine if changes to the materials will result in a greater response rate.	Yes, Cenpatico
	Collaborate with Sunflower to provide an article in their Member newsletter describing the program and how staff can assist with accessing services.	Yes
Low number of screened members successfully engaged in behavioral health care coordination/clinical outreach activities.	Cenpatico care coordination staff will ensure at least three outreach attempts to members scored moderate/high within five days of receipt of the members' screening scores.	Yes – Ongoing
	Cenpatico care coordination staff will engage Cenpatico disease managers in outreach and engagement efforts to increase engagement in behavioral health services.	Yes - Ongoing

UTILIZATION MANAGEMENT PROGRAM

Purpose

The purpose of the Utilization Management (UM) Program Description is to define the structures and processes within the Medical Management Department, 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, using 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 Sub-Committee (UMSC), including the review and appropriate approval of medical necessity criteria and protocols and utilization management policies and procedures. The UMSC 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 QIC and UMSC. 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, quality indicators, prescribed by the Plan as part of the patient safety plan, are identified. The required information is documented on the appropriate form and forwarded 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 recredentialing process. Such information may relate, for example, to specific case management decisions, discharge planning, precertification of non-covered benefits, etc. The information is forwarded to the QI Department in the format prescribed by Sunflower for review and resolution as

needed. The Chief Medical Director or Medical Director determines if the information warrants additional review by the Plan Practitioner Affairs or Credentialing Committee. If committee review is not warranted, the information is filed in the practitioner's folder and is reviewed at time of the practitioner's re-credentialing.

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 that may be identified.

In addition, Plan coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

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

Case Management

Case management or coordination of care is a collaborative process of assessment, planning, coordinating, monitoring and evaluation of the services required to meet the members' individual needs. Case management serves as a means for achieving member wellness, recovery, and autonomy through advocacy, communication, education, identification of services resources and service facilitation. The goal of case management is provision of quality health care along a continuum, decreased fragmentation of care across settings, enhancement of the member's quality of life, and efficient utilization of patient care resources. Sunflower offers case management services for those with special healthcare needs including:

- Sickle cell.
- Multiple Sclerosis.
- Renal disease.
- Organ transplants.
- HIV/AIDS.
- Hemophilia.

Members with these conditions are assigned a case manager who is registered nurses or social worker. The case manager will develop a care plan for the member and work with the member and the member's doctor to obtain the necessary care for the member.

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. Sunflower offers disease management to those members with the following conditions:

- Asthma.
- Diabetes.
- High blood pressure.
- Cardiac conditions.
- Obesity.

Utilization Management Sub-Committee (UMSC)
Daily oversight and operating authority of utilization management activities is delegated to the UMSC, which reports to the Plan's QIC and ultimately to the Plan BOD. The UMSC is responsible for the review and appropriate approval of medical necessity criteria and protocols and utilization management policies and procedures. The UMSC coordinates annual review and revision of the UM Program Description, Work Plan, and the Annual UM Program Evaluation.

These documents are presented to the QIC for approval. The UMSC monitors and analyzes relevant data to detect and correct patterns of potential or actual inappropriate under- or overutilization, which may impact health care services, coordination of care and appropriate use of services and resources as well as member and practitioner satisfaction with the UM process. Analysis of the above tracking and monitoring processes, as well as status of corrective action plans, as applicable, are reported to the Plan's QIC.

In addition to the above, the UMSC also provides ongoing evaluation of the appropriateness and effectiveness of practitioner quality incentive payments and assists in modifying and designing an appropriate quality incentive program. This includes evaluating the performance of the Practitioners using pay for performance measures and the impact of the contracts on participating physicians to ensure the goal of providing sufficient incentives to ensure the provision of high quality, cost effective care.

<u>UM Sub-Committee Scope</u>

- Oversees the UM activities of Plan in regard to compliance with contractual requirements, federal and State statutes and regulations, and requirements of accrediting bodies such as NCQA and/or URAC
- Development and annual review/approval of the UM Program Description, guidelines, policies and procedures
- Reviews practitioner-specific UM reports to identify trends and/or utilization patterns and makes recommendations to the QIC for further review
- Reviews reports specific to facility and/or geographic areas for trends and/or patterns

- Examines appropriateness of care reports to identify trends and/or patterns of under- or over-utilization; refers identified practitioners to the QIC for performance improvement and/or corrective action
- Examines results of annual member and practitioner satisfaction surveys to determine overall satisfaction with the UM program and identify areas for performance improvement
- Provides a feedback mechanism to the QIC for communicating findings, recommendations, and a plan for implementing corrective actions related to UM issues
- Identifies those opportunities whereby the UM data can be utilized in the development of quality improvement activities and submitted to the QIC for recommendations
- Reports findings of UM studies and activities to the QIC
- Liaisons with the QIC for ongoing review of quality indicators

UM Sub-Committee Members

The Plan actively involves participating network practitioners in utilization review activities as available and to the extent that there is not a conflict of interest. The Plan's UM Program Description and policies define when such a conflict may exist and describe the remedy when conflicts occur. Participation in the Plan's UMSC is one of the primary ways in which network practitioners participate in Plan utilization review activities.

Plan's Utilization Management Sub-Committee is comprised of the following members:

- Network physicians (in the areas of Family Practice/Internal Medicine, OB-GYN, Pediatrics, and BH practitioners.
- Plan Medical Directors.
- Plan VPMM.
- Plan executive leadership and UM and QI staff as appropriate also attend but are nonvoting members of the committee.

Meeting Frequency and Documentation of Proceedings

The UMSC meets at least six (6) times per year and the VPMM maintains detailed records of all UMSC meeting minutes, UM activities, case management program statistics and recommendations for UM improvement activities made by the UMSC. The UMSC submits to the QIC all meeting minutes and written reports regarding all UM studies and activities.

The utilization management process encompasses the following program components: 24-hr nurse triage, referrals, second opinions, prior authorization, pre-certification, concurrent review, ambulatory review, retrospective review, discharge planning and care coordination. All approved services, both medical and behavioral, must be medically necessary. The clinical decision process begins when a request for authorization of service is received at the Plan level. Request types may include authorization of specialty services, HCBS services, second opinions, outpatient services, ancillary services, behavioral health services, scheduled inpatient services, or emergent/urgent inpatient services, including obstetrical deliveries. The process is complete when the requesting practitioner and member (when applicable) have been notified of the determination.

Medical Necessity Criteria

The goal in utilization management is to help guide best practice medicine in the most efficient and economical manner while addressing patient-specific needs. To that end, the clinical decision criteria utilized aligns the interests of the health plan, the practitioner, and the member. The UM criteria are nationally recognized, evidence-based standards of care and include input from recognized medical experts. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate. Utilization review criteria are utilized as an objective screening guide and are not intended to be a substitute for physician judgment. Utilization review decisions are made in accordance with currently accepted medical or behavioral health care practices, while taking into consideration the individual member needs and complications at the time of the request, in addition to the local delivery system available for care. The Medical Director reviews all potential medical necessity denials for medical appropriateness and is the only one with authority to implement an adverse determination which results in reduction, suspension, denial, or termination of services.

In general, the Plan uses McKesson's InterQual guidelines to determine medical necessity and appropriateness of physical and behavioral health care. InterQual is a recognized leader in development of clinical decision support tools, and is used by 3000 organizations and agencies to assist in managing health care for more than 100 million people. InterQual is developed by generalist and specialist physicians representing a national panel from academic as well as community based practice, both within and outside the managed care industry. InterQual provides a clear, consistent, evidence-based platform for care decisions that promote appropriate use of services, enhance quality, and improve health outcomes. The Plan will use InterQual's Level of Care and Care Planning Criteria for Pediatric Acute, Adult Acute, Home Care, Durable Medical Equipment and Procedures to determine medical necessity and appropriateness of care. The Plan may also use the Sub acute/Skilled Nursing guidelines to assist in determining medical necessity for sub-acute or skilled nursing care for members with catastrophic conditions or special health care needs. For determination of medical necessity and appropriateness of substance use services, the Plan will use the ASAM as contained in KCPC. For determination of the community based services for behavioral health, the Plan develops a medical necessity criteria based on the service description; this criteria is submitted and approved to the Provider Advisory Council.

Timeliness of Decision Making

Utilization management decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Established timelines are in place for practitioners to notify the plan of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner.

For all pre-scheduled services requiring prior authorization, the provider must notify the Plan within five (5) days prior to the requested service date. Prior authorization is never required for emergent or urgent care services. Facilities are required to notify the Plan of

all inpatient admissions and long-term care facility admissions within one (1) business day following the admission. Post-stabilization services delivered in the emergency department do not require authorization. Once the member's emergency medical condition is stabilized, certification for urgent or emergent hospital admission or authorization for follow-up care is required as stated above.

The Plan will make determinations for standard, non-urgent, pre-service prior authorization requests within 14 calendar days of receipt of the request. A determination for urgent preservice care (expedited prior authorization) will be issued within 72 hours of receiving the request for service. The Plan will make determination for urgent concurrent, expedited continued stay and/or post stabilization review within 24 hours of receipt of the request for services. A request made while a member is in the process of receiving care is considered to be an urgent concurrent request if the care requested meets the definition of urgent, even if the earlier care was not previously approved by the Plan. If the request does not meet the definition of urgent care, the request may be handled as a new request and decided within the time frame appropriate for the type of decision (i.e., preservice and postservice). Medical necessity of post service decisions (retrospective review) and subsequent member/practitioner notification will occur no later than 30 calendar days from receipt of request.

New Technology Assessment

In instances of determining benefit coverage and medical necessity of new and emerging technologies and the new application of existing technologies or application of technologies for which no InterQual Criteria exists, the Medical Director shall first consult Centene's available Medical Policy Statements. The Centene Clinical Policy Committee, with representation from Sunflower and Centene Health Plans, develops these statements. The Corporate Clinical Policy Committee (CPC) is responsible for evaluating new technologies or new applications of existing technologies for inclusion in the benefit plan. The CPC shall develop, disseminate and annually update medical policies related to: medical procedures, behavioral health procedures, pharmaceuticals and devices. The CPC or assigned designee shall review appropriate information to make the coverage decision including published scientific evidence, applicable government regulatory body information, CMS's National Coverage Decisions database/manual and input from relevant specialists and professionals who have expertise in the technology. Practitioners are notified in writing through the provider newsletters and the practitioner web portal of new technology determinations made by Sunflower. As with standard UM criteria, the treating practitioner may, at any time, request the medical policy criteria pertinent to a specific authorization by contacting the Medical Management Department or may discuss the UM decision with the Medical Director.

Inter-Rater Reliability

The purpose of inter-rater reliability is to evaluate the consistency with which utilization management (UM) staff involved in the UM process apply InterQual criteria in decision-making. Sunflower's goal is for 100% of Sunflower's UM staff to pass all applicable IRR tests with a score of 80% or higher. At least annually, the Sunflower State Medical Management Department will conduct IRR tests as distributed by the Corporate Medical

Management Department. Only 2 staff members did not reach a passing score; neither of those individuals is currently employed by Sunflower so no corrective action was needed.

The table below reflects the result of the inter-rater reliability testing.

Results by Staff Member				
Staff member	**Pass/Fail**	**Submitted**	**Score**	**Subsets Completed**
1	Passed	11/14/2013	100	1 Subsets Completed
2	Passed	11/12/2013	94	2 Subsets Completed
3	Passed	11/13/2013	86	5 Subsets Completed
4	Passed	11/14/2013	88	1 Subsets Completed
5	Passed	11/1/2013	88	2 Subsets Completed
6	Passed	11/7/2013	83	2 Subsets Completed
7	Passed	12/9/2013	87	1 Subsets Completed
8	Passed	11/13/2013	97	4 Subsets Completed
9	Passed	11/14/2013	100	1 Subsets Completed
10	Passed	12/14/2013	98	5 Subsets Completed
11	Passed	11/13/2013	93	5 Subsets Completed
12	Passed	11/13/2013	84	3 Subsets Completed
13	Passed	11/14/2013	100	1 Subsets Completed
14	Passed	11/13/2013	93	5 Subsets Completed
15	Passed	12/11/2013	89	8 Subsets Completed
16	Passed	11/13/2013	98	5 Subsets Completed
17	Passed	11/18/2013	94	2 Subsets Completed
18	Passed	12/9/2013	91	5 Subsets Completed
19	Failed	11/14/2013	71	1 Subsets Completed
20	Failed	11/27/2013	67	5 Subsets Completed
21	Passed	12/4/2013	100	1 Subsets Completed

Case Management Survey

Sunflower monitors member satisfaction with case management programs by obtaining feedback from members enrolled in case management and by qualitatively and quantitatively analyzing member complaints about case management.

The results are stratified by individual survey question in the table below.

Question	**% of members responding as "very satisfied" or "somewhat satisfied"**	**Goal Met?**
1. How satisfied are you with the help you received from your Case Manager?	93%	Yes
2. Were you able to understand the information from your Case Manager about your health condition(s)?	96%	Yes

3. Have you been able to follow any of Case Manger's heath care suggestions to improve your health?	88%	No
4. Did you and your Case Manager come up with goals to work on?	78%	No
5. Was your Case Manager usually able to speak with you?	76%	No
6. Did your Case Manager help you get the health care services that you needed?	81%	No
7. How pleased are you with how well your Case Manager helped you with other resources?	85%	No
8. How satisfied are you with any learning materials you received from your Case Manager?	96%	Yes
9. If you had any cultural needs, how satisfied are you with how they were met by your Case Manager.	100%	Yes
10. How pleased are you with how your health and quality of life improved because you received help from your Case Manager?	96%	Yes
11. How satisfied overall are you with Case Management services you received?	96%	Yes

Barrier analysis conducted on the survey results revealed the following issues:

- The number of members surveyed was low. Initial attempts to obtain completed surveys by mail resulted in a very low return rate. Telephonic outreach was then attempted, but members were often difficult to reach by phone for survey completion. The number of low responses created a challenge for identifying areas of concerns across the membership in case management.
- There were many questions where no response was given by the member being surveyed; staff completing the telephonic surveys did not document why there was no response (e.g. question was not applicable to the individual member, member refused to answer the question, etc.). Lack of responses further reduced the number of overall responses that could be used to evaluate specific questions/areas of member satisfaction or dissatisfaction.
- Case managers are not adequately sharing care plan goals with the member and/or insufficient member involvement in creating care plan goals.
- Case managers not assuring member needs are fully met when assisting with arranging for healthcare services or community resources by asking members if they feel their needs have been adequately addressed.
- Case managers are not completing sufficient outreach attempts, or barriers to reaching the member were not discussed during initial assessment and care plan discussion.

The following opportunities for improvement were identified:

- To increase the survey completion rate, conduct surveys when member has already been contacted, i.e. when case managers are speaking with members, they can ask if the member is willing to conduct a short survey and transfer the member to another staff member, versus making outreach calls specifically for the purpose of conducting a survey. Members can be difficult to reach telephonically and the response rate to mailed surveys was very low.
- Educate staff to document reason why no response given to specific questions on surveys and attempt to gather specific information about why the member responded if a negative response given.
- Continue to educate staff regarding proper tracking and processing of complaints regarding the case management program.
- Regarding Q5: "Was your Case Manager usually able to speak with you?" - educate the case management team regarding the importance of other staff offering to assist members if the member's assigned case manager is not available.
- Regarding Q4: "Did you and your Case Manager come up with goals to work on?" -retrain staff on the importance of collaboration with the member regarding care planning. As all active complex case management cases include development of a care plan in collaboration with the member or caregiver, this may be due more to the case manager not clearly communicating the care plan goals to the member.
- Regarding Q6: "Did your Case Manager help you get the health care services that you needed?" and Q7: "How pleased are you with how well your Case Manager helped you with other resources? - educate staff to ensure members feel that their needs have been met when assistance has been given, either with arranging healthcare services or referring to community resources. Case managers may also need to more clearly explain if there are limitations to benefits or available services/resources.
- Regarding Q3: "Have you been able to follow any of Case Manger's heath care suggestions to improve your health?" - educate case managers on using clear language and evaluate the availability of health education materials utilized by Sunflower to determine if they are easily understandable. Explore use of a member advisory group to assess materials.
- Educate Sunflower staff regarding results of the survey and specific questions where goals were not met, and brainstorm on ways to address areas of concern.
- Remind case management staff to clearly address the follow-up schedule with the member and ensure the member is in agreement, as well as addressing any barriers to reaching the member for follow-up (e.g. potential upcoming moves, alternative phone numbers to reach the member, etc.).

<u>Grievances</u>

Grievances received by the Grievance Department were also reviewed. Five member grievances/complaints regarding the case management program were reported by Sunflower members in 2013. Three of these grievances were related to members complaining about limited follow-up/communication from their case manager. With one

of these complaints, there were numerous documented attempts by the case manager to reach the member; the other two complaints appeared valid and were brought to the attention of the case managers' supervisors. The other complaints involved one allegation of a HIPAA violation and the other was in relation to a denial of personal care attendant services. All grievances were investigated and resolved in a timely manner. Due to the low number of complaints received from Sunflower members, there were no overall opportunities regarding case management services that could be identified.

Member Satisfaction with UM

Sunflower annually monitors member satisfaction with UM through analysis of relevant CAHPS® survey question results. The 2013 scores for Sunflower are compared to the Quality Compass® All Plans means and percentiles for the applicable questions.

The table below reflects the CAHPS Medicaid Adult Survey Results

	2013 Rate	2013 Quality Compass All Plans	2013 Quality Compass All Plans Percentile
Getting Needed Care	**84.2%**	**80.6%**	**75th**
• Ease of getting care, tests, or treatment needed	84.7%	82.5%	50th
• Obtaining appointment with specialist as soon as needed	83.8%	79.0%	75th
Getting Care Quickly	**84.5%**	**81.2%**	**75th**
• Obtaining needed care right away	86.4%	83.1%	75th
• Obtaining appointment for care as soon as needed	82.6%	79.3%	75th

Table 2: CAHPS Medicaid Child Survey Results

	2013 Rate	2012 Quality Compass All Plans	2012 Quality Compass All Plans Percentile
Getting Needed Care	**79.8%**	**79.3%**	**50th**
• Ease of getting care, tests, or treatment child needed	90.0%	82.9%	75th
• Obtaining child's appointment with specialist as soon as needed	69.5%	75.7%	**<25th**
Getting Care Quickly	**90.1%**	**87.3%**	**50th**
• Obtaining needed care right away	91.1%	90.3%	**25th**
• Obtaining appointment for care as soon as needed	89.0%	84.2%	75th

Opportunity analysis was conducted to identify opportunities to improve performance, Sunflower conducted a barrier analysis to identify the root causes of member dissatisfaction with the UM process. Along with the CAHPS survey results, Sunflower

also looked at UM denials and appeals data to assess member satisfaction with the UM process. A high volume of denials and appeals within Sunflower are related to pharmacy requests. Many of the denials are related to lack of information and are subsequently overturned upon resubmittal or appeal when sufficient clinical information is provided by the prescriber. The high volume of pharmacy appeals is believed to be related to the transition to the KanCare program in January 2013.

Sunflower Quality Improvement, Medical Management, Member Services, and Provider Services staff completed an initial barrier analysis. Staff identified the following potential barriers and opportunities for improvement. Opportunities identified that were not selected for action at this time will be re-evaluated and considered in the future. The barriers and opportunities related to member satisfaction with the utilization management process are listed in the table below.

Barrier	Opportunity	Selected for Improvement?
Members' expectation of obtaining immediate appointment and services.	Member education regarding the appointment availability standards for primary care and specialty care providers.	Yes
Members are not aware of the assistance Sunflower can provide in locating a provider if they are experiencing difficulty.	Member education regarding assistance Sunflower can provide in locating providers, including the availability of case management services for members with complex needs who access care with many different providers.	Yes
Members do not understand the UM process or how authorization decisions are made.	Member education regarding UM process and how decisions about care are made.	Yes
Limited pediatric specialists of some specialty types in some geographic areas.	Determine if specific network gaps exist and increase contracting efforts in those geographic areas for specific specialty types.	Yes
Members unaware that UM requests with insufficient information from providers can lead to denials or delay authorization.	Educate providers on the need for complete clinical information to make a timely decision to not delay care for members.	Yes

The following table reflects action taken or planned

Date Implemented	Action Implemented/Planned	Barrier Addressed
Fall 2013	Member education provided regarding the appointment availability standards in a member newsletter article. Member postcard mailed, informing members of the availability of the newsletter. Posting on front screen of the website, alerting members to the availability of the newsletter.	Members' expectation of obtaining immediate appointment and services.
Fall 2013 Q1 2014	Member newsletter articles encouraging members to contact Sunflower Member Services for assistance in making healthcare appointments and on the availability of case management services. Increased outreach efforts for members with high ED utilization and for members with an inpatient discharge, offering assistance with linking members to practitioners if needed.	Members are not aware of the assistance Sunflower can provide in locating a provider if they are experiencing difficulty.
Fall 2013	Member newsletter article educating about the UM process and how decisions for care are made.	Members do not understand the UM process or how authorization decisions are made.
Q1 2014	GeoAccess reports ran; no specific network gaps identified for pediatric specialists. Further drill down analysis occurring to identify source of low rates on CAHPS question. Contracting/recruitment efforts will focus on areas and specialties where deficiencies are found.	Limited pediatric specialists of some specialty types in some geographic areas.

Date Implemented	Action Implemented/Planned	Barrier Addressed
Spring 2014 Ongoing	Provider education on importance of submitting sufficient clinical information so timely authorization decisions can be made. • Provider newsletter article planned encouraging providers to submit complete clinical information to avoid delays in pharmacy prior authorization decision making. • UM and appeals staff continues to educate providers about the importance of submitting complete clinical information.	Members unaware that UM requests with insufficient information from providers can lead to denials or a delay authorization.

Provider Satisfaction with UM

Sunflower monitors practitioner satisfaction with the UM process on an ongoing basis through internal quality monitoring, and annually through analysis of relevant questions on the practitioner satisfaction survey.

The table below reflects the Provider Satisfaction Survey Results

	2013 Summary Rate	2012 TMG Book of Business Benchmarks Medicaid
Utilization & Quality Management	**13.7%**	**50.8%**
3A. Access to knowledgeable UM staff.	14.5%	49.7%
3B. Procedures for obtaining pre-certification/ referral/ authorization information.	10.4%	47.1%
3C. Timeliness of obtaining pre-certification/referral/authorization information.	12.0%	49.6%
3D. The health plan's facilitation/support of appropriate clinical care for patients.	11.2%	50.8%
3E. Access to Case/Care Managers from this health plan.	12.2%	51.3%
3F. Degree to which the plan covers and encourages preventive care and wellness.	21.9%	56.2%
3G. Extent to which UM staff share review criteria and reasons for adverse determinations.	10.2%	NA
3H. Consistency of review decisions.	10.9%	NA
Pharmacy	**6.8%**	**36.3%**
5A. Consistency of the formulary over time.	7.5%	37.1%

	2013 Summary Rate	2012 TMG Book of Business Benchmarks Medicaid
5B. Extent to which formulary reflects current standards of care.	6.8%	38.5%
5C. Variety of branded drugs on the formulary.	9.1%	35.4%
5D. Ease of prescribing your preferred medications within formulary guidelines.	5.9%	36.5%
5E. Availability of comparable drugs to substitute those not included in the formulary.	4.8%	34.0%

* Summary Rates represent the most favorable response percentage(s).
* The Myers Group's 2012 Medicaid Book of Business consists of data from 4 plans representing 700 respondents.

To identify opportunities to improve performance, Sunflower conducted a barrier analysis to identify root causes of provider dissatisfaction with the UM process. Along with the provider satisfaction survey results, Sunflower also reviewed UM denials and appeals to assess provider satisfaction with the UM process.

Sunflower Quality Improvement, Medical Management, Member Services, and Provider Services staff completed an initial barrier analysis, along with support from the Centene Corporation Quality Improvement Department. Staff identified the following potential barriers and opportunities for improvement. Opportunities identified that were not selected for action at this time will be re-evaluated and considered in the future. The barriers, opportunities and whether those opportunities were selected for improvement are listed in the table below.

Barrier	Opportunity	Selected for Improvement?
Providers unaware that UM requests with insufficient information can lead to denials or a delay authorization.	Educate providers on the need for complete clinical information to make a timely decision to not delay care for members.	Yes
Providers unaware of the availability of case management services through Sunflower.	Educate and encourage providers to refer members to case management. Increase provider awareness of assigned case manager for members already in case management.	Yes Yes
Providers unfamiliar with the UM process, authorization requirements, and how to contact the appropriate UM staff.	Educate providers on the UM process, medical necessity criteria, and how to contact UM staff.	Yes
Knowledge deficit of UM staff regarding processes.	Staff re-training and onboarding of qualified staff.	Yes

Barrier	Opportunity	Selected for Improvement?
Providers not familiar with pharmacy processes and not aware that the PDL and authorization requirements are dictated by the State.	Provider education regarding the pharmacy program, and limitations of Sunflower due to State control.	Yes

The table below reflects actions implemented for the barriers selected for improvement.

Date Implemented	Action Implemented/Planned	Barrier Addressed
Spring 2014 Ongoing	Provider education on importance of submitting sufficient clinical information so timely authorization decisions can be made. • Provider newsletter article planned encouraging providers to submit complete clinical information to avoid delays in pharmacy prior authorization decision making. • UM and appeal staff continues to educate providers about the importance of submitting complete clinical information.	Providers unaware that UM requests with insufficient information from providers can lead to denials or a delay authorization.
Winter 2013 Q2 2014	Provider newsletter article regarding the CM program and how to refer a member. Develop fax blasts for ongoing provider education to increase awareness of the CM program.	Providers unaware of the availability of case management services through Sunflower.
Winter 2013 Q2 2014	Provider newsletter article regarding the UM process and how to contact UM staff. Develop routine UM fax blasts for ongoing provider education to increase awareness of the UM processes and UM staff.	Providers unfamiliar with the UM process, authorization requirements, and how to contact the appropriate UM staff.

Date Implemented	Action Implemented/Planned	Barrier Addressed
Q1 2014	Additional health plan trainers hired. Re-training of current staff on UM work flows. Revise productivity reports to make them more useful. Share results of UM cases with front-line staff; use for training purposes.	Knowledge deficit of UM staff regarding processes.
Winter 2013 TBD	Increase provider awareness of the PDL and pharmacy processes. • Provider newsletter article on the PDL and pharmacy processes. • Investigate additional means to educate providers, e.g. provider orientation, fax blasts, additional information on Sunflower's website, etc.	Providers not familiar with pharmacy processes and not aware that the PDL and authorization requirements are dictated by the State

Delegated Vendor Oversight

Sunflower selected delegated vendors to oversee certain activities to ensure quality of care for its members. Sunflower 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:

- Timely submission of data such as grievance and appeals results for those vendors who are deemed "fully delegated."
- Prior authorizations by service type.
- Provider network.
- Claims data.
- Complaints and grievances.

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

1. Cenpatico - Sunflower's managed behavioral health care vendor. Cenpatico provides utilization management, network development and maintenance, case management, credentialing of their network, and claims payment data.
2. OptiCare - Sunflower's vision care provider. OptiCare provides utilization management, network development and maintenance, credentialing of their network, and claims payment data.

3. US Script - Sunflower'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.
4. Nurtur - Sunflower's disease management provider. Nurtur provides disease management for the following programs: Asthma, Coronary Artery disease, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, Hypertension, Hyperlipidemia and Tobacco Smoking Cessation.
5. NurseWise - Sunflower's after-hours call center and nurse advice line. NurseWise is a bilingual care line of registered nurses which complete health screenings and after hours nurse advice.
6. DentaQuest- Sunflower's dental care network. DentaQuest provides prior authorizations, utilization management, network development and maintenance, and claim payment information.
7. National Imaging Associates (NIA) - Sunflower's high-tech radiological imaging provider. NIA provides prior authorizations, credentialing of their network, first level appeals, and claims information.
8. Logisticare - Sunflower's transportation vendor.
9. Alere - Assists Sunflower in obtaining risk assessment information on pregnant members and facilitating utilization of 17P.

Quarterly meetings are held with each vendor to review and monitor performance metrics and address any issues affecting Sunflower. Centene Corporation completes the annual vendor oversight audits on behalf of Sunflower and includes any KS-specific requirements in the audit, as well as conducting applicable file reviews of Sunflower members. In conjunction with Centene Corporate and the other Centene health plans, Sunflower reviews the vendor evaluation results. As needed, the QI 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 Sunflower team and ultimately with the Performance Improvement Team and Quality Improvement Committee as needed. As necessary, action plans are implemented and improvement monitored.

During the first quarter of 2013 Sunflower noted unexpected difficulties with our transportation vendor and a decision was made to contract with a different transportation vendor. Sunflower initiated the contract with the new transportation vendor in April 2013. Since this change was made, the average number of transportation grievances per quarter decreased by 9%.

Sunflower evaluates each delegated entity's capacity to perform the proposed delegated activities prior to the executing of a delegation agreement. Sunflower retains accountability for any functions and services delegated, and as such will monitor 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.

Sunflower 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 following table contains the results of vendor audits conducted in 2013 and scope of the review:

Vendor	Type of Vendor	Date of Audit	Areas Audited	Scored Below 90%/QIP implemented
NIA	**Radiology**	**January 2013**	**UM:** P&Ps & UM Program Description; denial files; appeal files	No
			Credentialing: P&Ps & Credentialing Program Description, credentialing/recredentialing file review	No
			Compliance: P&Ps; Compliance Program Description; sample reports; staff interviews	Yes
			Member Rights & Responsibilities: applicable P&Ps	No
			Quality Improvement: P&Ps & QI Program Description	No
Opticare	**Vision**	**August 2013**	**Claims:** P&Ps; claims file review	Yes
			Complaints: file review	Yes
			Compliance: P&Ps; Compliance Program Description; sample reports; staff interviews	Yes
			Credentialing: P&Ps & Credentialing Program Description, credentialing/recredentialing file review	No
			Member Rights & Responsibilities: applicable P&Ps	No
			Quality Improvement: P&Ps & QI Program Description	No
			UM: P&Ps & UM Program Description; denial files	Yes
Logisticare	**Transportation**	**July 2013**	**Compliance:** P&Ps; Compliance Program Description; sample reports; staff interviews	Yes
			Driver Requirements and Training: P&Ps; sample provider agreement; provider materials	No
			Invoice Processing: P&Ps; sample reports; claims/billing manual	No
			Provider: P&Ps; sample provider agreement; provider materials	Yes

			Safety & Security: sample provider agreement; provider materials; sample inspection form	No
			Vehicle Equipment Requirements & Maintenance: sample vehicle inspection form/report	No
US Script	**Pharmacy Benefits Manager**	**April 2013**	**Claims:** P&Ps; claims file review	Yes
			Compliance: P&Ps; Compliance Program Description; sample reports; staff interviews	Yes
			Credentialing: P&Ps & Credentialing Program Description, credentialing/recredentialing file review	No
			Member Rights & Responsibilities: applicable P&Ps	Yes
			Performance Standards: P&P; reports	No
			Quality Improvement: P&Ps & QI Program Description	Yes
			UM: P&Ps & UM Program Description; denial file review	Yes
Cenpatico & STRS	**Behavioral Health & Therapies**	**April 2013**	**Case Management:** P&Ps; file review	Yes
			Claims: P&Ps; claims file review	No
			Complaints: file review	No
			Compliance: P&Ps; Compliance Program Description; sample reports; staff interviews	Yes
			Credentialing: P&Ps & Credentialing Program Description, credentialing/recredentialing file review	Yes
			Member Rights & Responsibilities: applicable P&Ps	No
			Quality Improvement: P&Ps & QI Program Description	No
			UM: P&Ps & UM Program Description; denial file review; appeal file review	Yes
DentaQuest	**Dental**	**June 2013**	**Claims:** P&Ps; claims file review	Yes
			Compliance: P&Ps; Compliance Program Description; sample reports; staff interviews	Yes
			Credentialing: P&Ps & Credentialing Program Description, credentialing/recredentialing file review	No
			Member Rights & Responsibilities: applicable P&Ps	No
			Quality Improvement: P&Ps & QI Program Description	Yes
			UM: P&Ps & UM Program Description; denial file review; appeal file review	Yes

Nutur	**Disease Management**	**May 2013**	**NCQA Disease Management standards:** Care Coordination, Clinical Quality, Evidence-based Programs, Patient Services, Practitioner Services & Program Operations - applicable P&Ps, sample reports, etc.	No
			Compliance: P&Ps; Compliance Program Description; training documents; sample reports	Yes
			Disease Management: DM case file review	Yes
NurseWise	**Nurse Hotline**	**July 2013**	**Compliance:** P&Ps; Compliance Program Description; staff interviews; sample reports	Yes
			URAC Core Standards: applicable P&Ps, program descriptions/work plans, meeting minutes	No
			URAC Call Center Standards: applicable P&Ps, example reports	No
			Complaints/concerns: file review	No
			Triage calls: file review	Yes