Quality Assessment and Performance Improvement (QAPI) /Utilization Management Program Evaluation

January 1 - December 31, 2014

*Data as available by 2/28/15

Quality Assessment and Performance Improvement (QAPI)/Utilization Management Program Evaluation

Executive Summary

January 1 - December 31, 2014

*Data as available by 2/28/15

Introduction

The purpose of this evaluation is to provide a systematic analysis of Sunflower 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, 2014.

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.

Sunflower Health Plan is committed to the provision of a well-designed and well-implemented Quality Assessment and Performance Improvement Program (QAPI Program). Sunflower Health Plan'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.

Evaluation Process

Sunflower uses a multifactorial approach to review and evaluate the effectiveness of plan operations. The approach is standardized and is a consolidation of data available by the plan to evaluate the quality of services provided to our members and the outcomes produced by our work processes. Data are reviewed by department leadership as well as various organizational committees including plan staff, Medical Director, and network physicians for analysis and determination of opportunities for improvement. The consolidated annual program evaluation is reviewed and approved by the senior level QI Committee (QIC) as well as the Board of Directors (BOD) annually.

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 Health Plan's members including medical, behavioral health, dental and vision care. Sunflower Health Plan incorporates all demographic groups, lines of business, benefit packages, care settings, and services in its quality improvement activities, including preventive care, emergency care, primary care, specialty care, acute care, short-term care, long-term care (depending upon Sunflower Health Plan's products), and ancillary services. Sunflower's review includes the following topic areas, with data from various assessments reported therein to support performance and identify strengths and opportunities for improvement:

- Acute and chronic care management
- Behavioral health care
- Compliance with preventive health guidelines and practice guidelines
- Continuity and coordination of care
- Department performance and service
- Employee and provider cultural competency
- Member Grievance System
- Member satisfaction
- Patient safety

- Pharmacy
- Provider and Plan after-hours telephone accessibility
- Provider appointment availability
- Provider Complaint System
- Provider network adequacy and capacity
- Provider satisfaction
- Selection and retention of providers (credentialing and re-credentialing)
- Utilization Management, including under and over utilization
- Delegated entity oversight

Together review of these components give Sunflower a clearer picture of the quality of services provided and outcomes produced by plan operations.

Review of Findings

Membership Characteristics
When comparing the year-end information Sunflower's total membership increased from 139,886 in 2013 to 144,761 in 2014, a 3.4% increase. As in 2013, Sunflower's largest membership group was Temporary Assistance for Needy Families (TANF), making up 62% of the population. Little movement was seen overall by product in 2014.

Below are the 2013 year-end information and percentage of change from 2013 to 2014.

	CHIP	Foster Care	LTC Dual	LTC Non-Dual	SSI Dual	SSI Non-Dual	TANF	Total
2013	21,115	5,015	8,691	4,179	6,321	10,563	84,002	139,886
2014	19,868	5,330	8,922	3,994	6,400	10,638	89,609	144,761
Percentage of change	-5.91%	6.28%	2.66%	-4.43%	1.25%	0.71%	6.67%	**3.4%**

The following are the percent of the total membership that each product comprised, 2013 compared to 2014.

Percentage of membership	CHIP	Foster Care	LTC Dual	LTC Non-Dual	SSI Dual	SSI Non-Dual	TANF	Total
2013	15.1%	3.6%	6.2%	3.0%	4.5%	7.6%	60.1%	100.0%
2014	13.7%	3.7%	6.2%	2.8%	4.4%	7.3%	61.9%	100.0%

Based on information related to our population, 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 remained essentially the same in 2014 as no material changes in the membership relative to product line, age/gender, language, race and ethnicity were identified.

Quality Performance Measures and Outcomes
The plan has now executed the outreach for both Performance Improvement Plan (PIPs) and data collection are underway.

In 2014 Sunflower underwent a full NCQA survey and become fully accredited, an aggressive achievement for a new health plan and the first in Kansas among the Medicaid MCOs.

During 2014 Sunflower continued to work on internal process related to HEDIS such as data capture and work with providers to establish a collaborative relationship to review outcomes. Although HEDIS data are not complete for 2014, gains in performance are seen in many measures, some performing at the 75th or 90th percentile, which is unusual for a new MCO. The focus for 2014 on HEDIS has been predominantly on measures also related to Pay for Performance (P4P). Below show the general performance trends seen in data to date for these measures:

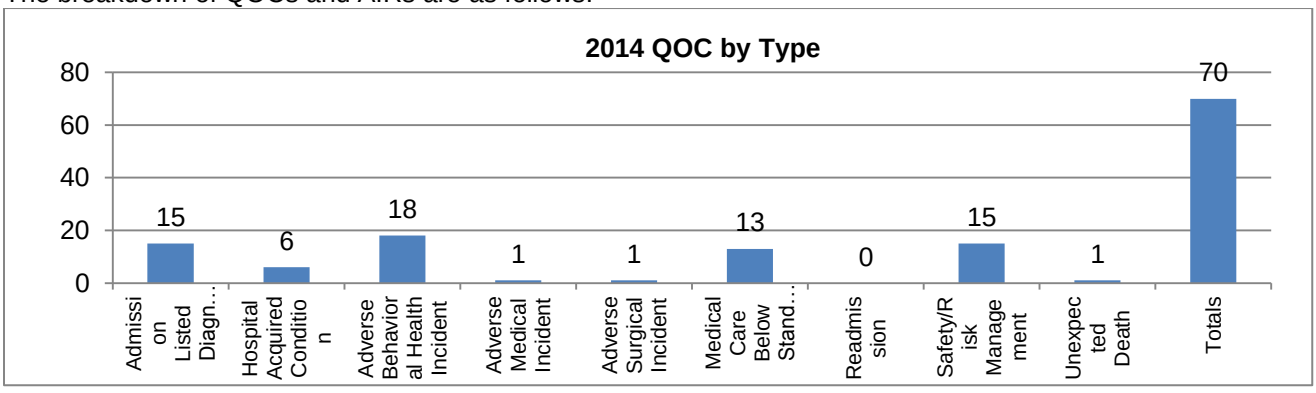
Measure	Rate Change from 2013 as of 1/31/15	Meeting Goal (50th percentile or P4P goal)
Comprehensive Diabetes Care	Improved in 4 of 5 sub-measures	No
Well Child Visits in First 15 Months of Life (four)	Improved	Yes
Annual Monitoring for Patients on Persistent Medications (MPM)	Improved	Yes
Follow-up After Hospitalization for Mental Illness (FUH)	Improved	Yes
Cholesterol Management (CMC)	No data to date-hybrid measure	N/A
Breast Cancer Screening (BCS)	No data, continuous enrollment	N/A
Cervical Cancer Screening (CCS)	Improved	No

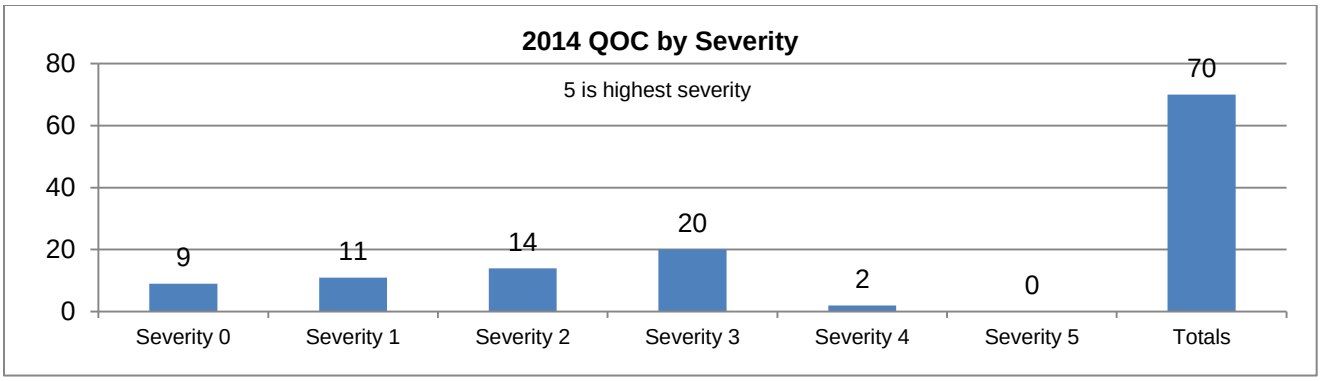
All measures were tracked and intervention plans developed and executed to improve patient outcomes in 2014. Sunflower will continue to focus on these areas, with the exclusion of CMD, and addition of others in 2015. Results available at the time of this report show despite progress, goals are not consistently met in all measures. In 2014 additional interventions were added, as well as staff, to focus on improvement in these key measures.

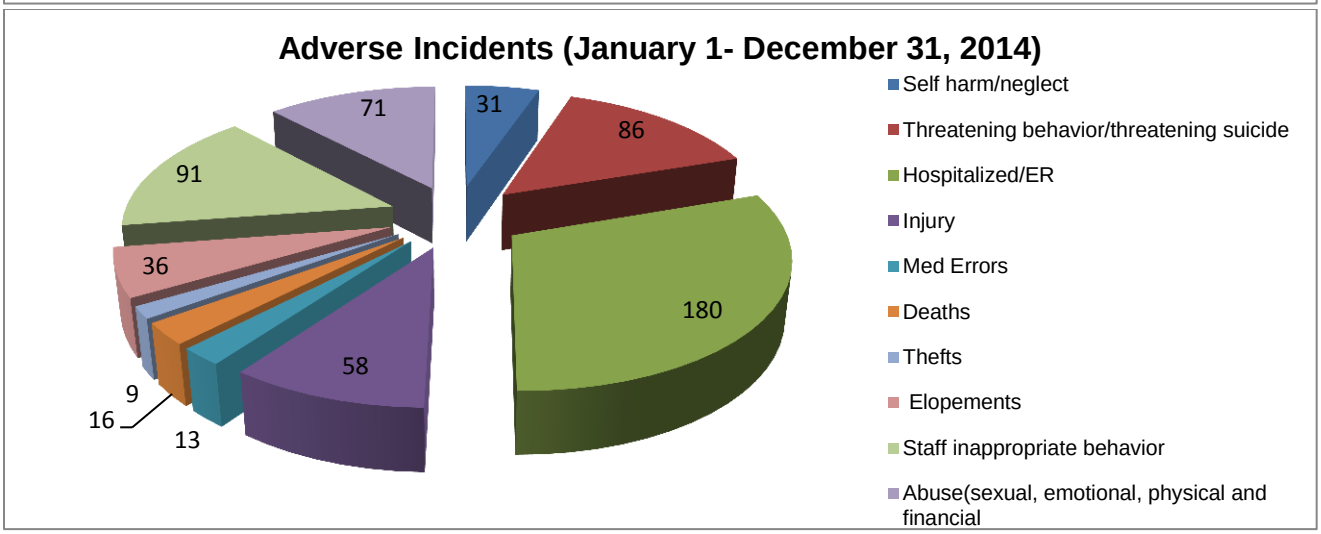
Patient Safety

Sunflower was forwarded 586 individual Adverse Incident Reports (AIRs) (90 unique providers) and 70 Quality of Care (QOCs) (61 unique providers) . A breakdown of those includes the highest category being reports of inpatient hospitalizations of members. Data were reviewed and no provider trends were noted, however individual remedial action were taking as needed with providers following investigation.

The breakdown of QOCs and AIRs are as follows:







Preventative Health Guidelines

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. Below are the measures and performance results. Goals for 2014 were the NCQA Quality Compass 50th percentile. Although progress toward goals were achieved, Sunflower did not meet goals and will continue to focus on this area in 2015.

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 survey data. A summary of these data are presented below:

Grievance Category	Jan. 1 - Dec 31, 2014	Per 1000	Jan. 1 - Dec 31, 2013	Per 1000
Total	633	4.43	574	4.25

Sunflower experienced a slight increase in member grievances in 2014, over half of which were transportation related. Sunflower has developed additional plans and monitoring to address concerns identified though the grievance process. The top three categories of complaints in 2014

were Availability, Attitude/Service, and Timeliness. Although greater than 2013, Sunflower continued to meet the goal of less than 5.00 grievances/1000 members.

Member appeals are also trended and categorized as a reflection of service and member satisfaction.

Appeal Category	Jan. 1 - Dec 31, 2014	Per 1000	Jan. 1 - Dec 31, 2013	Per 1000
Total	551	3.85	336	2.49

The appeal category with the highest volume of appeals is Criteria Not Met - Medical Procedure accounting for 17.42% (96/551) of total appeals, these appeals are based denial of medical necessity.

Of the total appeals in 2014, Sunflower upheld 57.7%, and overturned 42.3%. Sunflower has established a goal for total member appeals to remain less than 2.50/1000 members annually. With a rate of 3.85 /1000 members for all appeals, the goal was not met for 2014. The increase in appeals in 2014 is not unexpected as the plan is more heavily enforcing prior authorization and administrative rules now that providers have become familiar with Sunflower processes.

Member Satisfaction

Sunflower's KanCare contract was implemented on January 1, 2013. As a new plan, Sunflower's goal was to meet or exceed the NCQA Quality Compass 50th percentile for both the Adult and Child surveys. Sunflower met the goal for most areas on the 2014 Adult and on the Child surveys, and exceeded them in several others. The areas not meeting Sunflower's goal of meeting the 50th percentile or above are the areas Sunflower is focusing improvement efforts. Sunflower member satisfaction scores overall are a strength for the Plan in 2014, with very high results and improvement in most measures from 2013.

Adult Composite & Question Ratings	2013 Rate	2014 Rate	2013 Quality Compass All Plans	2013 Quality Compass All Plans Percentile
Getting Needed Care	84.2%	86.2%	80.6%	90th
Getting Care Quickly	84.5%	87.0%	81.2%	90th
How Well Doctors Communicate	90.4%	89.4%	89.3%	25th
Customer Service	79.1%	90.1%	86.2%	90th
Shared Decision Making	51.1%	50.9%	NA	Not available
• Health Promotion and Education	67.7%	68.4%	NA	Not available
• Coordination of Care	87.7%	82.1%	78.7%	75th
• Providing Needed Information	60.8%	69.3%	66.6%	50th
• Ease of Filling Out Forms	92.5%	93.7%	94.5%	<25th
Ratings Items				
Rating of Health Care	71.6%	73.8%	70.8%	75th
Rating of Personal Doctor	79.5%	78.9%	78.4%	50th
Rating of Specialist	79.2%	78.5%	79.4%	25th
Rating of Health Plan	67.6%	71.7%	73.5%	25th

Specific domains are key drivers for overall plan ratings, ass seen below those translate into strengths, opportunities or areas to monitor. Analysis was completed by population and action plans developed accordingly to address opportunity areas, those at performance <50th percentile.

Adult Survey	2014 Percentile Ranking	2014 Opportunity Analysis

Key Driver of Health Plan Rating		
Customer Service	89th	Strength
Getting Needed Care	93rd	Strength
Key Driver of Health Care Rating		
Getting Needed Care	93rd	Strength
How Well Doctors Communicate	46th	Opportunity
Getting Care Quickly	99th	Strength
Key Driver of Personal Doctor Rating		
How Well Doctors Communicate	46th	Opportunity
Coordination of Care	76th	Strength

Child Survey(s)	**2014 Percentile Ranking (T19/T21)**	**2014 Opportunity Analysis (T19/T21)**
Key Driver of Health Plan Rating		
Customer Service	85th / 94th	Strength
Getting Needed Care	76th / 51st	Strength / Monitor
Key Driver of Health Care Rating		
Getting Needed Care	76th / 51st	Strength / Monitor
How Well Doctors Communicate	55th / 87th	Monitor / Strength
Coordination of Care	75th / 37th	Strength / Opportunity
Key Driver of Personal Doctor Rating		
How Well Doctors Communicate	55th / 87th	Monitor / Strength
Coordination of Care	75th / 37th	Strength / Opportunity

Access & Availability
Access and availability of services is monitored through call center statistics/service goals, accessibility of primary care services, and review of grievances related to accessibility of services. Below are the results of review of each domain. Overall measures are met, future activities will be focused on maintaining results.

Area of Measurement	**Standard**	**2014 Performance**
Customer Service Call Statistics	Speed of answer-95% <60s	95%- Goal met
	Abandonment rate <4%	1.09%-Goal met
Accessibility of PCP	Appointment availability- Routine and Urgent	Not yet assessed
	After-hours care- 90% have acceptable coverage for urgent and emergent care	80.08%-Goal not met, action plans in progress
CAHPS Survey	Getting Care Quickly Domain- >50th percentile on each of three survey populations	90th, 75th, and 50th- Goal met
	Q4: Obtaining needed care right away - >50th percentile on each of three survey populations	90th, 50th, and 50th – Goal met
	Q6: Obtaining appointment for care as soon as needed - >50th percentile on each of three survey populations	90th, 75th, and 75th – Goal met
Member Grievances	Grievances <5.0/1000 members	Goal met
PCP Availability	95% of urban members have at least 1 PCP within 20 miles	100%-Goal met
	95% of rural members have at least 1 PCP within 30 miles	100%- Goal met
	At least 1 PCP per 2000 members	1:49- Goal met

Continuity and Coordination of Care between Medical and Behavioral Healthcare
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.

Area of Measurement	Standard	2014 Performance
Exchange of Information b/w PCP and BH Provider	Communication between behavioral health and PCP-Discharge assessments shared	47%-Goal not met
	Provider survey questions-Q4E: Rate the timeliness of exchange of information/ communication/reports from the behavioral health providers	6.9%- Improvement. Goal not met
	Provider survey questions-Q4F: How often do you receive verbal and/or written communication from behavioral health providers regarding your patients?	33.3%-Improvement. Goal not met
Appropriate Dx, Tx, and Referral & Use of Psychopharm. Meds	AMM-Acute Phase	49.09%- Goal not met
	AMM-Continuous Phase	33.78%- Goal not met
	AMM-Acute Phase	55.63%- Goal met
	AMM-Continuous & Maintenance Phase	64.55%-Goal met
Screening of Coexisting Disorders/Preventative BH Program	Screening survey completed	9.7%- Goal not met
	Prenatal successful outreach	72%- Improvement
	Post-partum successful outreach	50%-Improvement

Although data show an improvement in member response to outreach, action plans continue to improve integration and communication between primary care and behavioral health providers.

Utilization Management
Outcomes of the UM processes as they related to member health outcomes and authorizations have been discussed previously. To ensure consistency of operations, the Sunflower team uses InterQual for all UM decisions and completes annual Inter-Rater Reliability (IRR) testing to ensure all reviewers maintain consistent review standards. In 2014, all Sunflower staff completed IRR testing with passing results.

Sunflower monitors member satisfaction with Utilization Management processes through the annual CAHPS survey. Below are a summary results.

Composite & Question Ratings	Adult 2014 Rate	T19 Child 2014 Rate	T21 Child 2014 Rate	Goal Met?
Getting Needed Care	**86.2% (90th)**	**92.5% (75th)**	**86.0% (50th)**	**Yes**
Q14: Ease of getting care, tests, or treatment needed	87.7% (75th)	88.3% (75th)	93.0% (75th)	Yes
Q25: Obtaining appointment with specialist as soon as needed	84.7% (75th)	84.5% (50th)	78.9% (25th)	No

Composite & Question Ratings	Adult 2014 Rate	T19 Child 2014 Rate	T21 Child 2014 Rate	Goal Met?
Getting Care Quickly	**87.0% (90th)**	**92.5% (75th)**	**92.3% (50th)**	**Yes**
Q4: Obtaining needed care right away	89.3% (90th)	93.5% (50th)	92.6% (50th)	Yes
Q6: Obtaining appointment for care as soon as needed	84.7% (90th)	91.5% (75th)	90.0% (75th)	Yes

Sunflower monitors provider satisfaction with Utilization Management processes through the annual Provider survey. Below summarize the 2014 results. It should be noted that Sunflower improved on every area surveyed related to satisfaction with UM and Pharmacy from 2013.

Composite & Key Questions	2014 Summary Rate	2013 Summary Rate	2013 TMG Book of Business Benchmarks Medicaid
Utilization & Quality Management	**17.9%**	**13.7%**	**37.1%**
3A. Access to knowledgeable UM staff.	14.8%	14.5%	35.0%
3B. Procedures for obtaining pre-certification/ referral/ authorization information.	13.8%	10.4%	36.2%
3C. Timeliness of obtaining pre-certification/referral/authorization information.	16.1%	12.0%	37.5%
3D. The health plan's facilitation/support of appropriate clinical care for patients.	17.0%	11.2%	35.9%
3E. Access to Case/Care Managers from this health plan.	15.9%	12.2%	33.5%
3F. Degree to which the plan covers and encourages preventive care and wellness.	29.7%	21.9%	44.5%
3G. Extent to which UM staff share review criteria and reasons for adverse determinations.	15.2%	10.2%	NA
3H. Consistency of review decisions.	12.3%	10.9%	NA
Pharmacy	**10.2%**	**6.8%**	**23.1%**
5A. Consistency of the formulary over time.	8.9%	7.5%	24.3%
5B. Extent to which formulary reflects current standards of care.	9.3%	6.8%	24.8%
5C. Variety of branded drugs on the formulary.	11.4%	9.1%	22.0%
5D. Ease of prescribing your preferred medications within formulary guidelines.	11.7%	5.9%	23.6%
5E. Availability of comparable drugs to substitute those not included in the formulary.	9.6%	4.8%	20.8%

Sunflower monitors member satisfaction with Case Management through a plan administered survey. Survey results from 2014 did not meet performance thresholds of 90%. An action plan is in development that includes the possible re-design of the survey to include interim surveying so that satisfaction is improved through the course of the interaction.

Delegated Vendor Oversight

Sunflower has nine delegated vendors that assist with the care and benefit administration to our membership. Each vendor has annual audits to ensure they are meeting policy, contract, and Plan requirements. 100% of audits were successfully completed in 2014. These audits result in quality improvement plans issued to the vendor with immediate action necessary to mitigate gaps in performance.

Summary

Sunflower has identified strengths and opportunities for improvement which are outlined in more detail with action plans in the full annual evaluation report. Interventions included in the plan for 2014 were reviewed and continued as needed for measures requiring continued improvement.

Strengths:

- Member satisfaction results
- Steady improvement in HEDIS scores
- Access and Accessibility
- Re-design of Case Management
- Revised UM processes, strength of new executive leadership

Opportunities for Improvement:

- Provider satisfaction
- Practice Guideline adoption
- Physical and behavioral health provider integration

As a result of this analysis, it has been identified that processes and operational systems are starting to stabilize, producing early positive results, and in some cases negative findings as the plan matures and enforces guidelines. With two years of complete data, it is difficult to assert that trends have been identified for some processes, but statistically significant change has been found in some areas. The findings did not indicate the need for major revisions to Sunflower's QAPI, operations, or service delivery systems. Sunflower will continue to work to maintain and improve the gains achieved from 2013 to 2014, and improve on the areas noted as priority opportunities for improvement.

Quality Assessment and Performance Improvement (QAPI) /Utilization Management Program Evaluation

January 1 - December 31, 2014

*Data as available by 2/28/15

Introduction

The purpose of this evaluation is to provide a systematic analysis of Sunflower 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, 2014. 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 the Kansas Department of Health and Environment (KDHE) and the Kansas Department of Aging and Disability Services (KDADS) and by partnering with local healthcare providers, Sunflower seeks to achieve the following goals for our stakeholders:

- 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 2014 membership population was completed in first quarter 2015. 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 Sunflower membership characteristics for 2014 are shown in the tables below:

Product	2013	2014
CHIP	15%	14%
Foster Care	4%	4%
LTC Dual	6%	6%
LTC Non-Dual	3%	3%
SSI Dual	5%	4%
SSI Non-Dual	8%	7%
TANF	60%	62%
Total	100%	100%

Age Group	2013	2014
0-10	47%	48%
11-20	26%	25%
21-30	7%	7%
31-40	5%	5%
41-50	4%	3%
51-60	4%	4%
61-70	3%	2%
71-80	2%	2%
81+	2%	1.7%

Gender	2013	2014
M	54%	46%
F	46%	54%

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. These statistics had slight changes from 2013 to 2014, none that necessitated significant program or operational changes.

The table below reflects the 2014 membership for each product by month.

	CHIP	Foster Care	LTC Dual	LTC Non-Dual	SSI Dual	SSI Non-Dual	TANF	Total
1/2014	21,447	5,051	9,042	4150	6523	10,792	87,603	144,608
2/2014	21,477	5,115	9,094	4,120	6,581	10,765	88,623	145,775
3/2014	21,548	5,131	9,082	4,133	6,624	10,835	89,676	147,029
4/2014	21,554	5,180	9,073	4,112	6,659	10,865	90,692	148,135
5/2014	21,414	5,228	9,053	4,054	6,696	10,921	90,850	148,216
6/2014	21,329	5,205	9,053	4,036	6,716	10,871	91,005	148,215
7/2014	20,758	5,203	9,044	4,015	6,748	10,916	90,997	147,681
8/2014	20,437	5,236	9,046	3,995	6,705	10,911	90,920	147,250
9/2014	20,173	5,245	9,031	3,992	6,660	10,865	90,757	146,723
10/2014	19,997	5,284	9,033	3,992	6,608	10,847	90,295	146,056
11/2014	19,912	5,303	8,986	3,984	6,536	10,774	89,957	145,452
12/2014	19,868	5,330	8,922	3,994	6,400	10,638	89,609	144,761
% of Membership	13.72%	3.68%	6.16%	2.76%	4.42%	7.35%	61.90%	100.00%

Below are the 2013 year-end information and percentage of change from 2013 to 2014.

	CHIP	Foster Care	LTC Dual	LTC Non-Dual	SSI Dual	SSI Non-Dual	TANF	Total
2013	21,115	5,015	8,691	4,179	6,321	10,563	84,002	139,886
2014	19,868	5,330	8,922	3,994	6,400	10,638	89,609	144,761
Percentage of change	-5.91%	6.28%	2.66%	-4.43%	1.25%	0.71%	6.67%	**3.4%**

The following are the percent of the total membership that each product comprised, 2013 compared to 2014.

Percentage of membership	CHIP	Foster Care	LTC Dual	LTC Non-Dual	SSI Dual	SSI Non-Dual	TANF	Total
2013	15.1%	3.6%	6.2%	3.0%	4.5%	7.6%	60.1%	100.0%
2014	13.7%	3.7%	6.2%	2.8%	4.4%	7.3%	61.9%	100.0%

When comparing the year-end information Sunflower's total membership increased from 139,886 in 2013 to 144,761 in 2014, a 3.4% increase. As in 2013, Sunflower's largest membership group was Temporary Assistance for Needy Families (TANF), making up 62% of the population. Little movement was seen overall by product in 2014.

One change occurred in 2014 related to enrollment. Additional Long Term Services and Supports (LTSS) and Home Community Based Services (HCBS) benefits were included in managed care for the Intellectual and Developmentally Disabled (I/DD) population. These members were already covered members in the Medicaid program by the MCO's. However, Sunflower did see an increase in membership in this membership type during the extended open enrollment period for this population, changing slightly the mix of members included in the LTC-Dual product type. Sunflower serves members in all counties in KS.

The expectation for 2015 is that membership growth will remain stable as at this time there are no plans in Kansas to expand Medicaid. Members have an annual open enrollment period to change MCO's. As most members do not act upon making change, Sunflower does not expect much member movement in 2015.

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 Medical Management and Customer Service staff for member interactions with both Sunflower staff and network providers. The table below represents the top 11 languages for which members have requested translation services based on unique interactions in 2014. It should be noted that Sunflower has three Spanish-speaking and 1 Russian-speaking Customer Service

Representatives on staff. Sunflower increased Customer Service Representatives staff who are able to speak Spanish and Russian.

Language	Number of Calls	Percentage of Total
Spanish	5062	91.17%
Burmese	127	2.29%
Nepali	47	0.85%
Vietnamese	46	0.83%
Somali	43	0.77%
Russian	38	0.68%
Arabic	37	0.67%
Karen	29	0.52%
Mandarin	22	0.40%
Korean	13	0.23%
Lao	12	0.22%
Cambodian	7	0.13%
All other languages	69	0.12%
Total	**5552**	**100.00%**

Race/Ethnicity

The table below reflects race and ethnicity and is based on members who responded to the 2014 CAHPS survey and designated race/ethnicity on the survey.

Race / Ethnicity Category	2013 Child CAHPS	2014 Child CAHPS
White	77.3%	81.3%
Black /African American	16.0%	20.4%
Hispanic / Latino**	21.0%	23.7%
Asian	6.4%	4.8%
Hawaiian / Pacific Islander	3.4%	2.4%
American Indian / Alaskan	4.7%	6.1%
Other	8.6%	11.1%

Race / Ethnicity Category	2013 Adult CAHPS	2014 Adult CAHPS
White	87.2%	75.8%
Black /African American	7.9%	16.8%
Hispanic / Latino**	8.3%	12.9%
Asian	2.0%	3.9%
Hawaiian / Pacific Islander	0.8%	0.2%
American Indian / Alaskan	7.9%	7.4%
Other	3.9%	8.0%

*Race/Ethnicity will not equal 100% because they are separate questions on the CAHPS survey. “Other” includes all response options that are not shown.

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 remained 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 moved into the second year of operations. Some of the improvements made in 2014 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.
- Development of a program that does direct outreach to all new members to Sunflower to assist them with scheduling a PCP visit in the first 90 days of enrollment.
- Implementation of a dedicated Transplant Case Manager to assist transplant members.
- 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.
- 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 continue to complete the program.
- Medical Management underwent a significant reorganization in the fall of 2014 to create holistic care based on the ICM model which includes as its primary pillar a one case owner model. In doing so, behavioral health will be integrated into the health plan operations as opposed to a contracted service from our sister company. Additionally, by creating this model, we no longer have silos but rather work in teams across all populations to care for the entire population as opposed to segments. This member centric model allows for the primary case owner to remain if the member has an established relationship but allow them to bring in their SME for a particular health state.
- To improve coordination of care between departments, Sunflower began daily rounds on all inpatient members. Sunflower also began scheduling Complex Medical Rounds, Long Term Service and Supports (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 re-credentialing)
- 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.

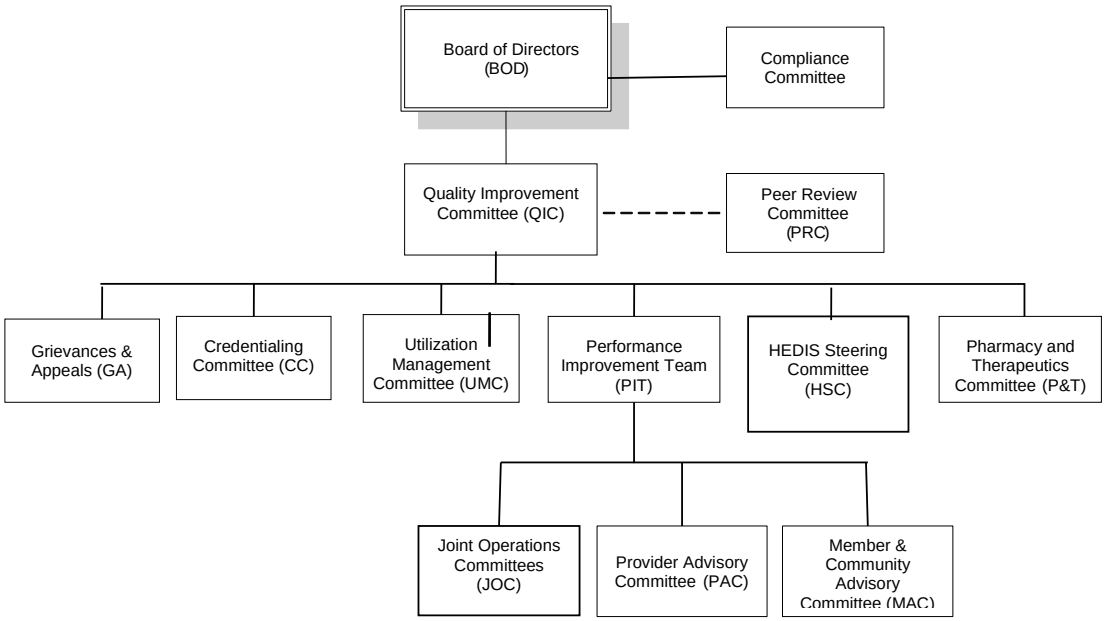
Objectives

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 options;
- To oversee peer review procedures that will address deviations in medical management and health care practices and devise action plans to improve services;
- To establish a system to provide frequent, periodic quality improvement information to participating providers in order to support them in their efforts to provide high quality health care;
- To recommend and institute "focused" quality studies in clinical and non-clinical areas, where appropriate.

Committee Structure

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 BOD 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 supports the QAPI Program by:

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

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

Quality Improvement Committee (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; 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 senior leadership, along with other Sunflower executive staff representing Medical Management (including Utilization Management and Case Management), Network Development/Contracting, Customer Service, Compliance, and Pharmacy departments, with other ad hoc members as necessary. Additional QIC attendees include staff responsible for clinical appeals and Fraud, Waste and Abuse. The first QIC meeting was held December 19, 2012, prior to implementation of KanCare, and has met four times in 2014. 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 12 times in 2014. 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 the 2014 Credentialing report for Sunflower.

2014 Credentialing Statistics	
Total number of practitioners in network (includes delegated providers) as of 12/31/2014	14,369
Initial Credentialing (excludes delegated)	
Number initial practitioners credentialed	1215
Average Credentialing TAT From Complete Application to Committee (Days)	13
Recredentialing	
Number practitioners re-credentialed	0 None Yet Due
Number practitioners re-credentialed within 36 month timeline	N/A

2014 Credentialing Statistics	
% re-credentialed timely	N/A
Terminated/Rejected/Suspended/Denied	
Number with cause	0
Number denied	3

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 2014. 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 has met seven times in 2014. 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 a minimum of quarterly and is facilitated by the HEDIS Coordinator. Membership includes the senior leadership of QI, 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 six times in 2014.

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. The PIT met seven times in 2014, with several subcommittee meetings of the PIT to address items such as the CAHPS survey results and Pay for Performance (P4P) activities. The PIT typically meets monthly.

Three subcommittees report to the PIT, as described below:

Member and Community Advisory Committee (MCAC)

The goal of the Member and Community Advisory Committee (MCAC) is to solicit member input into the Quality Improvement Program, operations, and services that are provided to members. The purpose of the MCAC is to act as a focus group to facilitate member and community perspective on the quality of care and services offered by Sunflower Health Plan and to offer recommendations for improvement to member services and community engagement, assisting the plan to remain member centric and provide services and activities that improve member quality of care and satisfaction. The MCAC met three times 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 2014.

Vendor	Number of meetings in 2014
National Imaging Association	14
US Scripts	4
Logisticare	6
NurseWise	3
DentaQuest/Dental Health and Wellness	2
Nurtur	3
OptiCare	4
Cenpatico Behavioral Health (CBH)	4
Cenpatico Physical, Occupational, Speech Therapy (STRS)	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 leadership, Grievance Coordinator, Clinical Appeals Coordinator, QI Nurse and representatives from Customer Service. The GAC provides summary reports to the QIC at regular intervals, but no less than quarterly. The GAC met four times in 2014. 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, in 2014 leadership roles for committee organization and participation were more clearly defined and 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. However, in the later part of 2014, unforeseen circumstances reduced network physician participation resulting in a need to do additional recruiting to ensure broad provider specialty representation is restored. In 2014 Sunflower followed the QAPI outlined committee structure. Revisions to the structure were completed in August of 2014 to more clearly define quorum and voting thresholds, consolidate subcommittees of the PIT, and strengthen/broaden membership to some committees. Additionally in 2014 Sunflower fully implemented the change initiated in 2013 to transition from the VP of Compliance chairing the Grievances and Appeals Committee to leadership in QI taking chair responsibilities. No other changes to the committee structure occurred in 2014 or are planned for 2015, other than recruitment of additional network practitioners for the Credentialing Committee, Quality Improvement, and Peer Review Committees.

Quality Improvement Department Structure and Resources

The QI resources were evaluated, and it was determined additional resources were needed to meet the needs of the QAPI Program during 2014. The QI department is now composed of the following members:

- Chief Medical Director, serving as the Senior Executive for Quality Initiatives (SEQI) (member by position and role, not formal reporting structure).
- Medical Director of Utilization Management (member by position and role, not formal reporting structure).
- Vice President, Quality Improvement (Nurse)-new position
- Manager, QI (Nurse)
- Quality Improvement Coordinator (Nurse)-1 position added, 2 total.
- EPSDT Coordinator.
- HEDIS Coordinator.
- Grievance Coordinator.
- Appeals Coordinator.
- NCQA Coordinator.
- Clinical Appeals Coordinator (Nurse)-1 position added, 2 total.
- QI Analyst.- 1 position added, 2 total
- QI Project Manager- new position
- Centene Corporate support.

Organizational Changes in 2014

Sunflower had transition in the QI leadership of the department again in 2014, with the Director of QI resigning in May 2014. Concurrently, the plan underwent a reorganization which was prompted by corporate quality priorities and the plan desire to elevate activities in QI. A Vice President of Quality Improvement position was added in May of 2014 that reported directly to the CEO. In

September, the plan changed the reporting structure and assigned the VP of QI to report to the COO. The incoming VP of QI, was a previous Sunflower VPMM, making the transition fairly immediate without a gap in QI leadership. The plan Medical Director, and SEQI, remained in place during the transition continuing to provide leadership and oversight of QI. There was turnover of three additional staff persons in 2014 in the QI Department, only one of which has occurred under the new QI leadership. An assessment of work volume and plan priorities identified additional resources were needed in quality, and in 2014, a total of five positions were added to the Department.

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. Staffing in nearly all departments across Sunflower have increased in 2014 to accommodate member needs, improve quality, and as a result of the volume of routine audits and reporting uniquely required by the state contract.

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, with results of these two evaluations received by Sunflower in November 2014. In early 2015 a desk audit with possible onsite will be completed related to the initial findings and Sunflower's remediation. The State also performed two Focused Review audits of Sunflower in 2014 to assess Health Homes readiness and found several areas for improvement which were acted upon by Sunflower. Additionally the EQRO performed validation surveys of both the Provider Survey, Mental Health Survey, CAHPS survey, all with minimal recommendations, none rising to the level of immediate need for mitigation or action plan. Sunflower continues to work with the state with anticipation of an Information Systems Capability Assessment (ISCA) re-survey, and a Performance Measure Validation survey in early 2015. Finally, Sunflower complied with record requests for quarterly HCBS documentation audit requests (over 500 records per quarter). Although the results were not shared with Sunflower in 2014, we anticipate further discussion and identification of areas for improvement from these data audits in 2015.

Health Insurance Portability and Accountability Act (HIPAA) 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 2014 and the results revealed no infractions.

QAPI Program Effectiveness

Throughout 2014, 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 2014 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 2015 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

- Additional executive leadership was added to the QI Department to support QI initiative and the culture of QI. Additions included two nurse leaders with Quality Improvement experience.
- Committee membership and structure revised and functional to support activities.
- Quality improvement initiatives and focus studies identified, using trend of data starting to take more shape with plan experience.
- Successfully implemented HCBS services for the I/DD population, developing an expansive network, implementing case management, and refining operations in claims processing to meet the member and provider needs.
- More finalization around P4P metrics and development of tracking tools, supporting reports, comprehensive intervention plans, and reporting tools. Final data are unavailable but early results show attainment of 9 of 14 2014 P4P measures at this date.
- Improvements seen in both the Member and Provider satisfaction surveys. Development of comprehensive plans for future improvement opportunities using multidisciplinary team.

- Expansion of skill in HEDIS operations to allow for the plan to not only do over-reads during hybrid season, but also complete medical record review of supplemental data for one HEDIS measure in 2014.
- Revised systems to incorporate state reporting criteria to reduce reporting errors and automate some reporting functions.
- Creation of templates for trending of Grievances and Appeals and Quality of Care issues data for more in depth analysis and display for team members and Committee, allowing improvement opportunities to be more easily identified.
- Review of all Sunflower and vendor grievance and appeals documentation, revising and creating more consistency to reduce member confusion.
- Development of reports to identify cases at risk of not meeting turn-around time (TAT) for grievances and appeals before they are out of TAT.
- Developed process in documentation system to route AIRS so all documentation remains in single entry/record and includes QOC nurse and CM in feedback.
- Initiated development of monitoring reports to do surveillance of routine QOC issues on whole population, allowing focused review when there are findings and trending of certain types of at risk diagnosis patterns.
- Refined processes for State Fair Hearings, including documentation storage, and increasing reliability and quality of work product to Office of Administrative Hearings (OAH).
- TAT time was met for CY 2014 for both Grievances and Appeals.
- Case Management worked with 15,655 members in 2014.
- NurseWise responded to 12,810 calls from Sunflower members.
- Participated in approximately 60 member outreach health fairs/community events.
- Participated in approximately 74 provider conferences and seminars, presenting and providing information or as a conference participant.
- Partnered with Nurtur to provide disease management services for Sunflower members. Nurtur enrolled 2992 members in active health coaching and 1806 in education programs in 2014.
- Answered 202,736 calls in the call center in 2014 with a 94% service level. The average speed to answer was 11 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 3,899 calls weekly regarding benefit inquiries, concerns, complaints, and request for arranging services.
- Expanded sources for supplemental data that allow better HEDIS data capture to reduce provider record request burden.
- Provided $1.8M in value added services to our membership and $2M in in-lieu of services.
- Achieved an overall claims payment average TAT of 6.5 days, on over 300,000 claims a month.

Opportunities for Improvements

- 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 2015.
- Sunflower will implement interventions to continuously improve Member and Provider satisfaction with Sunflower services and operations.
- Sunflower will continue to develop and expand trending reports for data analysis and focused intervention.
- Implementation of the State MCO collaborative Pre-Diabetes PIP. Development has been well past implementation date.
- Implement additional outreach to internal and external partners to share results of quality improvement activities.

- 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)

Diabetes Management PIP revised to Pre-Diabetes Management PIP

The state required all three Kansas Medicaid MCOs to participate in a collaborative diabetes performance improvement project (PIP). Initially, the MCOs were meeting with the state on a monthly basis to discuss issues related to the PIP. Initially the PIP was related to diabetic members and HEDIS data would be the measurement of performance related to the success of interventions implemented by the various MCOs. Through a course of many meetings with various plan, state, and EQRO staff, the project continued to evolve and eventually became focused on pre-diabetic members identified through specific codes provided by the state and interventions targeted at specific populations.

From January through September of 2014, the three MCO's continued to meet monthly with the state to work through finalizing the methodology, baselines, targets and member materials. The MCO's submitted materials in August, 2014 for the state to review and provide recommendations back to the MCO's. The criteria for members to be included into the population targeted in the PIP was determined to be those in the WORK program and receiving waiver services who were identified through claims data as being at risk for developing diabetes based on diagnosis codes. In October of 2014, the initial outreach to the targeted member population occurred to determine interest in participating in the PIP.

The PIP program offers choices to members in Southeast Kansas, Wichita and Kansas City area to allow the members to choose an opportunity to participate in a program that allows them to increase their knowledge, activity and decrease the likelihood of developing diabetes through implementing changes in their diet and daily activities. The members have the option of participating in multiple programs, including the Diabetes Prevention Program (DPP) offered at the YMCA's located in the Wichita and Kansas City areas. There was a second option developed by the MCO's called the KanBeWell program that includes educational materials that are specific to healthy eating, increasing activity and monitoring their diet/activity on a log provided to the members. For the members located in Southeast Kansas a list of available resources were developed for the members to choose from and to be used in conjunction with the materials of the KanBeWell program. The overall goals for the members who choose to participate in one of these programs is to help them determine their risk for developing diabetes, learn about healthy eating, increasing activity and allow them to modify the factors in their lifestyle that decrease their risk for developing diabetes. Results from the members' participation will be determined.

The process of reviewing, making recommendations and revisions continued into December 2014 on the PIP project. The approval by the state was granted to the MCO's on December 18, 2014 to move forward with production of current educational materials to allow the MCO's to get the project implemented for the members. The progress on this PIP has shifted: ~~to~~ the educational materials are in production;~~,~~ efforts to modify the database for data collection and train Sunflower staff to perform member outreach and collect data are underway.

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 quarterly and ad hoc 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, Cenpatico care coordinators/case managers reach out to the member to help them with:

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.

Cenpatico care coordinators and case managers also work with the Providers to insure engagement with treatment and ask about any barriers the providers may see to prevent the member from successfully completing treatment.

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:, 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.

Challenges for 2014:
The implementation of this PIP did not take place until January 2014. Data collection did not start until April and reports were still being built in July. Data alignment continued to be an issue during the 2014 data collection period. The state system for inclusion criteria, KCPC, was found to be incompatible with the Sunflower data systems used in this report. At the end of the calendar year, a meeting was held with the state to address a workaround for providing the data. There were several iterations to the project which also provided inconsistency in how the data was reported. The state discontinued the monthly meetings for reports and went to a quarterly reporting time frame.

Successes:
All members who are identified as needing SUD treatment are referred to a care coordinator or case manager. Several trainings were conducted with the Providers around Motivational Interviewing and ASAM criteria. The response to these trainings was very positive. There is a pilot project in development to determine the efficacy of the ACHESS mobile application which supports members through their recovery process. Two providers have been identified to participate in the pilot project. Meetings have been held monthly with providers to address any issues that may arise regarding initiation and engagement of members.

NCQA Accreditation
Sunflower received accredited status with the National Committee for Quality Assurance (NCQA) effective May 21, 2014. As a result, Sunflower is preparing for the NCQA accreditation renewal through the remainder of 2014. The next NCQA survey is anticipated for March 1, 2017. In preparation for the review, Sunflower continues to review all plan and quality improvement processes to be consistent with NCQA standards. During 2014, additional refinements were made to hardwire accreditation compliance into processes including revision of member letters with auto attachments that include appeal information, development of a process for policy review, and training of new staff on documentation requirements. In 2015 readiness reviews/audits, ongoing health plan NCQA education and reminders, and development of a NCQA education module in Cornerstone by Centene will be completed. Additionally in 2014 an individual was hired to lead NCQA efforts to ensure the plan had a focus on continued readiness.

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 submitted HEDIS data in accordance with the performance measure specifications and designed and implemented key interventions to increase the Plan's HEDIS rates reported each calendar year.

Sunflower has been collecting HEDIS data since plan inception 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, the following list represents the 2014 HEDIS measures that Sunflower focused more intensively on and some related interventions for each. These measures were chosen as priorities in 2014 due to their relationship to P4P metrics however may now have changed due to the continued evolution of the P4P measures:

Comprehensive Diabetes Care (CDC)

- Provider profile sent to providers of non-compliant members
- Member report card sent out

- New member outreach in first 90 days to promote establishing care with primary care provider
- Member/provider newsletter communications
- Care gaps report available to providers via Provider Portal

Well Child Visits in First 15 Months of Life

- Monthly letters sent out to children having birthdays to promote Well Child Checks and Immunizations
- Monthly post cards sent for newborns born previous month to promote Well Child Checks and Immunizations
- SHP sponsored baby showers to educate mothers to be on Well Child Checks and Immunization
- Member Connection visits to newborns and Moms
- Start Smart program
- Initiated POM calls
- Developed Provider Resource Kit on Well Child Checks, billing, and other resources

Annual Monitoring for Patients on Persistent Medications (MPM)

- Faxes sent to providers identifying their non-complaint members, requesting lab data for verification
- Member outreach reminding of screenings needed
- Abstraction of charts for lab data acquired by the plan
- Provider Profile mailer

Follow-up After Hospitalization for Mental Illness (FUH)

- Ongoing reminders to providers to bill with the correct code
- All staff retraining in order to encourage members to adhere to follow-up guidelines
- Educate major hospitals to elevate awareness of the need to collaborate with the follow-up appointments

Cholesterol Management (CMD)

- “Healthy Reminders” mailings from Corporate Office to non-compliant members
- Provider Profile mailer
- Care Gap Reports available on Provider Portal
- Member education

Breast Cancer Screening (BCS)

- Mailer to female members
- Mammogram post cards and “Healthy Reminders” mailing from Corporate office
- Provider Profile mailer
- Member education

Cervical Cancer Screening (CCS)

- Mailer to female members
- “Healthy Reminders” mailing from Corporate office
- Care Gap Reports available on Provider Portal
- Member education

Sunflower has tracked progress on these measures on a monthly basis throughout 2014 while actively working interventions and continues to track these measures on a monthly basis for our performance in 2015. Unfortunately due to the timing of the due date of this report, a determination as to whether the measure goals will be met will not be able to be determined until the HEDIS 2015

results are available, after July 2015. As an area for improvement, this year the HEDIS work-plan will focus on the P4P measures and three additional measures targeted for improvement due to their relative performance rate, or significance to the Sunflower population.

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 warrant 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.

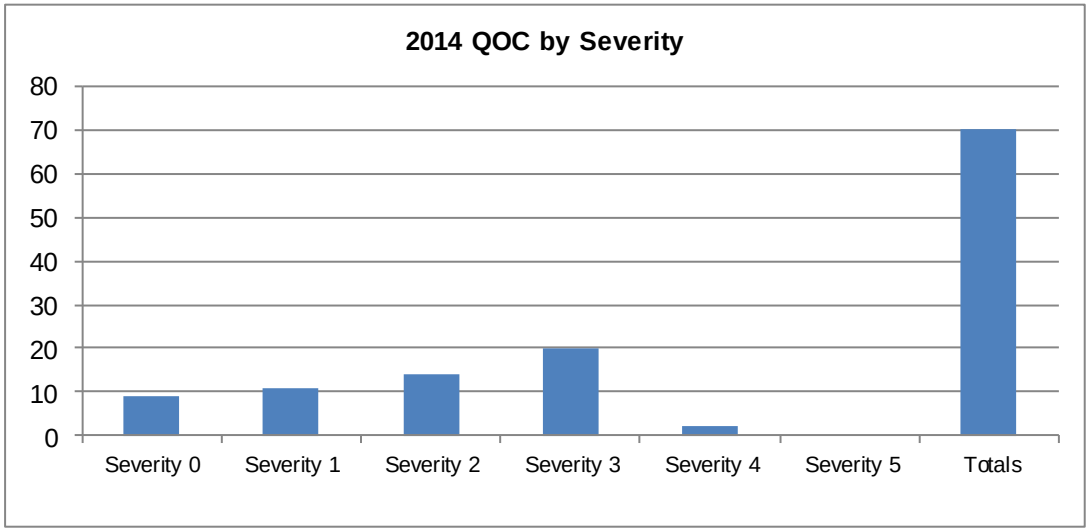
Potential quality of care issues are defined as any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care, or that signals a potential sentinel event.

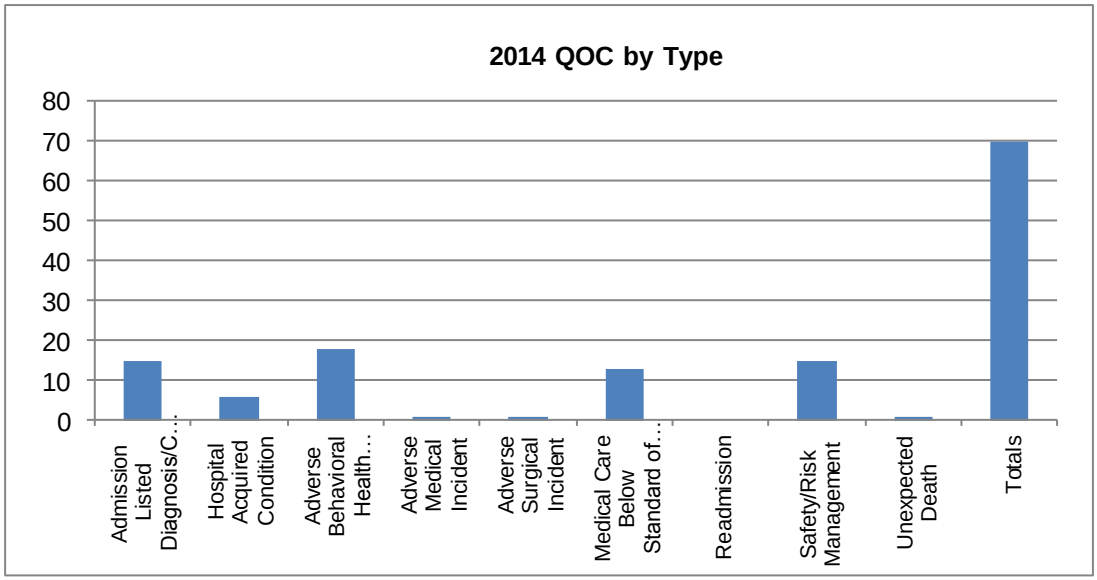
Quality of care events include but are not limited to the following:

- 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.

Left Blank Intentionally

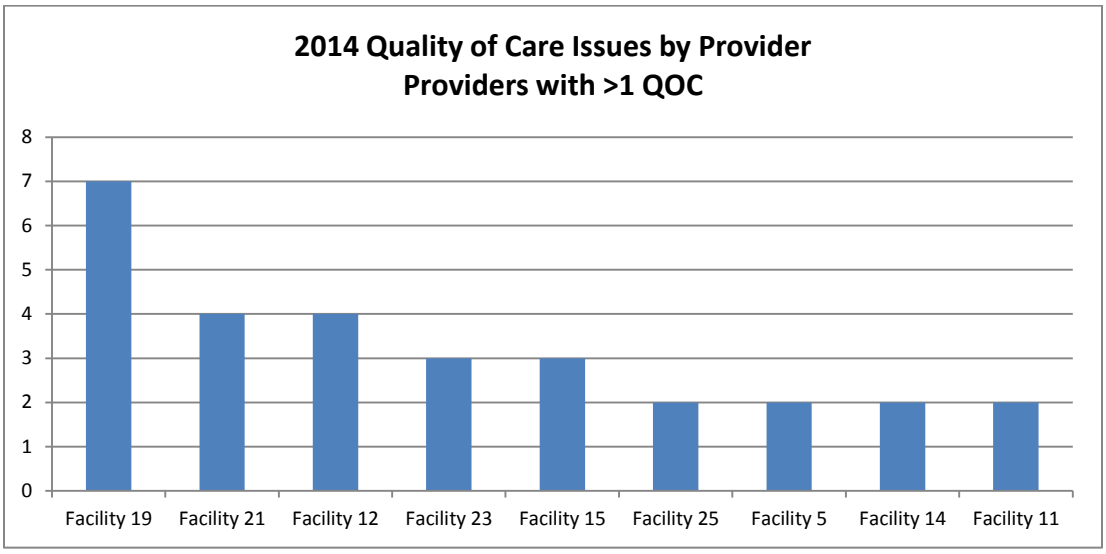
Sunflower reviews events both at an aggregate and provider/facilty level. The below graphics show the type and severity of QOCs reviewed by Sunflower in 2014.





Left Blank Intentionally

Trending graphs below show the facilities or providers with greater than one QOC in 2014. Sunflower worked with all providers with a severety level of ≥3 on activities to mitigate the risk of future recurrance of the reviewed event. It should be noted that in cases where it is felt prudent to review additional cases for a pattern or trend, Sunflower will request additional records for review, thus some providers may have greater QOCs attributed to them for a behavior or pattern of one specific practice.



The State of Kansas has defined, and developed a system of provider reporting for events considered “Adverse Incidents”. Selected providers are able to report the defined events into a state developed portal and these reports are named Adverse Incident Report(s) or AIRS. Adverse incidents are defined by the state to providers for purposes of this self-reporting 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 below:

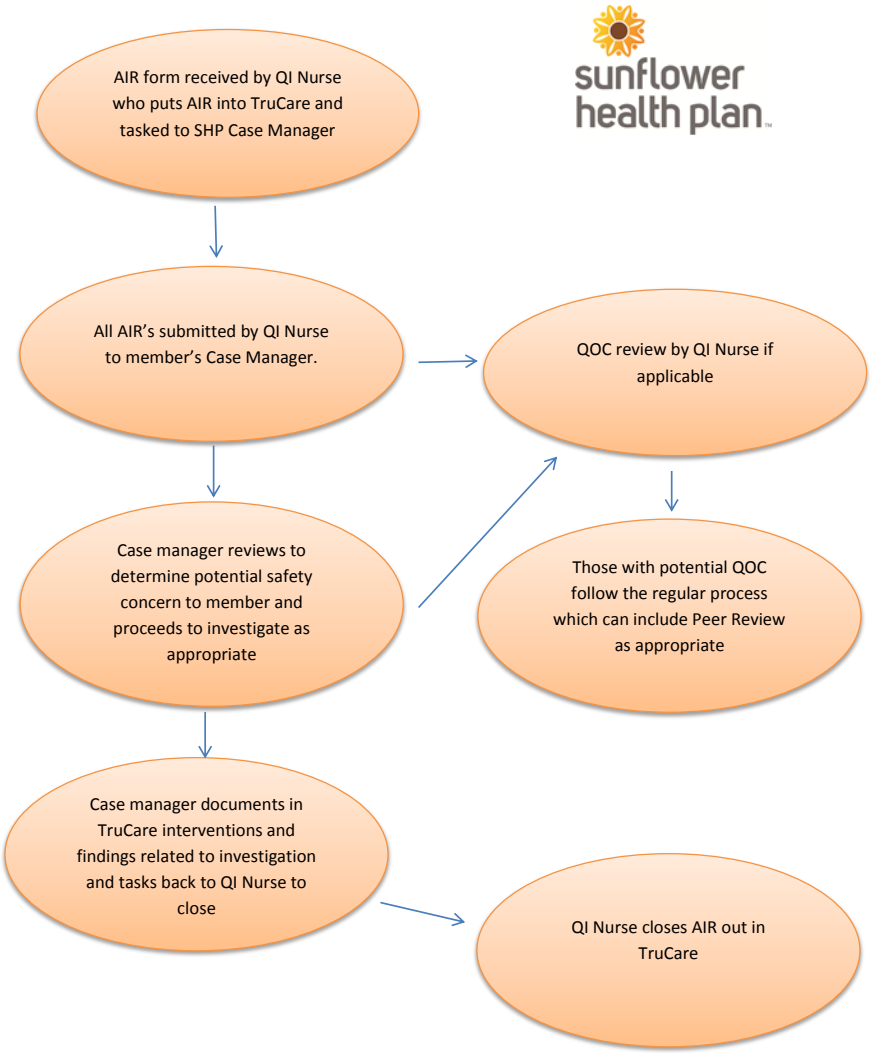
1. Preventable death- Any death that occurs as a direct result of the actions (or lack thereof) of any CSP provider that can be reasonably confirmed by the providers or upon medical examination.
2. Physical abuse - Any allegation of intentionally or recklessly causing physical harm to a consumer by any 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.

These Adverse Incidents are included in the routine QOC reviews completed at the Plan. As stated previously, the State of Kansas has developed parallel reporting mechanisms for providers to report Adverse Events to the state and MCOs through an "Adverse Incident Reporting System (AIRS)". Using this model, Sunflower receives reported AIRS, completes initial review by the QOC nurse, then receives follow-up and input from a Case Manager on the merit of the report and follow up actions taken to mitigate potential harm or provide services to the member. AIRs reports are aggregated in the following graphs for review but those rising to the level necessitating more in depth review by the Quality Department and/or Medical Director take a parallel path as a QOC as well.

In 2014, Sunflower's Quality Improvement team worked on making the process for documenting and tracking AIR's more automated within the clinical documentation system utilized by both Quality and the Medical Management teams. This new process was implemented in December of 2014 and is still being refined as the two teams continue to work through the use of a new system and process. The process for AIR is demonstrated in the diagram provided. This process also depicts how an AIR can be addressed related to being a potential QOC issue.

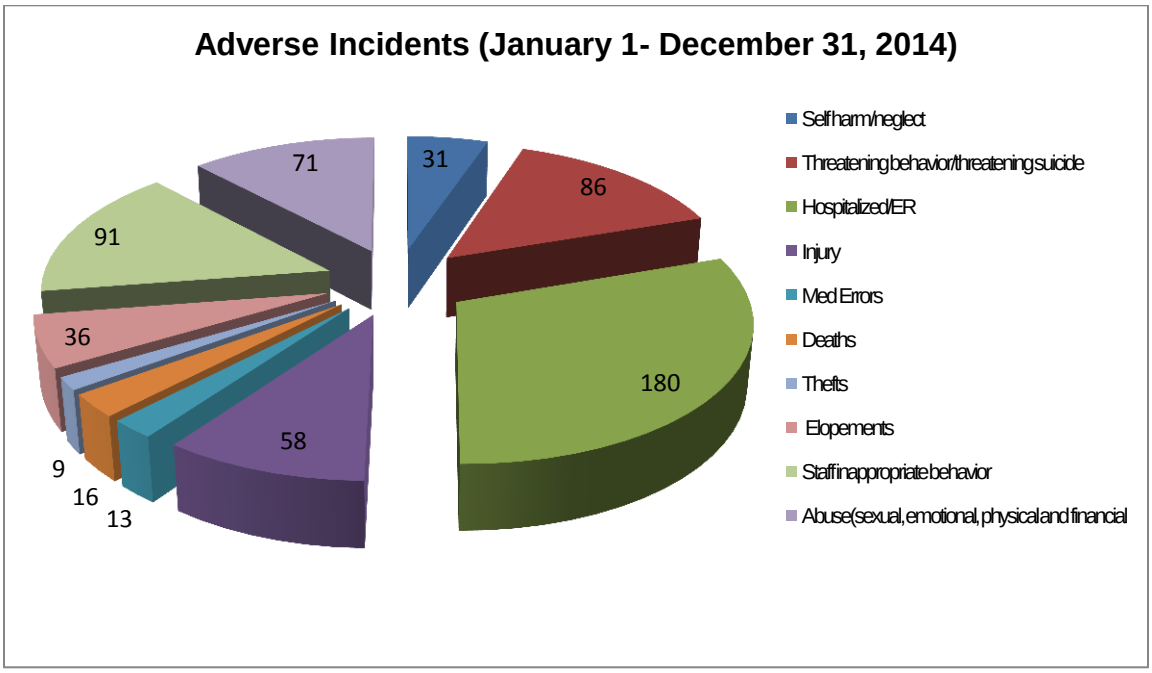
Left blank intentionally



Left blank intentionally

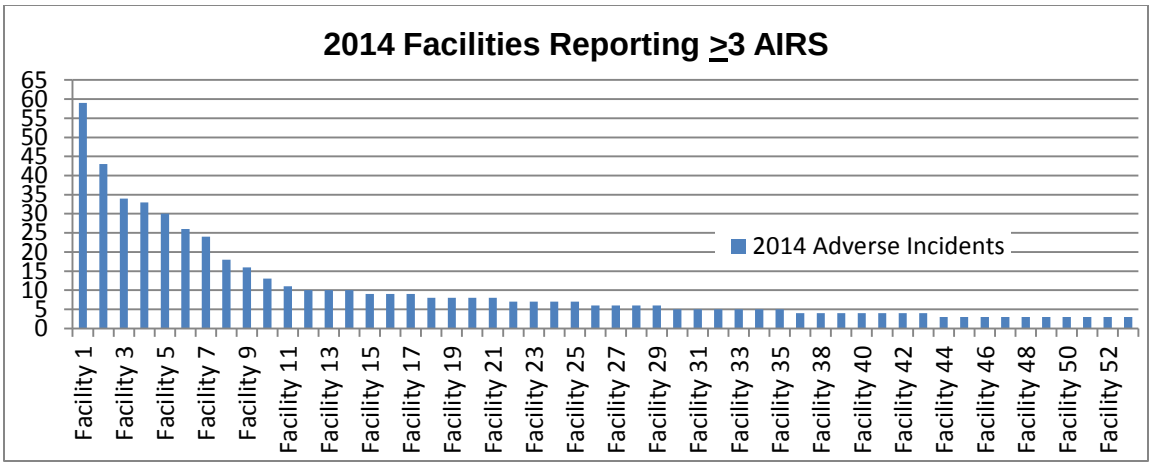
In 2014, Sunflower was forwarded 586 individual AIRs from 90 unique providers. Each AIR reported was reviewed and processed as discussed previously.

The following graphic demonstrates the categorization type of 2014 AIR reports. Hospitalized/ER visits represent the highest category, having 180 AIRS related to them. Historical practice in KS has been to report any time a vulnerable member visits the ED or is hosptialized, any unexplained abrasion, or otherwise noteworthy behavior for these vulnerable populations.



These data are also trended by provider to ensure that there are not provider trends in member reported AIRs. Below is a graph depicting those results. At this time, due to the low number of events that come in as AIR and are converted to true QOCs, no specific trends of providers have been noted. However, it is suspected that some agencies are more diligent reporters of events making the frequency of events skewed. In 2014 Sunflower did identify one facility with a quality event that necessitated action and engaged Provider Relations and Medical Management to work with the facility to make environmental and behavioral changes that will increase member safety. The graphic below shows the providers that reported three or more AIRs during calendar year 2014. All events that meet mandatory reporting requirements and trends of concerns are also reported to the appropriate state and/or local agency or personnel.

Left Blank Intentionally



Recommendations for 2014 related to the quality of care and adverse incident reporting include continuing to evaluate for provider trending, developing more objective follow-up documentation to allow for trending of findings and provider follow up on AIR reporting, and continued work on refining AIR system workflows in TruCare for more efficiency.

Practice Guidelines (CPG)

Sunflower continued with the following 2013 clinical and preventive health practice guidelines in 2014. Sunflower made providers aware of the guidelines and their expected use through the provider newsletters, inclusion in the provider manual, and on the Sunflower website. Performance on CPGs is monitored through performance on applicable HEDIS measures.

- 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 2014. Opportunities in 2014 related to practice guidelines are to continue and expand provider profiles in 2015 to a larger provider group to help increase compliance.

2014 Intervention Evaluation and 2015 Goal Setting:

- Continue annual review of CPGs and PHGs, review and update as needed based on the policy and procedure requirements.-Goal met in 2014, continue in 2015.
- Continue to notify practitioners about the guidelines via newsletter and website announcements.- Goal met in 2014, continue in 2015.
- Continue member and provider outreach and education-based initiatives regarding all guidelines.- Goal partially met in 2014 due to limited distribution of provider profiles. Continue in 2015.
- Continue to meet applicable NCQA Standards throughout 2014. -Goal met in 2014, continue in 2015.

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 (PHG)

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 2014 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.

Adult Preventive Health Guideline Performance Measurement

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.

Chlamydia Screening	HEDIS 2015*	NCQA Quality Compass Benchmark 50th Percentile	Goal Met?
	43.02% 2009/4671	10-25%	No

*Rates not final: Data Source QSI as of 2/18/2015

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. Although slight improvement (45.65% to 46.29%) was noted from 2013 to 2014, Sunflower did not realize the improvement anticipated. This measure does not have a NCQA comparison, but, will following the 2015 HEDIS season making analysis of results more complete.

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.

Cervical Cancer Screening	HEDIS 2015*	NCQA Quality Compass Benchmark 50th Percentile	Goal Met?
	46.29% (6085/13145)	No benchmark available since revision of specifications for measure, HEDIS 2014	No

*Rates not final; Data Source QSI as of 2/18/2015

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 2015 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 2015 and re-evaluated against Sunflower's goal once available. An increase of 3.66 percentage points in cervical cancer screening rates was seen with hybrid data collection for HEDIS 2014 for Sunflower.

Barriers Sunflower identified for adult preventative measures 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.

Implemented or planned actions Sunflower identified to improve adult preventative rates include:

- 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.
- Mailer to female members to remind of 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.

Well-Child Visits Age 3-6	HEDIS 2015*	NCQA Quality Compass Benchmark 50th Percentile	Goal Met?
	61.53% (14540/23631)	10-25%	No

*Rates not final; Data Source QSI as of 2/18/2015

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.

Adolescent Well Care	HEDIS 2015*	NCQA Quality Compass Benchmark 50th Percentile	Goal Met?
	42.59% (11502/25812)	25-50%	No

*Rates not final; Data Source QSI as of 2/18/2015

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.

Lead Screening	HEDIS 2015*	NCQA Quality Compass Benchmark 50th Percentile	Goal Met?
	49.08% (3005/6123)	10-25%	No

*Rates not final; Data Source QSI as of 2/18/2015

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. Also, charts will be collected and reviewed for additional data on the Lead Screening measure. Results will be final in June 2015 and re-evaluated against Sunflower's goal once available. Although Sunflower has not been successful in obtaining supplemental lead screening data from KDHE, our numbers of our eligible population took a large increase due to the enrollment specifications of this measure, which look at 12 months prior to the child's second birthday. The 2015 rate will be more representative of Sunflower membership.

Barriers Sunflower identified for Well-Child metrics include:

- 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.

Implemented or planned actions Sunflower identified to improve Well-Child rates include:

- 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.
- Newborn Letters sent to out monthly to members who were born within the month, reminding of the importance of scheduling a well-child visit and of CentAccount incentive for preventative visits.
- 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 an 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 Guides to educate practitioners on measures, including well-child/adolescent visits and lead screening, and correct billing codes.
- Schedule of Health Check visits included in New Member packets.
- Participation in Back-to School Fairs to promote regular Health Checks by distributing pertinent informational materials.
- 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 survey data

Member Grievances

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, 2014 through December 31, 2014, compared to calendar year 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, 2014	Per 1000	Jan. 1 - Dec 31, 2013	Per 1000
Access to care & Services	15	0.10	388	2.87
Accessibility of Office	15	0.10	0	NA
Attitude/Service of Staff	133	0.93	110	0.81
Availability	168	1.18	0	NA
Billing and Financial Issues	48	0.34	34	0.25
Criteria Not Met - Durable Medical Equipment	6	0.04	0	NA
Criteria Not Met - Medical Procedure	4	0.03	0	NA
HCBS	3	0.02	0	NA
Lack of Information from Provider	9	0.06	0	NA
Level of Care Dispute	12	0.08	0	NA
Other	60	0.42	0	NA
Overpayments	1	0.01	0	NA
Pharmacy	8	0.06	0	NA
Prior or Post Authorization	10	0.07	0	NA
Quality of care	16	0.11	26	0.19
Sleep Studies	1	0.01	0	NA
Timeliness	124	0.87	0	NA
Benefit	0	NA	13	0.09
Cultural/Linguistic	0	NA	3	0.02
Total	633	4.43	574	4.25

The grievance category with the highest volume in 2014 was Availability, representing 26.54% (168/633) 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 21.01% (133/633) of all member grievances received in 2014. Timeliness represents 19.59% (124/633) of total grievances. All other categories represented a minimal number of overall grievances, from 9.48% of grievances related to Other, 7.58% Billing and Financial issues, , 2.53% Quality of Care, 2.37% Accessibility of office, and Criteria Not Met –DME, Criteria Not Met -Medical

Procedure, HCBS, Lack of Information from Provider, Level of Care Dispute, Overpayments, Pharmacy, Prior or Post Authorization and Sleep Studies each are < 1% . Sunflower has established a goal for total grievances to remain less than 5.00/1000 members annually. With a rate of 4.43/1000 for all grievances, the goal was met for 2014. 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 NCQA sub-category code. A drill down analysis was performed on the three highest categories, comprising 67.14% (423/633) of the total grievances, to understand the key issues driving these grievances. The three tables below display the results by NCQA sub-category for the three categories having the largest number of grievances.

The first category with the largest number of grievances for 2014 was Availability/Access to Care.

1. Availability/Access to Care	**Jan. 1 - Dec 31, 2014**	**Per 1000**	**Jan. 1 - Dec 31, 2013**	**Per 1000**
Transportation vendor issue	98	0.69	314	2.32
Access - Other	19	0.13	0	NA
Out-of-network provider	14	0.10	0	NA
Unable to obtain medications	9	0.06	0	NA
Behavioral health (refer to BH vendor)	5	0.03	0	NA
Service/benefit limitations or exclusions	4	0.03	0	NA
Billing - other	2	0.01	0	NA
Dissatisfaction with CM/CM process	2	0.01	0	NA
Distance to provider	2	0.01	0	NA
Lack of Primary Care Provider	2	0.01	0	NA
PCP – appointment availability	2	0.01	6	0.04
After-hours access	1	0.01	5	0.03
Dental vendor issue	1	0.01	0	NA
Health plan service - other	1	0.01	0	NA
Lack of facility - IP/OP services	1	0.01	5	0.03
Lack of specialist	1	0.01	0	NA
Non-receipt of member material	1	0.01	0	NA
Provider refused to treat member	1	0.01	2	0.01
Provider service - other	1	0.01	0	NA
Specialist – appointment availability	1	0.01	2	0.01
Pharmacy	0	NA	22	0.16
Vendor Issue (e.g. dental, vision)	0	NA	14	0.10
Miscellaneous	0	NA	18	0.13
Total	168	1.18	388	2.87

The second category with the largest number of grievances for 2014 was Attitude/Service of Staff.

2. Attitude/Service of Staff	Jan. 1 - Dec 31, 2014	Per 1000	Jan. 1 - Dec 31, 2013	Per 1000
Transportation vendor issue	40	0.28	7	0.05
Rude/unprofessional office staff	39	0.27	19	0.14
Dissatisfaction with CM/CM process	9	0.06	8	0.06
Provider service - other	9	0.06	0	NA
Access - Other	8	0.06	0	NA
Vision vendor issue	4	0.03	0	NA
Discrimination by provider	3	0.02	0	NA
Privacy/confidentiality issue with site	3	0.02	0	NA
Dental vendor issue	2	0.01	0	NA
Home health/DME vendor issue	2	0.01	0	NA
Poor care received	2	0.01	0	NA
After-hours access	1	0.01	0	NA
Appointment availability	1	0.01	0	NA
Behavioral health (refer to BH vendor)	1	0.01	0	NA
Billing - other	1	0.01	0	NA
Did not return telephone call	1	0.01	0	NA
Excessive wait time in office	1	0.01	0	NA
Excessive telephone wait time (Provider)	0	NA	3	0.02
Failure to respect Member's rights	1	0.01	0	
Health plan service - other	1	0.01	8	0.06
Incorrect PCP Assignment	0	NA	2	0.01
PCP – appointment availability	1	0.01	0	NA
Provider refused to treat member	1	0.01	0	NA
Rude/unprofessional health plan staff	1	0.01	2	0.01
Rude/unprofessional provider or clinical staff	1	0.01	48	0.36
UM Process	0	NA	2	0.01
Miscellaneous	0	NA	11	0.08
Total	133	0.93	110	0.81

The category with the third largest number of grievances for 2014 included Timeliness.

Timeliness	Jan. 1 - Dec 31, 2014	Per 1000
Access - Other	3	0.02
Benefit Exclusion	1	0.01
Dissatisfaction with CM/CM process	1	0.01
Excessive telephone wait time	1	0.01
Transportation vendor issue	118	0.83
Total	124	0.87

The most common grievance within the Availability category was grievances related to transportation, comprising of 58.33% (98/168) of the grievances in this category, and representing 51.97% (314/574) of grievances overall. Access-Other was the 2nd largest category, but with a much lower volume than grievances regarding transportation (11.31% for Access – Other).

The most common areas within the Attitude/Service category were related to Sunflower "Transportation vendor issue" (30.08% or 40/133) with "Rude/unprofessional office staff" second most common (29.32% or 39/133). Overall, all complaints regarding providers represented 59.40% of the Attitude/Service grievances, when including grievances against the transportation vendor.

The most common area within the Timeliness category was complaints related to transportation, comprising of 95.16% (118/124) of the grievances in this category.

Grievances regarding transportation are clearly the most significant issue impacting member satisfaction in looking at member grievance data. All grievances regarding transportation comprise 51.97% of total member grievances received in 2014. The table below reflects the transportation grievances by NCQA subcategory.

Transportation Provider Grievances by NCQA Subcategory	Jan. 1 - Dec 31, 2014	Percentage of total grievances
Access - Other	4	0.63%
Billing - other	3	0.47%
Claims payment	6	0.95%
Eligibility issues	3	0.47%
Provider billing member	3	0.47%
Provider service - other	4	0.63%
Rude/unprofessional office staff	20	3.16%
Service/benefit limitations or exclusions	1	0.16%
Transportation vendor issue	285	45.02%
Total	329	51.97%

In 2013, Sunflower had two different transportation vendors. Despite the decrease in transportation grievances from 2013 of 70% to 52% in 2014, Sunflower continues to place an emphasis on reducing grievances related to transportation. Therefore, Sunflower has set a goal to decrease grievances related to transportation by 5% for 2015.

Throughout 2014 Sunflower worked with the current transportation vendor, Logisticare to further analyze these grievances. A brief list of barriers identified and activities aimed to improve the frequency of these complaints are identified below. Sunflower plans to meet more routinely with Logisticare to review these data and develop an intervention planned for this goal in March 2015:

Barriers:

- State has large rural population with limited providers
- Members in certain populations have specific needs
- SOW with vendor not specific to outlier situations causing confusion
- Logisticare staff not trained to handle unique needs of LTC population
- Members difficulty in transition to new transportation vendor and prior auth guidelines
- High volume of short notice trips requested by members

Anticipated activities for 2015:

- Discuss formal goals with Logisticare and develop cooperative action plan
- Review of unique needs of LTC population with Logisticare
- Additional education to call center staff at Logisticare
- Development of scripting related to assessment of additional specific needs of a person with a physical disability that may impact or assist with transportation
- Work with Logisticare to review 'thresholds' for trends in complaints for individual drivers/services
- Establish workgroup with Logisticare specifically for Sunflower grievances
- Work with Centene Corporate to assist with leveraging service standards in national contract

Sunflower has also determined that grievances related to transportation are common member grievances in other Centene health plans that have a transportation benefit. Analysis by corporate on transportation grievances by plan and type is underway with analysis to be completed in 2015.

Member Appeals

During the latter part of 2013, categorization of appeals became more precise and used additional subcategories than those used in 2013. For that reason, comparability of results from 2013 to 2014 is unavailable. Results for member appeals for 2014 by category are displayed in the table below.

Appeal Category	Jan. 1 - Dec 31, 2014	Per 1000	Jan. 1 - Dec 31, 2013	Per 1000
Criteria Not Met - Medical Procedure	96	0.67		
Billing & Financial	0	NA		
Prior or Post Authorization	91	0.64		
Pharmacy	87	0.61		
HCBS	81	0.57		
Criteria Not Met - Inpatient Admissions	80	0.56		
Level of Care Dispute	53	0.37		
Criteria Not Met - Durable Medical Equipment	47	0.33		
Lack of Information from Provider	7	0.05		
Other	5	0.03		
Quality of care	3	0.02		

Appeal Category	Jan. 1 - Dec 31, 2014	Per 1000	Jan. 1 - Dec 31, 2013	Per 1000
Availability	1	0.01		
Total	551	3.85	336	2.49

The appeal category with the highest volume of appeals is Criteria Not Met - Medical Procedure accounting for 17.42% (96/551) of total appeals, these appeals are based denial of medical necessity. Common reasons for denial in this category include lack of sufficient documentation from the provider to meet review criteria. Sunflower overturned 43.75% of the appeals in this category and upheld 56.25% during the appeal review process. The second highest category of appeals received were those related to Prior or Post Authorization accounting for 16.52% (91/551) of total appeals. In further research this category is used by one particular partner specialty company that has 91/91 of the appeals in this category. Sunflower intends to research this further in 2015 and determine if other subcategories should be used for more granular analysis.

The volume of pharmacy appeals is believed to be related to the transition to the KanCare program from fee for service and the continued addition of edits and prior authorization requirements not previously in place for the pharmacy benefit.

Due to monitoring trends related to pharmacy appeals, the pharmacy team evaluated and implemented changes related to prior authorization processes. In addition, provider education was performed provider related to the criteria for another medication frequently encountered on appeals. As a result of the changes made with the prior authorization process, a decrease of 22% was noted in pharmacy appeals from 1st quarter 2014 and 2nd quarter 2014.

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 has made efforts to focus on educating providers and members related to the criteria and need for sufficient clinical information in order to process requests in a timely and appropriate manner.

Sunflower upheld 57.7% of the appeals and overturned 42.3% in 2014. Below is a summary of the upheld and overturned appeals by category.

Member Appeal Category	2014 Upheld	2014 Overturned
Criteria Not Met - Medical Procedure	54	42
Billing & Financial	0	NA
Prior or Post Authorization	45	46
Pharmacy	23	64
HCBS	56	25
Criteria Not Met - Inpatient Admissions	67	13
Level of Care Dispute	37	16
Criteria Not Met - Durable Medical Equipment	19	28
Lack of Information from Provider	0	7
Other	3	2
Quality of care	2	1
Availability	1	0

Member Appeal Category	2014 Upheld	2014 Overturned
Total	306	224

Sunflower has established a goal for total member appeals to remain less than 2.50/1000 members annually. With a rate of 3.85 /1000 members for all appeals, the goal was not met for 2014. During 2014 a number of activities impacted the volume of appeals contributing to the higher rate. The following are some of those identified factors:

- Prior authorization policies were more strictly enforced
- Administrative denial procedures were more strictly adhered, requiring provider appeal for missing information or untimely notification
- MCOs had the authority to propose a reduction, based on service review for HCBS members without state approval.
- KanCare continuity of care period expired in 2013.

Due to the increased number of appeals and Sunflower overall appeal overturn rate (42.3%), an in depth review of the appeals was conducted. It was determined that there was no trend in turnover by initial reviewer, appeal reviewing physician or appeal type. Sunflower continues to review for trends in appeal data for opportunities. At this time the opportunities to reduce appeals include assisting providers in understanding the criteria used for medical necessity review and submitting appropriate and timely reviews to the plan. In 2015 Sunflower will provide outreach to our network to improve these areas. It is not anticipated that 2015 appeals will decrease due to the continued plan focus on requiring timely notification and the additional appeal benefits afforded to the HCBS population (verbal appeals and ombudsman and Disability Rights Center representation notification on all letters, etc.). The goal for 2015 for appeals will be adjusted to reflect this factor that makes Sunflower unique from other Centene plans. A goal of 3.5 appeals/1000 will be in place for 2015.

Provider Appeals

Provider appeals, also known as claims disputes, although not large drivers of member satisfaction, are also monitored for opportunities for improvement. Additional metrics evaluated in the annual provider survey also speak to satisfaction with prior authorization services. Below are the number of provider appeals Sunflower received in 2014. Provider issues most commonly identified included claims/billing issue 58.46% (646/1105) and authorizations 20.63% (228/1105). Throughout the course of 2014 Sunflower continued to make adjustments to claims edits and rules affecting provider claims payment. These adjustments were due to further clarification of KMAP guidelines, provider contracts, or as a result of claims projects due to global issues identified affecting provider payment. The goal for Sunflower will be a 5% reduction in provider claim payment appeals in 2015. All Medicaid populations are now served by Sunflower. A stable year is anticipated in 2015 which should improve performance in this area along with the enhancements implemented in 2014.

Provider Appeal Category	Jan. 1 - Dec 31, 2014	Per 1000
Authorizations	228	1.59
Claims/Billing Issue	646	4.52
Credentialing/Contracting	NA	NA
Provider Relations	NA	NA
Formulary	10	0.07
Customer Service	NA	NA
Health Plan Administration	28	0.20
Clinical/Utilization Management	187	1.31
Quality of Service or Care	1	0.01

Provider Appeal Category	Jan. 1 - Dec 31, 2014	Per 1000
Other	5	0.03
Total	1105	7.73

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 2014 consisted of 1,350 members. The Medicaid Adult survey response rate for 2014 was 42.8%. The sample size for the 2014 Medicaid Child Survey (MCS-CCC) Title 19 consisted of 5584 members, with a response rate of 38.5%. The sample size for the 2014 Medicaid Child Survey (MCS-CCC) Title 21consisted of 4712 members, with a response rate of 46.8%.

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

Adult Composite & Question Ratings	2013 Rate	2014 Rate	2013 Quality Compass All Plans	2013 Quality Compass All Plans Percentile
Getting Needed Care	**84.2%**	**86.2%**	**80.6%**	**90th**
• Ease of getting care, tests, or treatment needed	84.7%	87.7%	82.5%	75th
• Obtaining appointment with specialist as soon as needed	83.8%	84.7%	79.0%	75th
Getting Care Quickly	**84.5%**	**87.0%**	**81.2%**	**90th**
• Obtaining needed care right away	86.4%	89.3%	83.1%	90th
• Obtaining appointment for care as soon as needed	82.6%	84.7%	79.3%	90th
How Well Doctors Communicate	**90.4%**	**89.4%**	**89.3%**	**25th**
• Doctors explaining things in an understandable way	90.3%	90.8%	89.5%	50th
• Doctors listening carefully to you	91.0%	88.9%	89.9%	25th
• Doctors showing respect for what you had to say	92.2%	89.8%	91.2%	25th
• Doctors spending enough time with you	88.2%	88.2%	86.5%	50th
Customer Service	**79.1%**	**90.1%**	**86.2%**	**90th**
• Getting information/help from customer service	70.8%	84.6%	79.8%	75th

Adult Composite & Question Ratings	2013 Rate	2014 Rate	2013 Quality Compass All Plans	2013 Quality Compass All Plans Percentile
• Treated with courtesy and respect by customer service	87.4%	95.6%	92.5%	90th
Shared Decision Making	**51.1%**	**50.9%**	**NA**	**Not available**
• Doctor/health provider talked about reasons you might want to take a medicine	47.1%	49.5%	NA	Not available
• Doctor/health provider talked about reasons you might not want to take a medicine	27.4%	26.4%	NA	Not available
• Doctor/health provider asked you what you thought was best when talking about starting or stopping a prescription medicine	78.8%	76.6%	NA	Not available
Health Promotion and Education	67.7%	68.4%	NA	Not available
Coordination of Care	87.7%	82.1%	78.7%	75th
Providing Needed Information	60.8%	69.3%	66.6%	50th
Ease of Filling Out Forms	92.5%	93.7%	94.5%	<25th
Ratings Items				
Rating of Health Care	71.6%	73.8%	70.8%	75th
Rating of Personal Doctor	79.5%	78.9%	78.4%	50th
Rating of Specialist	79.2%	78.5%	79.4%	25th
Rating of Health Plan	67.6%	71.7%	73.5%	25th

Title 19-Child Composite & Question Ratings	2013 Rate - Title 19 and 21 combined	2014 Rate Title 19 (QC 2013 all plan percentile)	2014 Rate Title 21 (QC 2013 all plan percentile)
Getting Needed Care	**79.8%**	**88.3% (75th)**	**86.0% (50th)**
• Ease of getting care, tests, or treatment child needed	90.0%	92.2% (75th)	93.0% (75th)
• Obtaining child's appointment with specialist as soon as needed	69.5%	84.5% (50th)	78.9% (25th)
Getting Care Quickly	**90.1%**	**92.5% (75th)**	**92.3% (50th)**
• Obtaining needed care right away	91.1%	93.5% (50th)	92.6% (50th)
• Obtaining appointment for care as soon as needed	89.0%	91.5% (75th)	92.0% (75th)
How Well Doctors Communicate	**93.9%**	**93.5 (50th)**	**95.6% (90th)**
• Doctors explaining things in an understandable way	92.9%	95.2% (50th)	95.9% (75th)

Title 19-Child Composite & Question Ratings	2013 Rate - Title 19 and 21 combined	2014 Rate Title 19 (QC 2013 all plan percentile)	2014 Rate Title 21 (QC 2013 all plan percentile)
• Doctors listening carefully to you	94.7%	95.1% (50th)	96.0% (75th)
• Doctors showing respect for what you had to say	95.0%	95.6% (50th)	97.3% (90th)
• Doctors spending enough time with your child	92.9%	87.9% (25th)	93.3% (90th)
Customer Service	**86.8%**	**89.9% (75th)**	**91.1% (75th)**
• Getting information/help from customer service	79.3%	84.7% (75th)	86.4% (75th)
• Treated with courtesy and respect by customer service staff	94.2%	95.1% (75th)	95.8% (75th)
Shared Decision Making	**52.1%**	**56.4% (NA)**	**57.2% (NA)**
• Doctor/health provider talked about reasons you might want your child to take a medicine	56.3%	62.2% (NA)	61.4% (NA)
• Doctor/health provider talked about reasons you might not want your child to take a medicine	23.8%	30.5% (NA)	28.1% (NA)
• Doctor/health provider asked you what you thought was best for your child when starting or stopping a prescription medicine	76.2%	76.7% (NA)	82.2% (NA)
Health Promotion and Education	67.7%	74.1% (NA)	61.2% (NA)
Coordination of Care	75.7%	83.7% (25th)	79.7% (25th)
Ease of Filling Out Forms	94.2%	95.9% (50th)	96.0% (50th)
Rating Items			
Rating of Health Care	84.9%	86.0% (75th)	86.9% (75th)
Rating of Personal Doctor	87.1%	87.9% (50th)	87.9% (50th)
Rating of Specialist seen most often	78.7%	85.7% (50th)	82.8% (25th)
Rating of Health Plan	80.7%	86.5% (75th)	84.9% (50th)

Sunflower's KanCare contract was implemented on January 1, 2013. As a new plan, Sunflower's goal was to meet or exceed the NCQA Quality Compass 50th percentile for both the Adult and Child surveys. Sunflower met the goal for most areas on the 2014 Adult and on the Child surveys, and exceeded them in several others. The areas not meeting Sunflower's goal of meeting the 50th percentile or above are the areas Sunflower is focusing improvement efforts.

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.

Adult Survey	2014 Percentile Ranking	2014 Opportunity Analysis
Key Driver of Health Plan Rating		
Customer Service	89th	Strength
Getting Needed Care	93rd	Strength
Key Driver of Health Care Rating		
Getting Needed Care	93rd	Strength
How Well Doctors Communicate	46th	Opportunity
Getting Care Quickly	99th	Strength
Key Driver of Personal Doctor Rating		
How Well Doctors Communicate	46th	Opportunity
Coordination of Care	76th	Strength

Child Survey(s)	2014 Percentile Ranking (T19/T21)	2014 Opportunity Analysis (T19/T21)
Key Driver of Health Plan Rating		
Customer Service	85th / 94th	Strength
Getting Needed Care	76th / 51st	Strength / Monitor
Key Driver of Health Care Rating		
Getting Needed Care	76th / 51st	Strength / Monitor
How Well Doctors Communicate	55th / 87th	Monitor / Strength
Coordination of Care	75th / 37th	Strength / Opportunity
Key Driver of Personal Doctor Rating		
How Well Doctors Communicate	55th / 87th	Monitor / Strength
Coordination of Care	75th / 37th	Strength / Opportunity

*Separate Title 19 (T19) and Title 21 (T21) surveys were conducted in 2014 with no consolidated report, an opportunity for 2015 is to include a consolidated report for all child results.

In the CAHPS 2013 survey, the Sunflower opportunity analysis had zero strengths, six opportunities and two monitor findings. In the 2014 survey there are now 11 strengths, four opportunities, and four strengths.

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 in the results analysis, the opportunities for improvement, and whether the intervention was targeted for implementation.

Barrier	Opportunity	Selected for Improvement?
Providers are busy and members feel the providers do not spend enough time with them.	Assist providers with development of tools or communication skills that increase time with members or increased communication.	Y

Barrier	Opportunity	Selected for Improvement?
Providers not aware of the impact of their communication with members on member satisfaction.	Share results of survey with providers. Report to individual providers information received about their care or service.	Y
Members unaware of access standards, i.e. typical timeframe for obtaining appointments.	Member education regarding access standards.	Y
Providers not trained in culturally competent communication or special needs of LTC population.	Develop webinar and training tool for providers to assist with cultural competency and linguistically appropriate care and communication.	Y
Members unaware of covered services, including covered medications, and the UM/prior authorization process.	Member education regarding covered services and UM requirements.	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. Integration of KRAMES member information sheets and posting of these tools on website.	Y
Members have difficulty coordinating information between providers if their child sees multiple providers for care.	Participate in pilot program to include a notebook that allows members to record information they take to all appointments. Continue to enroll members with multiple providers in CM.	Y

Access & Availability

Customer Service Call Statistics

Sunflower monitors customer telephone access throughout the year. Customer Service statistics are reported to the state 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**
95% within 60 seconds or less	Less than 4%

Left Blank Intentionally

The table below reflects the results of the call metrics for 2014.

Month	Calls Volume	Service Level %	Average Speed of Answer	Abandonment %	Goal Met
Jan-2014	19,220	84%	:00:26	3.3	No
Feb-2014	15,400	84%	:00:31	2.8	No
Mar-2014	17,062	96%	:00:08	0.64	Yes
Apr-2014	16,531	97%	:00:07	0.68	Yes
May-2014	15,613	98%	:00:06	0.66	Yes
Jun-2014	15,691	99%	:00:05	0.49	Yes
Jul-2014	19,892	98%	:00:06	0.44	Yes
Aug-2014	18,781	97%	:00:06	0.65	Yes
Sep-2014	16,680	97%	:00:07	0.84	Yes
Oct-2014	17,021	96%	:00:08	0.71	Yes
Nov-2014	14,479	95%	:00:10	0.97	Yes
Dec-2014	15,760	96%	:00:09	0.87	Yes
CY 2014	202,130	95%	:00:11	1.09	Yes

The Customer Service Department consistently met most of Sunflower's performance goals in 2014. The 95% service level was not met in January and February 2014. Five Customer Service Representatives were promoted to other departments for I/DD implementation effective February 1, 2014. Opportunities noted are to continue monitoring staffing ratios to meet service levels. 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. Members receive an updated Member Handbook annually. Member Rights and Responsibilities are a part of the training curriculum for all new Customer Service Representatives.

Accessibility of Primary Care Services

Sunflower 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. Below is a table showing the standards, performance goal, measurement, and frequency for each area of assessment of accessibility.

Accessibility Type	Standard and Performance Goal	Measurement Method	Measurement Frequency
Primary care: Routine, Non-Symptomatic	90% within 21 calendar days of request	Phone Survey	Annually

Accessibility Type	Standard and Performance Goal	Measurement Method	Measurement Frequency
Primary care: Urgent, Symptomatic	90% within 48 hours of request	Phone Survey	Annually
Primary care: Emergent	90% within 24 hours of request	Phone Survey	Annually
OB: First Trimester	90% within 14 calendar days of request	Phone Survey	Annually
OB: Second Trimester	90% within 7 calendar days of request	Phone Survey	Annually
OB: Third Trimester	90% within 3 calendar days of request	Phone Survey	Annually
OB: High Risk Pregnancy	90% within 3 calendar days of request	Phone Survey	Annually
Wait Time in Office	Patients seen in less than 45 min. of appointment time	Phone Survey	Annually
After-hours Care	90% have acceptable after-hours coverage	Phone Survey	Annually
Q4 Adult Survey: Percent of members who responded always or usually to “Obtaining needed care right away”	Quality Compass 50th percentile	CAHPS Survey	Annually
Q6 Adult Survey: Percent of members who responded always or usually to “Obtaining appointment for care as soon as needed”	Quality Compass 50th percentile	CAHPS Survey	Annually
Q4 Child Survey: Percent of members who responded always or usually to “Child obtaining needed care right away”	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”	Quality Compass 50th percentile	CAHPS Survey	Annually
Supplemental Adult and Child (in 2015 survey): In the last 12 months, when you phoned after regular office hours, how often did you get the help or advice you needed?	NA-Will compare against other health plans in book of business for vendor and across Centene Corporation	CAHPS Survey	Annually
Member Grievances related to Appointment Access	< 5.0/1000 members	Grievance Database	Annually

Practitioner Office Survey- Conducted late 2013, scheduled to repeat in next 45 days

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.

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

The results of the appointment access web survey in 2013 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. Since Sunflower had not received access complaints, the intent of the web survey was to primarily to assess performance of 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 and make questions mandatory that apply for all providers if a web-based tool is used as the survey method.

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.

After-hours Care

Access to after-hours care was assessed per the web-based survey noted above in 2013, and through calls placed directly to practitioner offices after business hours by Sunflower vendor staff in 2014. Provider offices were called after regular business hours to verify their responses regarding after-hours coverage and the results documented.

Year	Goal	N	D	No Response	Rate
2013 (web survey and phone verification)	90% have acceptable after-hours coverage	202	246	0	82.11%
2014 (phone verification)	90% have acceptable after-hours coverage	265	331	NA	80.06%

In 2013, 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.

In 2014, Sunflower changed its method for evaluating after hours coverage compliance. Instead of allowing providers to self-report their compliance and supplementing with phone verification, Sunflower completed all calls to the provider offices after hours and independently assessed provider performance against after-hours standards. In 2014, that translated into a 80.06% performance rate. This performance does not meet the goal, thus immediate corrective action is necessary for providers surveyed and a reminder of call standards is planned in 2015 as well consideration of additional monitoring.

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. In 2014 Sunflower is transitioning away from the appointment phone survey and will be using additional CAHPS questions to capture data for more providers to more globally assess primary care access information.

Composite & Question Ratings	Adult 2014 Rate	T19 Child 2014 Rate	T21 Child 2014 Rate	Goal Met?
Getting Care Quickly	**87.0% (90th)**	**92.5% (75th)**	**92.3% (50th)**	**Yes**
Q4: Obtaining needed care right away	89.3% (90th)	93.5% (50th)	92.6% (50th)	Yes
Q6: Obtaining appointment for care as soon as needed	84.7% (90th)	91.5% (75th)	90.0% (75th)	Yes

Sunflower's goal for 2014 was to meet or exceed the NCQA Quality Compass 50th percentile. Sunflower met the goal for the relevant CAHPS questions on the 2014 Adult, and both child surveys.

Left Blank Intentionally

Member Grievances

Sunflower incorporates member complaints/grievances related to accessibility of appointments into the review and analysis of primary care access. The table below reflects the access sub-categories, the number of grievances for each category and the grievances per thousand for each sub-category.

Availability/Access to Care	Jan. 1 - Dec 31, 2014	2014 Per 1000
Transportation vendor issue	98	0.69
Access - Other	19	0.13
Out-of-network provider	14	0.10
Unable to obtain medications	9	0.06
Behavioral health (refer to BH vendor)	5	0.03
Service/benefit limitations or exclusions	4	0.03
Billing - other	2	0.01
Dissatisfaction with CM/CM process	2	0.01
Distance to provider	2	0.01
Lack of Primary Care Provider	2	0.01
PCP – appointment availability	2	0.01
After-hours access	1	0.01
Dental vendor issue	1	0.01
Health plan service - other	1	0.01
Lack of facility - IP/OP services	1	0.01
Lack of specialist	1	0.01
Non-receipt of member material	1	0.01
Provider refused to treat member	1	0.01
Provider service - other	1	0.01
Specialist – appointment availability	1	0.01
Pharmacy	0	NA
Vendor Issue (e.g. dental, vision)	0	NA
Miscellaneous	0	NA
Total	168	1.18

Sunflower established a goal in 2014 for total grievances, and grievances per sub-category, to remain less than 5.00/1000 members annually. With a rate of 1.18/1000 for access to care grievances, the goal was met for 2014. 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.

The table below reflects the barriers identified, opportunities for improvement, and whether the intervention was targeted for implementation regarding access and availability of providers and services.

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 after-hours call standards.	Educate providers on after hours call standards, work with individual providers on corrective action plans.	Yes
Transportation provider lack of use of appropriate vehicle on first call	Work with transportation vendor to create member questions that assist them to send the correct vehicle and person to assist the member on the first call.	Yes
Members and providers not familiar with out of network provider policies/processes for prior authorization.	Work with members and providers to understand out of network provider appointment policies and in network provider options.	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 vendor, monitors and analyzes behavioral health practitioner availability on behalf of Sunflower Health Plan.

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

Practitioner Type	Standard	Method	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	Annually

Practitioner Type	Standard	Method	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	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	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	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	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	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	Annually
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	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	Annually

Practitioner Type	Standard	Method	Frequency
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	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	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	Annually

The table below reflects access standard results by provider type.

Practitioner Type	Standard	Results	Goal Met?
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	100% 100% 1:49	Yes Yes Yes
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	100% 100% 1:123	Yes Yes Yes
PCPs: Internal Medicine	• 95% of urban members ≥19 have at least 1 internist within 20 miles • 95% of rural members ≥19 have at least 1 internist within 30 miles. • At least 1 IM per 2000 adult members	99.8% 92.3% 1:88	Yes **No** Yes
PCPs: Pediatrics	• 95% of urban members ≤18 years of age have at least 1 pediatrician within 20 miles • 95% of rural members ≤18 years of age have at least 1 pediatrician within 30 miles. • At least 1 Pediatrician per 2000 members under age 19	86.6% 78.8% 1:363	**No** **No** Yes

Practitioner Type	Standard	Method	Frequency
PCP Extenders: Nurse Practitioners	• 95% of 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	99% 99.6% 1:296	Yes Yes Yes
PCP Extenders: Physician Assistants	• 95% of 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	98.2% 97.1% 1:468	Yes Yes Yes
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	98.4% 95.3% 1:208	Yes Yes Yes
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	98.1% 98.23% 1:403	Yes Yes Yes
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	99.9% 98.7% 1:640	Yes Yes Yes
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	99.8% 98.8% 1:1572	Yes Yes Yes
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	99.7% 98.13% 1:1390	Yes Yes Yes
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	85.3% 95.7% 1:3909	**No** Yes 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 nearly 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 with the exception of pediatricians at 86.6% (decreasing from 98.7% due to correcting provider data set-up with age demographic for pediatricians). Two standards were not met for Sunflower members residing in rural areas: PCP access for internists at 92.3% (increasing from 87.1% in 2013, and access to pediatricians at 78.8 (increasing from 75.1%).

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

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 hospitals, as Sunflower is contracted with all available hospitals in the rural and frontier areas.

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 urban members (results = 85.3%). 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 2015.

In addition to the above results, Sunflower also monitors member grievances for access to care. Of the grievances received during the time period, two grievances were reported in 2014 for lack of availability of a PCP.

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 outlines the measurement and frequency of monitoring.

Continuity and Coordination 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 providers for members who are discharged from an inpatient facility for a behavioral health admission.	Annually	January-December 2014
	Rate of practitioner satisfaction with behavioral health practitioner communication as reported through the annual provider satisfaction survey.	Annually	January - August 2014
Appropriate Diagnosis, Treatment and Referral and Appropriate Use of Psychopharmacological Medications	The percentage of children newly prescribed Attention Deficit/h\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	2014 HEDIS
	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.	Annually	2014 HEDIS

Continuity and Coordination Monitoring and Evaluation Plan			
Specific Area Monitored	**Description of Monitor**	**Frequency**	**Time Period Monitored**
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 2014
Preventive Behavioral Program	Screening and referral of pregnant women scoring moderate or high on the Edinburg Depression Screening tool.	Annually	January -December 2014

Exchange of Information

Communication of discharge assessment:

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.

The table below shows results from monitoring of communication with PCPs.

Communication with PCP January 1, 2014 thru December 31, 2014 Goal: 65%		
	2013	**2014**
Total Discharge Assessments	3214	3139
Assessments with substance abuse documentation	450	237
Assessments with HIV/AIDS documentation	68	40
PCP Unknown	118	431
PCP Declined	625	761
Total Eligible Discharge Assessments	1953	1670
Total Discharge Assessments faxed	617	201
% of Discharge Assessments faxed	32%	12%
% of Discharge Assessments excluded	39%	47%

Cenpatico faxed 12% of eligible discharge summaries to members' PCPs in 2014, a marked decrease from the 32% faxed in the previous measurement period and well below the process target of 65%. As seen in analysis of 2013 performance, the primary reason that faxes are not sent remains that the PCPs decline receipt of this information from Cenpatico. This category comprised close to 24% of the eligible faxes not getting to member's PCPs in 2014, similar to the 20% designated to this category in 2013. Cenpatico did not meet its goal of at least 65% of eligible discharge assessments faxed to members' PCPs.

Performance in 2014 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, which continued in the 2014 measurement year. 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.

To address the issue of lack of PCP refusal of receipt of this important care management information, Cenpatico will work with Sunflower staff to educate PCPs on the importance of this activity, the purpose and how it will assist PCPs in better management of their member's health needs. 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.

Provider Satisfaction Survey:
The Centene Corporation provider satisfaction survey includes evaluation of satisfaction with communication between behavioral health practitioners and primary care practitioners. Levels of primary care practitioner satisfaction with behavioral health practitioner communication are collected through the annual provider satisfaction survey, and shared with Cenpatico. Centene utilizes The Myers Group (TMG), a National Committee for Quality Assurance (NCQA) Certified Survey Vendor, to conduct the provider satisfaction survey for all Centene health plans.

Sunflower Health Plan's 2014 provider survey sample size was 1,500. The Myers Group collected 305 surveys (97 mail, 8 Internet, and 200 phone) from the eligible provider population from September to October of 2014. After adjusting for ineligible members, Sunflower Health Plan's mail/Internet survey response rate was 7.5%, and the phone survey response rate was 37.6%. A response rate is only calculated for those providers who are eligible and able to respond.

The mail/Internet survey was distributed to a sample of 1,500 providers, and a total of 105 surveys were considered ineligible. Mail surveys are considered ineligible if returned for the following reasons: bad address with no forwarding information, provider is deceased, or if the provider no longer participates with the health plan.

2014	Component	Completed Surveys	Response Rate
272 Completed Surveys	Mail and Internet	105/1395	7.5%
	Phone	200/532	37.5%

In the standardized survey tool administered by The Myers Group, two questions measure the timeliness and the frequency of communication from behavioral health practitioners to primary care practitioners. Responses for the specific questions are noted in the table below:

Sunflower Provider Satisfaction Questions	Respondents
Q4E: Rate the timeliness of exchange of information/communication/reports from the behavioral health providers.	144
Q4F: How often do you receive verbal and/or written communication from behavioral health providers regarding your patients?	159

Interventions completed in 2013 and early 2014 showed incremental improvement in the satisfaction for both of these questions. Q4E went from an overall satisfaction score of 5.9% in 2013 to 6.9% in 2014 and Q4F improved significantly from 21.4% in 2013 to 33.3% satisfaction in 2014. The results of the survey are shared with Cenpatico and they are represented on Sunflower Health Plan's internal committee to develop and execute actions to drive improvement with overall satisfaction of contracted providers.

The following table reflects 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.	**6.9%** (1.0% improvement over 2013)	Excellent	Very Good	Good	Fair	Poor
		1	9	85	42	7
Q4F: How often do you receive verbal and/or written communication from behavioral health providers regarding your patients?	**33.3%** (11.9% improvement over 2013)	Always	Usually	Some-times	Rarely	Never
		11	42	52	35	19

In review of the individual responses, poor results yielded (poor and never) in 2013 improved in 2014, with more respondents indicating “good” on question 4E and “usually/sometimes” for question 4F. It is Sunflower Health Plan and Cenpatico’s goal to continually improve the rate, quality and frequency of BH specialist communication and coordination with members’ PCPs. We will continue to work with our providers to drive increased positive responses in the “excellent” and “always” categories (questions 4E and 4F, respectively). While incremental improvement was seen, 2014 satisfaction survey results indicate ongoing areas for improvement related to coordination of care. Sunflower will work with Health Homes providers on communication in 2015.

The importance of continuity of care between healthcare practitioners of all specialties cannot be overstated. Many behavioral health provider sites continue to have limited staff resources and may not have PCP communication as a priority in their care of the member.

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

Barrier	Opportunity	Selected for Implementation
Behavioral health clinicians do not know members’ current PCPs	Sunflower to work with providers on implementing Health Homes which facilitate better provider communication for physical and behavioral health. Cenpatico QI and Centene Corporate staff to audit CM documentation monthly for real time feedback	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
Lack of provider awareness of the importance of exchanging information with PCPs.	Re-educate provider on benefits of collaborating with all providers treating the member through a provider bulletin or newsletter and	Yes

Barrier	Opportunity	Selected for Implementation
	provide resources to provider to facilitate communication.	

Appropriate Diagnosis, Treatment and Referral and Appropriate Use of Psychopharmacological Medications

HEDIS Measure: Antidepressant Medication Management (AMM):
Sunflower and Cenpatico collaborate 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. Cenpatico utilizes this HEDIS measure in evaluating practitioners' compliance with Cenpatico's Clinical Practice Guideline (CPG) – Practice Guideline for the Treatment of Patients with Major Depressive Disorder (Third Edition, 2010 American Psychiatric Association).

The AMM HEDIS measure has two indicators:
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.

Antidepressant Medication Management (AMM) Goal: NCQA 50th Percentile				
AMM Indicator	2014			
	Numerator	Denominator	Rate	Goal Met
Acute Phase	834	1699	49.09%	No *25th percentile
Cont. Phase	574	1699	33.78%	No *25th percentile

*These data are a HEDIS measure and the final results or percentiles will not be available until June, 2015. The results are based on the administrative data through February 18, 2014. It is expected for the results to increase slightly as additional claims are received.

Performance on the Acute Phase indicator did not meet the performance target in 2014, with a rate of 49.09%. Rates reported for Sunflower Health Plan in calendar year 2013 yielded stronger results on this indicator (57.14%) but comparison should be conducted in caution, as a statistically significant increase in the denominator was seen in 2014 as compared to the baseline year.

Performance on the Continuation Phase indicator did not meet the goal of the HEDIS 75th percentile in 2013 or 2014. 2014 performance (33.78%) is a slight decrease from the 2013 rate (37.44%) but is not statistically significant (p>.01). As the performance goal was not met for either indicator, Cenpatico and Sunflower have prioritized improvement for this measure in 2015.

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

HEDIS measure. Cenpatico utilizes this HEDIS measure in evaluating practitioners' compliance with Cenpatico's Clinical Practice Guideline (CPG) – Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/ Hyperactivity Disorder (Journal of American Association of Child and Adolescent Psychiatry, July 2007).

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.

Attention Deficit Disorder Medication Management (ADD) Goal: NCQA 50th Percentile				
ADD Indicator	**2014**			
	Numerator	**Denominator**	**Rate**	**Goal Met**
Initiation	553	994	55.63%	Yes *90th percentile
Cont.& Maint. Phase	224	347	64.55%	Yes *90th percentile

*These data are a HEDIS measure and the final results or percentiles will not be available until June, 2015. The results are based on the administrative data through February 18, 2014. It is expected for the results to increase slightly as additional claims are received.

Interventions deployed in 2014 were successful, performance on both ADD indicators passed the performance goals in the 2014 measurement year. Cenpatico and Sunflower will continue to implement controls to maintain strong performance on the ADD measure in 2015.

Sunflower has identified barriers and opportunities with both HEDIS measures. The table below reflects the results of the barrier analysis and the interventions selected for implementation.

Barrier	**Opportunity**	**Selected for Implementation?**
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
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.	Yes

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.

The goals of the program are:

- Educate members in the perinatal period about the risks of depression,
- Educate members regarding the signs and symptoms of depression,
- Promote members access to necessary services for the treatment of depression,
- Educate providers on the use of the Edinburgh Depression Scale for pregnant members.

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).

Outreach is performed for each member regardless of their score. For members with moderate or high risk for depression, Cenpatico staff educates the member about depression and encourages the member to access behavioral healthcare services. Cenpatico staff assists the member with scheduling and transportation for necessary services, if needed.

Results for this report timeframe are noted below, stratified by prenatal and post-partum periods. There may be some duplication between the two stratifications as women may receive additional surveys at Baby Showers hosted by Sunflower.

2013	# 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%

2014	# Sent	# Received	Return Rate	Low	Percent	Moderate	Percent	High	Percent
Pregnant	3635	122	3.4%	90	73.8%	19	15.6%	13	10.7%
Delivered	3523	63	1.8%	43	68.3%	15	23.8%	5	7.9%
Total	7158	185	2.6%	133	71.9%	34	18.4%	18	9.7%

As evidenced above, the response rates for both Prenatal and Post-Partum respondents are 3.4% and 1.8%, respectively, with a total response rate of 2.6% in 2014. This year's response rates are commensurate with rates reported in 2013 (2.8% and 2.1%, respectively, with a total response rate

of 2.5%). 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. However it should be noted that the percent of 'high risk' responses doubled from 4.1% in 2013 to 9.7% in 2014.

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 members who accessed behavioral health care services in the 45 days following the completion of the survey. Cenpatico clinicians were able to successfully outreach to 63% of at risk members, a marked increase from the 29% engagement rate yielded in 2013. Unlike 2013 rates, Cenpatico saw the most success in outreach attempts with pregnant members in 2014, who responded to clinical engagement at a rate of 72% (increase from the 50% rate in 2013), as compared to a rate of 50% engagement for newly delivered members. It should be noted that the rate of engagement for newly delivered members also increased this measurement year (50% in 2014 as compared to 35% in 2013). Of the members that engaged in outreach from a Cenpatico clinician, 17% 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.

2014	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
Pre-natal	32	23	72%	9	28%
Post-partum	20	10	50%	0	0%
Total	52	33	63%	9	17%

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

Barrier	Opportunity	Selected for Implementation
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. Sunflower to educate PCPs and OB providers on the need to assess the pregnant member for	Yes

Barrier	Opportunity	Selected for Implementation
	depression during the prenatal and post-partum periods. Review member materials to determine if changes to the materials will result in a greater response rate. Collaborate with Sunflower to provide an article in their Member newsletter describing the program and how staff can assist with accessing services.	
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. Cenpatico care coordination staff will engage Cenpatico disease managers in outreach and engagement efforts to increase engagement in behavioral health services.	Yes

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

The Chief Medical Director has operational responsibility for and provides support to the Plan's UM Program. The Plan Chief Medical Director (SEQI), 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 UMC. A board certified psychiatrist and licensed behavioral health practitioners are involved in the implementation, monitoring and directing of behavioral health aspects of the UM Program, and a dentist is involved in the implementation, monitoring and directing of dental health aspects of the UM program. A pharmacist oversees the implementation, monitoring and directing of pharmacy services. In addition to the Chief Medical Director, the Plan may have one or more Medical and/or associate Medical Directors.

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

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

Program Integration
The UM Program, Pharmacy and Therapeutics (P&T) Program, Quality Improvement (QI), Credentialing, and the Fraud and Abuse Programs are closely linked in function and process. The UM process utilizes quality indicators as a part of the review process and provides the results to the Plan's QI department. As case managers perform the functions of utilization management, member quality of care measures indicators prescribed by the Plan as part of the patient safety plan, are identified. Additionally as the quality department is made aware of issues, they work directly with members of the Medical Management team to discuss and follow up with the member to ensure safety and immediate remediation as needed. All required information is documented 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 re-credentialing process. Such information may relate,

for example, to specific case management decisions, discharge planning, precertification of non-covered benefits, etc. The information is 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 Peer Review or Credentialing Committee. If committee review is not warranted, the information is documented and may be used for provider trending and/or reviewed at the time of the provider's re-credentialing process.

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

In addition, the Plan coordinates utilization/care management and education activities with local community providers 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 outreach.
- 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.
- Organ transplants.
- HIV/AIDS.
- Hemophilia.
- Others as plan data demonstrate need for complex care coordination for a specific population or diagnosis.

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 Committee (UMC)
Daily oversight and operating authority of utilization management activities is delegated to the UMC, which reports to the Plan's QIC and ultimately to the Plan BOD. The UMC 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 UMC 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 USC also provides ongoing evaluation of the appropriateness and effectiveness of provider incentive programs based on utilization data. This includes evaluating the performance of the provider 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.

UM Committee Scope

- 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
- Annually review and approve the UM program description, guidelines, and procedures
- Annually review and approve the criteria for determination of medical appropriateness to be used for nurse review
- Adapt criteria for determination of medical appropriateness to work within the delivery system
- Review provider specific reports for trends or patterns in utilization
- Review reports specific to facility or geographic areas for trends or patterns
- Formulate recommendations for specific providers for further study
- Monitor the adequacy of the network to meet the needs of the patient population
- Examines results of annual member and practitioner satisfaction surveys to determine overall satisfaction with the UM program and identify areas for performance improvement
- Examine reports of the appropriateness of care for trends or patterns of under or over utilization and refer them to the proper provider group for performance improvement or corrective action
- Examine results of annual surveys of members and providers regarding satisfaction with the UM program
- Include a feedback mechanism for communicating findings and recommendations, and contain a plan for implementing corrective actions
- Report findings to the QIC
- Liaison with the QIC for ongoing review of indicators of clinical quality

UM 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 UMC is one of the primary ways in which network practitioners participate in Plan utilization review activities.

The UMC includes leadership the following (all voting members):

- Chief Executive Officer
- Chief Medical Director / Medical Director(s)
- Plan Network Physicians representing the range of practitioners within the network and across the regions in which it operates (at least one being a behavioral health provider)
- VP of Medical Management
- VP of Quality Improvement
- Other Plan operational staff as requested

Meeting Frequency and Documentation of Proceedings:
The UMC meets at least four (4) times per year and the VPMM maintains detailed records of all UMC meeting minutes, UM activities, case management program statistics and recommendations for UM improvement activities made by the UMC. The UMC 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 uses the ASAM as contained in KCPC. For determination of the community based services for behavioral health, the Plan uses InterQual and develops a medical necessity criteria based on the service description as needed; 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 pre-service 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., pre-service and post-service). Medical necessity of post service decisions (retrospective review) will be limited to special circumstances 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. There were no staff members that did not reach a final passing score, there are two allowed attempts. All staff that failed an IRR subset initially went through InterQual retraining for that subset before taking the re-take IRR for that subset.

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

2014 IRR Results by Staff Member			
Staff Member	Initial Pass/Fail	*Retake Pass/Fail/NA	Subset Completed
1	Pass	NA	5
2	Pass	NA	5
3	Pass	NA	5
4	Fail	Pass	5
5	Pass	NA	5
6	Pass	NA	5
7	Fail	Pass	4
8	Fail	Pass	4
9	Pass	NA	4
10	Pass	NA	4
11	Fail	Pass	9
12	Pass	NA	9
13	Pass	NA	9
14	Fail	Pass	9
15	Fail	Pass	9

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 goal is 90% satisfaction on all components of the Case Management program through direct member satisfaction survey.

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?	75%	No
2. Were you able to understand the information from your Case Manager about your health	89%	No

Question	% of members responding as "very satisfied" or "somewhat satisfied"	Goal Met?
condition(s)?		
3. Have you been able to follow any of Case Manger's heath care suggestions to improve your health?	82%	No
4. Did you and your Case Manager come up with goals to work on?	74%	No
5. Was your Case Manager usually able to speak with you?	68%	No
6. Did your Case Manager help you get the health care services that you needed?	82%	No
7. How pleased are you with how well your Case Manager helped you with other resources?	68%	No
8. How satisfied are you with any learning materials you received from your Case Manager?	58%	No
9. If you had any cultural needs, how satisfied are you with how they were met by your Case Manager.	63%	No
10. How pleased are you with how your health and quality of life improved because you received help from your Case Manager?	63%	No
11. How satisfied overall are you with Case Management services you received?	78%	No

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 Case management team went through a re-organization in 2014 which may have some impact on results due to transition of member to a new case manager.

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.).

Grievances

Grievances received by the Grievance Department were also reviewed as they relate to Case Management satisfaction. Nine (9) member grievances/complaints regarding the case management program or case management process were reported by Sunflower members in 2014. 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. Individual issues were addressed individually with the involved Case Management staff.

Member Satisfaction with UM

Sunflower annually monitors member satisfaction with UM through analysis of relevant CAHPS® survey question results. The 2014 scores for Sunflower are compared to the Quality Compass® All Plans means and percentiles for the applicable questions. As a new health plan, the goal is to reach the 50th percentile compared to Quality Compass.

The table below reflects the CAHPS Medicaid Adult and Child Survey Results:

Composite & Question Ratings	Adult 2014 Rate	T19 Child 2014 Rate	T21 Child 2014 Rate	Goal Met?
Getting Needed Care	**86.2% (90th)**	**92.5% (75th)**	**86.0% (50th)**	**Yes**
Q14: Ease of getting care, tests, or treatment needed	87.7% (75th)	88.3% (75th)	93.0% (75th)	Yes
Q25: Obtaining appointment with specialist as soon as needed	84.7% (75th)	84.5% (50th)	78.9% (25th)	No
Getting Care Quickly	**87.0% (90th)**	**92.5% (75th)**	**92.3% (50th)**	**Yes**
Q4: Obtaining needed care right away	89.3% (90th)	93.5% (50th)	92.6% (50th)	Yes
Q6: Obtaining appointment for care as soon as needed	84.7% (90th)	91.5% (75th)	90.0% (75th)	Yes

*Percentile rankings are compared to 2013 Quality Compass all Plans (General Population)

An opportunity analysis was conducted to identify opportunities to improve performance and 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, previously discussed.

Sunflower Quality Improvement, Medical Management, Customer Service, and Provider Relations staff completed an initial barrier analysis. Staff identified the following potential barriers and opportunities for improvement, with associated interventions.

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 through website and newsletters.	Yes

Barrier	Opportunity	Selected for Improvement?
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

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:

Composite & Key Questions	2014 Summary Rate	2013 Summary Rate	2013 TMG Book of Business Benchmarks Medicaid
Utilization & Quality Management	**17.9%**	**13.7%**	**37.1%**
3A. Access to knowledgeable UM staff.	14.8%	14.5%	35.0%
3B. Procedures for obtaining pre-certification/ referral/ authorization information.	13.8%	10.4%	36.2%
3C. Timeliness of obtaining pre-certification/referral/authorization information.	16.1%	12.0%	37.5%
3D. The health plan's facilitation/support of appropriate clinical care for patients.	17.0%	11.2%	35.9%
3E. Access to Case/Care Managers from this health plan.	15.9%	12.2%	33.5%
3F. Degree to which the plan covers and encourages preventive care and wellness.	29.7%	21.9%	44.5%
3G. Extent to which UM staff share review criteria and reasons for adverse determinations.	15.2%	10.2%	NA
3H. Consistency of review decisions.	12.3%	10.9%	NA
Pharmacy	**10.2%**	**6.8%**	**23.1%**
5A. Consistency of the formulary over time.	8.9%	7.5%	24.3%
5B. Extent to which formulary reflects current standards of care.	9.3%	6.8%	24.8%
5C. Variety of branded drugs on the formulary.	11.4%	9.1%	22.0%
5D. Ease of prescribing your preferred medications within formulary guidelines.	11.7%	5.9%	23.6%
5E. Availability of comparable drugs to substitute those not included in the formulary.	9.6%	4.8%	20.8%

* Summary Rates represent the most favorable response percentage(s).
* The Myers Group's 2013 Medicaid Book of Business consists of data from 10 plans representing 6,569 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. It should be noted that from the 2013 to the 2014 Provider Satisfaction survey, significant gains were achieved which were reflected by improvement in every composite

score or key measure of provider satisfaction with the UM process. For that reason, many activities implemented in 2014 will be maintained.

Sunflower Quality Improvement, Medical Management, Customer Service, 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. 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, provide ability to complete referral via web portal and view information. Increase provider awareness of assigned case manager for members already in case management.	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
Inconsistent application of UM policies.	Create 'play cards' for UM processes to create efficient, effective, and standardized process implementation.	Yes
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 PDL	Yes

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 and encounter data.
- Complaints and grievances.

The following is a listing of the delegated vendors. The first five are wholly-owned subsidiaries of Centene, as is the final listed, Dental Health and Wellness:

1. Cenpatico (CBH) - 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. DentaQuest provided service through July 31, 2014 only.
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.
10. Dental Health and Wellness (DHW)- Sunflower's dental care network effective August 1, 2014. They provide prior auth authorizations, utilization management, network development and maintenance and claim payment information.

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 Kansas 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 VP of Quality Improvement 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 Quality Improvement Committee as needed. As necessary, action plans are implemented and improvement monitored.

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. On July 31, 2014, Sunflower discontinued the use of their dental vendor, DentaQuest. On August 1, 2014, the new provider Dental Health and Wellness (DHW), was operational with a seamless transition. The following table contains the results of vendor audits conducted in 2014 and scope of the review:

Vendor and Type	Date of Audit	Areas Audited	Scored Below 90%/QIP Implemented
NIA Radiology	**January 2014**	**UM:** P&Ps & UM Program Description; denial files; appeal files	No
		Credentialing: P&Ps & Credentialing Program Description, credentialing/recredentialing file review	Yes
		Compliance: P&Ps; Compliance Program Description; sample reports; staff interviews	No
		Member Rights & Responsibilities: applicable P&Ps	No
		Quality Improvement: P&Ps & QI Program Description	No
Opticare Vision	**September 2014**	**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	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	**September 2014**	**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

Vendor and Type	Date of Audit	Areas Audited	Scored Below 90%/QIP Implemented
		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 Manger	**April 2014**	**Claims:** P&Ps; claims file review	No
		Compliance: P&Ps; Compliance Program Description; sample reports; staff interviews	No
		Credentialing: P&Ps & Credentialing Program Description, credentialing/recredentialing file review	No
		Member Rights & Responsibilities: applicable P&Ps	No
		Performance Standards: P&P; reports	No
		Quality Improvement: P&Ps & QI Program Description	No
		UM: P&Ps & UM Program Description; denial file review	No
Cenpatico Behavioral Health & STRS Therapies	**May 2014**	**Case Management:** P&Ps; file review	Yes
		Claims: P&Ps; claims file review	Yes
		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	**Contract Termed July 2014**	**Claims:** P&Ps; claims file review	Yes
		Compliance: P&Ps; Compliance Program Description; sample reports; staff interviews	Yes

Vendor and Type	Date of Audit	Areas Audited	Scored Below 90%/QIP Implemented
		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
Dental Health and Wellness Dental	**Pre-delegation June 2014 For August 2014 implementation**	**Claims**: P&Ps; claims file review	N/A
		Compliance: P&Ps; Compliance Program Description; sample reports; staff interviews	N/A
		Credentialing: P&Ps & Credentialing Program Description, credentialing/recredentialing file review	N/A
		Member Rights & Responsibilities: applicable P&Ps	N/A
		Quality Improvement: P&Ps & QI Program Description	N/A
		UM: P&Ps & UM Program Description; denial file review; appeal file review	N/A
Nutur Disease Management	**June 2014**	**NCQA Disease Management standards:** Care Coordination, Clinical Quality, Evidence-based Programs, Patient Services, Practitioner Services & Program Operations - applicable P&Ps, sample reports, etc.	Yes
		Compliance: P&Ps; Compliance Program Description; training documents; sample reports	No
		Disease Management: DM case file review	Yes
NurseWise Nurse Hotline	**August 2014**	**Compliance:** P&Ps; Compliance Program Description; staff interviews; sample reports	Yes

Vendor and Type	Date of Audit	Areas Audited	Scored Below 90%/QIP Implemented
		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

Summary

Sunflower has identified strengths and opportunities for improvement which are outlined in more detail with action plans in the full annual evaluation report. Interventions included in the plan for 2014 were reviewed and continued as needed for measures requiring continued improvement.

Strengths:

- Member satisfaction results
- Steady improvement in HEDIS scores
- Access and Accessibility
- Re-design of Case Management
- Revised UM processes, strength of new executive leadership

Opportunities for Improvement:

- Provider satisfaction
- Practice Guideline adoption
- Physical and behavioral health provider integration

As a result of this analysis, it has been identified that processes and operational systems are starting to stabilize, producing early positive results, and in some cases negative findings as the plan matures and enforces guidelines. With two years of complete data, it is difficult to assert that trends have been identified for some processes, but statistically significant change has been found in some areas. The findings did not indicate the need for major revisions to Sunflower's QAPI, operations, or service delivery systems. Sunflower will continue to work to maintain and improve the gains achieved from 2013 to 2014, and improve on the areas noted as priority opportunities for improvement.