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

January 1 - December 31, 2016

*Data as available by 3/14/2017

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, 2016. 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 Health Plan's Board of Directors (BOD).

Mission

Sunflower strives to provide improved health status, successful outcomes, both 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 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 and management. Sunflower plans to retain members by offering coordination of care, financial incentives for targeted healthy behaviors, health education workshops, healthy lifestyle 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 membership population has been completed annually from 2013 through 2016. 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

Sunflower is in its fourth year of operations and TANF and CHIP members consistently make up the majority of the Sunflower membership. The children ages 0-10 continue to comprise nearly half of the membership each year. Males and females remained consistent in distribution. Sunflower's membership by month data demonstrates there has been a slight decrease in CHIP, however overall the Sunflower membership by product line has remained stable.

The Sunflower membership characteristics for comparative purposes for 2014, 2015 and 2016 are shown in the tables below:

Product	% of Population for 2014	% of Population for 2015	% of Population for 2016
CHIP	14%	14%	10%
Foster Care	4%	4%	4%
IDD	*	*	3%
LTC Dual	6%	6%	4%
LTC Non-Dual	3%	3%	2%
SSI Dual	5%	5%	4%
SSI Non-Dual	7%	7%	7%
TANF	62%	61%	66%
Total**	100%	100%	100%

*IDD not previously broken out

**Rounding results in some totals >100%

Age Group	2014	2015	2016
0-10	48%	47%	46%
11-20	25%	26%	27%
21-30	7%	7%	7%
31-40	5%	5%	6%
41-50	3%	4%	3%
51-60	4%	4%	4%
61-70	2%	3%	3%
71-80	2%	2%	2%
81-90	1.70%	2%	1%
91+	0	0	1%

Gender	2014	2015	2016
M	46%	54%	54%
F	54%	46%	46%

The table below depicts the membership for each product throughout the timeframe demonstrating relative consistency. The data contained within this table represents Sunflower's membership based on financials for those said months and does not reflect any retro activities for those timeframes. IDD started being reported separately in April of 2016 compared to it being previously included within the LTC Dual and LTC Non-Dual product data. Consistency was noted for Foster Care, IDD, LTC Dual and Non-Dual and both SSI products. There were changes noted related to TANF that demonstrated an increase and CHIP noted a decrease. Foster Care demonstrated the most consistency over the assessment timeframe.

There was enrollment variation noted in some products. The Kansas Department of Health and Environment reported a backlog of applicants for Medicaid contributing to the month over month changes noted below. Contributing factors include the implementation of the Kansas Eligibility Enforcement System (KEES), the KanCare Clearinghouse processing all Medicaid applications and the ACA open enrollment period which resulted in a backlog of applications.

Product	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
CHIP	20,036	20,218	19,443	19,744	19,792	19,783	19,549	18,960	19,242	19,459	19,361	15,104
Foster Care	5,350	5,360	5,321	5,361	5,396	5,371	5,386	5,333	5,366	5,407	5,445	5,419
IDD	*	*	*	*	*	*	*	*	*	4,081	4,091	4,100
LTC Dual	8,733	8,755	8,770	8,751	8,768	8,750	8,692	8,609	8,654	6,284	6,269	6,297
LTC Non-Dual	3,902	3,988	3,954	3,981	4,008	4,012	3,993	4,011	4,043	2,393	2,465	2,488
SSI Dual	6,491	6,435	6,490	6,471	6,427	6,428	6,314	6,195	6,114	6,070	5,938	5,873
SSI Non-Dual	9,763	9,774	9,730	9,793	9,839	9,842	9,789	9,748	9,708	9,731	9,682	9,675
TANF	85,874	86,351	83,041	84,978	86,105	86,478	85,420	85,541	87,003	88,868	90,004	95,089
Total	140,149	140,881	136,750	139,080	140,335	140,664	139,143	138,397	140,130	142,294	143,256	144,044

**IDD was not reported separately until April of 2016, prior to that it was included in LTC Dual and LTC Non-Dual*

From comparing year end population data, Sunflower membership has been relatively stable. Kansas Medicaid remained unchanged with respect to expansion. Members continue to have an annual open enrollment period to allow them to change MCO's. As most members do not act upon making change, Sunflower does not expect much member movement to be reflected in 2017.

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Languages Spoken by Sunflower Members as Assessed for 2016

Language	Member Count	% of Population
Arabic	133	0.09%
Chinese	60	0.04%
English	112,471	79.42%
French	7	0.00%
German	4	0.00%
Guajarati	2	0.00%
Hindi	14	0.01%
Italian	2	0.00%
Korean	12	0.01%
LAO	34	0.02%
Other	460	0.32%
Persian	10	0.01%
Portuguese	1	0.00%
Russian	45	0.03%
Serbo-Croatian	8	0.01%
Somali	48	0.03%
Spanish	4,508	3.18%
Sudanese	6	0.00%
Tagalog	2	0.00%
Thai	7	0.00%
Unknown	23,659	16.71%
Urdu	6	0.00%
Vietnamese	110	0.08%
Total	**141,609**	**100.00%**

Sunflower assesses members' linguistic needs based on the state eligibility files which query members on their primary language spoken, 79.42% of Sunflower members speak English, the number that did not report a primary language demonstrated a decrease to 16.71% for 2016 compared to 2015, and those who speak Spanish remained relatively consistent at 3.18%. A detailed breakdown of other less common languages is also noted in the table above. The group who reported their language as other was 0.32%, followed then by Arabic, Vietnamese, Chinese, Somali, Russian and Laotian.

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 Care Management, Customer Service, or Provider/Practitioner staff for member interactions with both Sunflower staff and network providers. The table below represents the top languages for which members have requested translation services by unique interactions during

the assessment time period. Sunflower also has Spanish-speaking Care Management and Customer Services Representatives on staff. The Sunflower Customer Service Supervisor and Call Quality Analyst are also Spanish-speaking to ensure Spanish-speaking members are well served by the health plan.

Language	# of Calls	% of Population
Spanish	5137	89.78%
Burmese	136	2.38%
Russian	58	1.01%
Nepali	54	0.94%
Arabic	47	0.82%
Mandarin	43	0.75%
Vietnamese	43	0.75%
Somali	42	0.73%
Hmong	27	0.47%
Karen	20	0.35%
Chin	20	0.35%
Hindi	16	0.28%
Swahili	11	0.19%
All Other Languages	68	1.20%
Total	**5722**	**100.00%**

Race/Ethnicity

The tables below reflects race and ethnicity and is based on members who responded to the 2016 CAHPS adult and child member satisfaction surveys and with regard to how they responded to provide designated race/ethnicity information on the survey. This data provided allows for comparison to the designated race/ethnicity provided on the 2015 CAHPS member satisfaction surveys as well.

Child Race / Ethnicity Category	2015 Child General Population CAHPS	2016 Child General Population CAHPS	2015 Child With Chronic Conditions CAHPS	2016 Child With Chronic Conditions CAHPS
White	79.5%	81.5%	84.2%	83.8%
Black /African American	15.0%	10.1%	14.5%	15.6%
Hispanic / Latino**	30.5%	31.7%	21.1%	19.6%
Asian	3.6%	4.4%	1.6%	2.0%
Hawaiian / Pacific Islander	1.4%	1.2%	1.6%	1.5%
American Indian / Alaskan	6.3%	4.9%	6.8%	7.0%
Other	13.2%	13.3%	10.6%	8.7%

Adult Race / Ethnicity Category	2015 Adult CAHPS	2016 Adult CAHPS
White	80.1%	77.2%
Black /African American	15.4%	15.0%
Hispanic / Latino**	11.1%	12.8%
Asian	2.2%	2.4%
Hawaiian / Pacific Islander	0.6%	0.2%
American Indian / Alaskan	8.0%	8.3%
Other	7.2%	9.5%

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

Ethnicity is reported for CAHPS surveys as either being Hispanic/Latino or Not Hispanic/Latino. Sunflower noted a small change from those responding as Hispanic/Latino for the general child population from 30.5% in 2015 to 31.7% in 2016. While the child with chronic conditions population sampled demonstrated a decrease from 21.1% in 2015 to 19.6% in 2016. Specific to the adult population there was a small increase from 11.1% in 2015 to 12.8% in 2016.

Results from the 2016 CAHPS surveys for both adult and child populations indicate that there was consistency with respect to the race/ethnicity of the Sunflower membership in comparison from 2015 to 2016. The majority of Sunflower adult membership is white followed by Black/African Americans and then by the Hispanic/Latino membership. The child survey results demonstrated consistency from 2015 to 2016, with the majority respondents indicating their race/ethnicity as white, followed by Hispanic/Latino and then Black/African American. This remains consistent with results demonstrated on both the adult and child 2015 CAHPS surveys as well to include the general child and children with chronic conditions as well.

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, administrative and network services.

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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, radiology, 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, prevention and reporting
- Home support service utilization for LTSS services
- Information Management
- Marketing practices
- Member enrollment and disenrollment
- Member Grievance System
- Member satisfaction
- Customer Services
- Network performance
- Organization Structure
- Patient safety
- Primary Care Provider changes
- Pharmacy
- Provider and Plan after-hours telephone accessibility
- Provider appointment availability
- Provider Complaint System
- Provider network adequacy and capacity
- Provider satisfaction
- Provider Services
- Selection and retention of providers (credentialing and re-credentialing)
- Utilization Management, including under and over utilization
- Policies 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, 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.

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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/President, 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 Waste Abuse and Fraud. The first QIC meeting was held December 19, 2012, prior to implementation of KanCare, and continues to meet on a quarterly basis, at a minimum. For 2016, QIC met quarterly but also held two additional ad hoc meetings.

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 2016. 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 2016 Credentialing report for Sunflower.

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Sunflower's number of practitioners in network for 2016 was 14,094 which was down from 15,884 in 2015. In 2016, 1634 Sunflower practitioners completed there-credentialing process. 99.9% of those were re-credentialed successfully and timely. These details are depicted in the table that follows. Provider credentialing turnaround time averaged 12 days from application completion to committee. It is important to note that during 2016, there were some efforts aimed at Network Optimization which included evaluation of providers who had not submitted any claims to Sunflower in 1-2 years and those were termed from the network which comprised 258 providers and then there were some DME and lab providers that were related to another project totaling 52. There was also the term of a provider group that included 49 groups that involved approximately 130 practitioners.

2016 Credentialing Statistics	
Total number of practitioners in network (includes delegated providers) as of 12/31/2016	14,094
Initial Credentialing (excludes delegated)	
Number initial practitioners credentialed	1508
Average Credentialing TAT from Complete Application to Committee (Days)	12
Re-credentialing	
Number of practitioners re-credentialed	1634
Number of practitioners re-credentialed within a 36 month timeline	1632
% re-credentialed timely	99.9%
Terminated/Rejected/Suspended/Denied	
Number with cause	0
Number denied	1

Pharmacy and Therapeutic Committee

The Pharmacy and Therapeutics (P&T) Committee is a standing subcommittee of the QIC and is responsible for administering the routine oversight and operating authority of the Pharmacy Program. The QIC is the vehicle through which 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. For 2016, P&T met three (3) times. Typically, the P&T Committee meets quarterly.

Utilization Management Committee

Routine and consistent oversight and operating authority of utilization management activities is delegated to the Utilization Management Committee (UMC) which reports to the QIC and ultimately to the Sunflower Board of Directors. The UMC is responsible for the review and appropriate approval of medical necessity criteria, protocols, utilization management policies and procedures. Additionally, the UMC monitors and analyzes relevant data to detect and correct patterns of potential or actual inappropriate under- or over-utilization which may impact

health care services, coordination of care, appropriate use of services and resources as well as member and practitioner satisfaction with the UM process. The UMC is composed of Sunflower's Chief Medical Director, Medical Director(s), Sunflower's Vice Presidents of Medical Management, and other operational staff as needed. For 2016, UM Committee met four (4) times. 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 HEDIS rate trending, identifies data concerns, and communicates both plan and corporate initiatives to Sunflower Senior Leadership. The Committee directs clinical, non-clinical, member and provider initiatives to improve selected HEDIS measure performance. The HEDIS Steering Committee oversees the implementation, progression and outcomes monitoring of initiatives specific to HEDIS, recommends resources necessary to support the on-going improvement of HEDIS scores, reviews/establishes benchmarks or performance goals for HEDIS and oversee delegated vendor roles in improving HEDIS scores. The Committee meets a minimum of quarterly and is facilitated by the HEDIS Coordinator. Membership includes the senior leadership of QI, the CEO/President, Chief Medical Director, Associate Medical Director, and Senior Leadership of Medical Management, with representation from Contracting/Network Management, Member/Provider Services, and Pharmacy. The HEDIS Steering Committee meets quarterly and met four (4) times in 2016 with one (1) additional ad hoc meeting.

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. For 2016, PRC met on three (3) occasions to review cases and make recommendations as appropriate.

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, Customer Services, Network Development, Prior Authorization, Provider Relations/Services, Quality Improvement or other members as determined by the topic under discussion. The PIT met eleven (11) times in 2016, 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 Customer 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 four (4) times in 2016.

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.

Vendor	Number of Meetings in 2016
National Imaging Association	12
US Scripts	4
Logisticare	10
NurseWise	6
/Dental Health and Wellness	7
Nurtur	6
OptiCare	4
EPC Behavioral Health (CBH)	4
EPC 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, 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 Coordinators, Clinical Appeals Coordinators, Lead Clinical Appeals Nurse and representatives from Customer Service and Medical Management. The GAC provides summary reports to the QIC at regular intervals, but no less than quarterly. Meetings typically are held quarterly or more frequently as needed. The GAC met four (4) times in 2016.

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 2016. 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)
- Medical Director of Utilization Management (member by position and role, not formal reporting structure)
- Director, QI (Nurse)
- Manager, QI (Nurse)
- Quality Improvement Auditor (Nurse)
- EPSDT Coordinator
- HEDIS Coordinator (Nurse starting late 2016)
- Grievance and Appeals Coordinator (2 total)
- NCQA Coordinator
- Lead Clinical Appeals Coordinator (Nurse)
- Clinical Appeals Coordinator (Nurse – 3 total)
- QI Project Manager
- Centene Corporate support

Quality Leadership in 2016

The plan Chief Medical Director served as the SEQI and provided continued leadership and oversight of QI. There was turnover of five (5) staff persons in 2016 in the QI Department. The turnover was attributed to retirement, relocation or taking positions outside of Sunflower; two of which went to Corporate or another Centene plan. QI assessed the volume and trends of appeals which resulted in an additional Clinical Appeals Coordinator position added and the need to establish a Lead Clinical Appeals Coordinator to ensure policy and procedures are met so that appeals and State Fair Hearings are addressed timely to meet the needs of members and providers. Routine assessments of work volume and progress with respect to plan priorities allow for reallocation of staff resources to address needs encountered in work volume spikes and also to address priority areas that are in need.

In 2016, the employment positions at Sunflower have remained relatively consistent as the plan membership had minimal change and product lines remained unchanged. Staffing needs continue to be assessed on an ongoing basis to ensure the plan is able to accommodate member needs, improve quality, and to adequately address 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 waste, abuse and fraud 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 2016, Sunflower underwent the BBA/state audit, KID Financial Exam, KDADS member quarterly files submissions and KDADS Provider Credentialing Audit. Additionally, in 2016

KFMC our EQRO performed validation of HEDIS-like measures and the following surveys: Provider Survey, Mental Health Survey, CAHPS to include both adult and child surveys. The results included recommendation to change CAHPS survey methodology to consist of one survey for Title XIX and Title XXI in addition to the adult survey. Sunflower also underwent Performance Measure Validation survey in 2016 and the opportunities identified on the survey were addressed. Sunflower complied with record requests for quarterly HCBS documentation audit requests for the first three quarters of 2016 and have not received any reports of the findings from those audits. Sunflower is currently uploading the requested documents for the fourth quarter 2016 review. Sunflower participated in an Information Systems Capability Assessment (ICSA) audit in 2015 which occurs every other year and was determined to have an infrastructure that enables collection, analysis and reporting of data to support quality assessment and improvement activities. Additionally, the system provides capability of tracking enrollees should they change programs allowing for continual assessment of continuity of enrollees. The system also provides ability to restrict reports to KanCare data and stratification by product line for report submission to State up to CMS. Sunflower submitted for the ISCA review in early 2017 and anticipates further discussion and identification of areas for improvement from these data audits in 2017. Sunflower also underwent an internal audit in 2016 to assess contractual requirements and identify opportunities for improvement. Additionally, CMS came onsite in the fall of 2016 for assessment of KanCare, or Kansas Medicaid.

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 Sunflower'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 were audited to make sure that member PHI was secured, laptops were locked and PHI was disposed of properly. The Compliance Department conducted four desk audits in 2016, including all three office locations as well as remote workers, and the results revealed 99 infractions out of 1284 desks/workspaces audited This resulted in a 93% compliance rate with securing PHI. Sunflower continues to focus on opportunities to improve the protection of PHI.

QAPI Program Effectiveness

Throughout 2016, the QI Department continued its collaboration with all organizational departments to facilitate continuous improvement in performance by empowering all stakeholders through education, communication, data analysis and evaluation. Sunflower has continued to improve the quality of care and services provided to the membership through continuous assessment of patterns, trends and identification of barriers to desired outcomes.

Sunflower continues to strive to include network physicians in the program through committee participation. Sunflower believes network physician involvement ensures policies and initiatives reflect the needs of Kansans in the context of the local healthcare delivery system. Further, network physician involvement encourages the spread of clinical practice guidelines and care improvement programs.

Quality Improvement Work Plan

The QI Department has a QI Work Plan that details all activities to ensure it is operational. Activities include a due date and a synopsis of the activity including implementation and the progress. The 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 2016 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 2017 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:

- Quality Improvement continued to have two nurse leaders with Quality Improvement experience
- Chief Medical Director directly involved in Quality initiatives
- Developed Pay for Performance Champion teams to focus on improvement of measures that directly impact the health and well-being of members through various interventions
- 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 continued support for HCBS services, developing an expansive network, implementing case management, and refining operations in claims processing to meet the member and provider needs
- Continued refinement around P4P metrics and development of tracking tools, supporting reports, comprehensive intervention plans, and reporting tools
- Year over year noted improvements in both the Member and Provider satisfaction surveys. Development of comprehensive plans for future improvement opportunities using multidisciplinary team.
- Continued use of skill in HEDIS operations to allow for the plan to do over-reads during hybrid season, optimization of data captured through state immunization registry and collection of supplemental data for potential impact on HEDIS measures in 2016.
- Continued evaluation and updates to systems to incorporate state reporting criteria to reduce reporting errors and automate some reporting functions.

- Modified and updated 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.
- Continued efforts to review all Sunflower and vendor grievance and appeals documentation, revising and creating more consistency to reduce member confusion.
- Continued used of developed reports to identify cases at risk of not meeting turn-around time (TAT) for grievances and appeals before they are out of TAT.
- Utilize developed process in documentation system to route AIRS so all documentation remains in single entry/record and includes QOC nurse and CM in feedback.
- Monitoring of reports to do surveillance of routine QOC issues on whole population, allowing focused review when there are findings and trending of certain types of at risk diagnosis patterns.
- Efforts continue to evaluate and refine processes for State Fair Hearings, including documentation storage, and increasing reliability and quality of work product to Office of Administrative Hearings (OAH).
- Creation of Clinical Analytics Team to improve data integrity and accuracy related to member outcomes, strategic initiatives and to meet state reporting requirements.
- Implemented changes in GAR along with process changes to ensure that grievances are worked timely to meet State contractual requirements.
- TAT for timely resolution was met for CY 2016 for Appeals.
- Care Management worked with 12, 996members in 2016.
- NurseWise advice line handled 9,950 total calls in 2016
- Participated in approximately 120 member outreach health fairs/community events.
- Participated in approximately 84 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 1,036 members in active health coaching and 513 in education programs in 2016.
- Answered 159,304 calls in the call center in 2016 with an 85.52% service level. The average speed to answer was 20 seconds.
- The Sunflower Customer Services/Provider Services call center provides education and referral services to members and providers. The call center received and responded to an average of 3,063 calls weekly regarding benefit inquiries, concerns, complaints, and request for arranging services.
- Continued to focus on expanded sources for supplemental data that allow better HEDIS data capture to reduce provider record request burden.
- Utilized WebIZ, state immunization registry to improve capture of immunization data for HEDIS.
- Provided $2.27M in value added services to our membership and $717,112 for in-lieu of services.
- Achieved an overall claims payment average TAT of 9.12 days on over 330,000 claims a month (excluding pharmacy claims).
- Partnered with providers and health departments with a goal to impact our members' health and well-being through preventative care for diabetes care, immunizations, dental care, and other preventive services like well-child visits.

Opportunities for Improvements:

- HEDIS rates are a focus for continued improvement; Sunflower continues to evaluate resources and opportunities for education and incentives to improve rates.
- Sunflower continues to work on P4P interventions for 2017.
- Sunflower will implement interventions to continuously improve Member and Provider satisfaction with Sunflower services and operations based on survey results and other avenues of feedback.
- Sunflower will continue to develop and expand trending reports for data analysis and focused intervention.
- Continued HPV PIP to strive for improvement in the HPV vaccination compliance for adolescents
- 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.
- GAR changes identified system opportunities as well as report and/or process changes, to ensure State reporting requirements are being met.

QUALITY PERFORMANCE MEASURES AND OUTCOMES

Performance Improvement Projects

Sunflower is required by state contract to have at least two Performance Improvement Projects (PIPs) annually. Additionally, it is required that one of those is related to behavioral health. Sunflower's PIPs for 2016 were related to HPV Vaccination Rates for Adolescent Females and Initiation and Engagement for Alcohol and Other Drugs. Late in 2015, Sunflower worked with fellow MCOs to close out the previous Prediabetes Management PIP and begin implementation of the HPV PIP for Adolescent Females.

Human Papilloma Virus (HPV) Vaccination

As a result of the state requirement for collaborative performance improvement projects, Sunflower worked in collaboration with the other two MCOs to propose a new PIP focusing on increasing the compliance with the HPV vaccination rates in Kansas. Kansas HPV vaccination rates were noted in 2015 to be the lowest in the nation and clearly indicated an area for improvement. The focus was based on the HEDIS measure for HPV vaccinations with the performance being based on the numbers of female adolescents who turn 13 years old in the measurement year who have completed the series of three HPV vaccinations. This collaborative PIP was proposed to the state late in 2015 and was approved for implementation in 2015 which allowed one quarter to implement and focus interventions on this improvement related specifically to this measure.

Each of the MCOs had a separate goal for 2015 performance that was based of their HEDIS 2015 final rate for the measure. Sunflower's baseline was the HEDIS 2015 rate was 21.67% for measurement year 2014. This rate exceeded the 2014 Quality Compass 50th percentile. Therefore, the goal for 2015 performance was established to be 22.03% which if met will continue to demonstrate exceeding the 50th percentile according to the 2015 Quality Compass. Sunflower did not meet this goal in 2016 with a final rate of 18.81%. Based on this performance, the 2017 goal for Sunflower is 19.75%, which would demonstrate a 5% increase from the previous years' performance. The HEDIS Technical Specifications changed in 2016 to

include males. However for measurement year 2016, performance will be measured on females only.

The three MCOs started with provider profiles to raise provider awareness and enlist their assistance with member compliance. Letters were also sent to the parents/guardians of the members who were non-compliant to provide educational material to help increase awareness and understanding related to the importance of the vaccination with the intended outcome of increasing the vaccination rate. Additionally, efforts were initiated with multiple clinics to offer extended hours to provide well child visits and vaccinations that were not limited to just the HPV vaccination and included both the Tdap and Meningococcal vaccines for Adolescents and CIS as well. Outreach to members by phone was implemented to assist in scheduling appointments and arranging transportation to promote attendance with appointments. Educational materials were provided on the plan website as resources specifically aimed to assist providers with having conversations related to HPV vaccinations with parents of adolescents. These resources included a webinar that offered CME credits through February of 2016. Additionally, the MCO's partnered with health departments to engage members by promoting walk-in clinics and community events. These efforts did not produce the desired results however. Analysis has led the MCO's to look at ways to increase collaboration with providers to address missed opportunities.

HEDIS Measure	HEDIS 2016 (MY2015) Hybrid	HEDIS 2017 (MY2016) Administrative Rates	Achieved NCQA 2016 HEDIS 50th Percentile
Meningococcal	64.90	*67.12	No
Tdap	81.74	*80.79	No
HPV (boys and girls)	N/A	*19.26	N/A
HPV (girls only)	17.01	*22.08	No
HPV (boys only)	N/A	*16.58	N/A

**Awaiting final HEDIS 2017 hybrid rates*

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 EPC, Sunflower's Behavioral Health partner, with oversight provided by Sunflower. Sunflower and EPC provide quarterly and ad hoc updates to the State regarding progress and barriers. In 2016, Sunflower initiated additional steps to identify members earlier for referral to the internal case management department. Sunflower started offering members a smart phone application called ACHESS through two providers. ACHESS is designed to support members in maintaining active engagement in treatment, support members with their recovery efforts, and connect members to a recovery network. The offering of the ACHESS application is in addition to the MyStrength program which provides education and recovery support to members.

Upon identification of members who may be in need of substance use services, Sunflower begins care management to improve initiation of substance use disorder treatment. In follow-up, EPC care managers reach out to the member to:

- Offer transportation assistance.
- Provide the member with contact information for the care manager.

- Provide overview of behavioral health care management/disease management programs.
- Offer MyStrength's application.
- Provide assistance in establishing substance use disorder (SUD) and behavioral health (BH) services.
- Work with members to identify barriers to treatment while finding solutions to overcoming those barriers.
- Coordinate with and between treatment providers.
- Establish interpretation services, if needed.

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

Care managers will schedule follow up calls with the member upon the member agreeing to care management services. The calls will be documented in the case management note section in TruCare. The calls are designed to:

- Engage members in continued treatment.
- Ensure members are scheduled for their continued SUD follow up services.
- Assess for treatment compliance and barriers while identifying resources for the members to improve access.
- Encouraging member use of the ACHESS mobile phone application if the member has enrolled in the study pilot.
- Develop a care plan with the member/guardian.
- Provide the member with continued education as needed.

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

- Names, contact numbers and overview of all Sunflower behavioral health/co-occurring programs.
- Information to access transportation assistance.
- 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.

EPC care managers also work with the Providers to ensure member engagement with treatment and ask about any barriers the providers may see to prevent the member from successfully completing treatment. Monthly provider performance reports are sent to each provider. EPC established a provider mental health team email account that connects providers with Sunflower behavioral health clinicians. Assistance with SUD screening and treatment referral is available.

The interventions discussed 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. 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 in addition to follow-up activities.

Sunflower and EPC continued to encounter challenges in 2016 related to reporting. There have been insufficiencies noted with the state systems allowing for early identification of pregnant women who are using in addition to IV drug users. The 2015 report was submitted to the state in November 2016. The 2016 report is scheduled to be completed and submitted to the state in the fall of 2017 after HEDIS validation has been completed.

There were successes noted for 2016. Members who were identified as needing SUD treatment and accepted care management services in 2015 had higher initiation and engagement rates into treatment than those who were not part of the care management program. 2015 data is the most recent completed data from which Sunflower can report. In 2016 Sunflower identified additional sources from which members with a substance use diagnosis were able to be identified. These additional resources included the daily inpatient census reports and the ER utilization reports to identify members who were presenting with diagnosis related to SUD or commonly associated with SUD. These members were also referred to the care management team. There is a pilot project underway 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 bi-weekly with providers to address any issues that may arise regarding initiation and engagement of members.

In the fourth quarter of 2016, Sunflower evaluated and proposed to the state opportunities for a PIP that would replace this PIP that was concluding on Initiation and Engagement for Alcohol and Other Drugs.

NCQA Accreditation

Sunflower received an upgraded commendable accreditation status from the National Committee for Quality Assurance (NCQA) effective August 31, 2016 based on improvement in HEDIS and CAHPS metrics. Additionally, Sunflower prepared for the NCQA accreditation renewal through the remainder of 2016. The next NCQA survey submission was completed on February 28, 2017 with onsite planned for April of 2017. In preparation for the review, Sunflower continues to review all plan and quality improvement processes to be consistent with NCQA standards. Continued focus on opportunities for 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 2016 readiness reviews/audits, and ongoing health plan NCQA education and reminders continued. Sunflower has a lead for NCQA accreditation efforts to ensure the plan has a focus on continued readiness. The Sunflower Quality Manager attended the NCQA conference in 2016 and an outside NCQA consultant was used to strengthen sunflower NCQA accreditation readiness. Sunflower also works very closely with corporate resources to maintain NCQA compliance.

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 accreditation process. Preliminary reports are provided by Centene's corporate office for monthly review based on administrative data that allow Sunflower to assess the plan's performance and take the appropriate actions to better impact member health, well-being, and preventative care.

HEDIS Indicators

HEDIS is a collection of performance measures developed and maintained by NCQA. Participation in the program enables organizations to collect and submit verified data in a standardized format. In 2014 through 2016, Sunflower submitted HEDIS data in accordance with the performance measure specifications. Sunflower also continued to design and implement 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. Sunflower focuses efforts to improve on HEDIS measures by factoring in those that are required for NCQA accreditation and those that are included in the yearly state Pay for Performance (P4P) measures. Sunflower tracked progress on these measures on a monthly basis throughout 2016 while actively working interventions throughout 2016. 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 provided until the final HEDIS 2017 results are available, which will likely be in July 2017. As an area for improvement, for 2017 the HEDIS work-plan will focus on the NCQA and state recognized P4P measures. Sunflower's performance on HEDIS measures in 2016 achieved a 'Commendable' status by NCQA.

Childhood Immunizations

Much of Sunflower Health Plan's immunization data comes from the Kansas State Immunization Registry or WebIZ as supplemental data. This data has been utilized since 2013 by Sunflower. Sunflower uses the auditor approved CDC mapping table for the CVX immunization codes, in order to map them over from WebIZ to allow for translation to the CPT codes that are accepted in our HEDIS software. A significant improvement was observed in most of our immunizations, and this can be attributed to our interventions, listed below.

- Alerts for Customer Service Representatives and Medical Management to indicate members who have care gaps and can remind them of the need for an appointment and/or assist with making one along with treatment, if needed
- Birthday card mailings the month prior to the member's birthday, as a reminder of Well Child Checks and Immunizations

- Monthly post cards sent for newborns born previous month with Periodicity schedule
- Baby showers given for parents of newborns, providing educational information concerning child wellness issues
- Start Smart for Your Baby Program – outreach to parents of newborns to educate on Periodicity schedule
- POM calls made to parents/guardians of newborns to remind them of schedule for well-child visits, including immunizations
- Back to school initiatives in Sedgwick County to promote immunization compliance
- Corporate "Healthy Reminders" mailer sent out bi-monthly to remind members of immunizations completed and due
- HEDIS Quick Reference Guide distribution to new providers and annual updates to existing providers with ICD-10 updates
- Gap analysis for high volume providers currently available on the Provider Portal
- Provider newsletter article completed in Summer 2016 issue with an article pertaining to supporting HEDIS scores
- Provider EPSDT Reference Kit developed and distributed to high volume providers
- Obtaining WebIZ Immunization Registry data, Web-IZ data pulled for all CIS September, October, November, and December. All of IMA pulled for October, November, and December and partially for September.
- Implemented provider focus with fax campaign in 4Q2016

The table provided below demonstrates results related to HEDIS measure. It is important to note that the final HEDIS 2017 rate is not available at the time of this report, therefore an administrative rate is provided.

HEDIS MEASURE	HEDIS 2016 (MY2015) Hybrid	HEDIS 2017 * (MY2016) Admin.	Achieved NCQA 2016 HEDIS 50th Percentile
DTaP Immunizations	88.33	*72.01	Yes
H Influenza Type B Immunizations	89.76	*82.93	Yes
Hepatitis A Immunizations	87.86	*86.44	Yes
Hepatitis B Immunizations	93.81	*85.93	Yes
Influenza Immunizations	47.86	*37.11	Yes
Measles, Mumps and Rubella Immunizations	88.57	*86.53	No
IPV Immunizations	93.33	*85.22	Yes
Pneumococcal Conjugate	78.81	*73.03	Yes
Rotavirus Immunizations	79.76	*67.26	Yes
Chicken Pox (VZV)	88.57	*86.38	No

**Awaiting HEDIS2017 Final Hybrid Rates*

Adolescent Immunizations

Immunizations for Adolescents continues to be a priority for Sunflower Health Plan. None of the immunizations covered in the IMA HEDIS metric exceeded the 50th percentile. Sunflower continued with direct outreach to members and/or their parents. At the end of 2016, Sunflower

also initiated an end of year push to providers, faxing them the list of their non-compliant members who were still in need of immunizations that had December birthdays.

Immunizations for Adolescents Interventions for 2016 were:

- A Cent Account reward of $15 is given to adolescent members who complete the HPV series.
- Provider Profiles were mailed to providers alerting them to members who were non-compliant on immunizations.
- Alerts for Customer Service Representatives and Medical Management to indicate members who have care gaps and can remind them of the need for an appointment and/or assist with making on along with treatment, if needed.
- Corporate "Healthy Reminders" mailer sent out bi-monthly to remind members of immunizations completed and due.
- HEDIS Quick Reference Guide distribution to new providers and annual updates to existing providers with ICD-10 updates.
- Gap analysis for high volume providers currently available on the Provider Portal.
- Provider EPSDT Reference Kit developed and distributed to high volume providers.
- Obtaining KDHE Immunization Registry data. Web-IZ data pulled for all of IMA pulled for October, November, and December, and partially for September.
- In June, letters were sent to non-complaint members alerting them to nearby clinics that would administer immunizations.
- Telephonic outreach to non-compliant members was made by Sunflower Health Plan, Johnson and Sedgwick County Health Departments, and Grace Med in November and December encouraging members to obtain immunizations.

HEDIS MEASURE	HEDIS 2016 (MY2015) Hybrid	HEDIS 2017 * (MY2016) Admin.	Achieved NCQA 2016 HEDIS 50th Percentile
Meningococcal	64.90	*67.10	No
Tdap	81.74	*80.49	No
HPV	18.81	*22.08	No

**Awaiting HEDIS 2017 Final Hybrid Rates*

Comprehensive Diabetes Care

Sunflower continued to work on this HEDIS measure and its sub measures, with the assistance of Envolve Vision Care (OptiCare) for the Eye Exam sub measure. The current administrative rates for 2016 are 8.95 % above the previous year, and the final hybrid rates are expected to meet or exceed the previous year's rate. Sunflower continued the venture, established in fourth quarter of 2015, with Quest/ExamOne throughout 2016. The project's goal was to impact those members who were still showing non-compliant with their diabetes monitoring and to allow them the option to have their lab draws, blood pressure, height and weight measurements taken in their own home by a Quest/ExamOne staff member. This resulted in approximately 700 members who were willing to participate and getting these tests and measurements completed to allow for proper monitoring and treatment as needed based on the results with their provider right after implementation. 76 members did not get CDC testing done in 2015 but were engaged early in 2016 to complete. From that group, the members with A1c reading ≥8 were referred to

Nurtur for disease management. Of those members, 3 demonstrated a reduction of their A1c results upon repeat testing in third quarter of 2016.
Interventions: Comprehensive Diabetes Care

- Corporate "Healthy Reminders" mailed September of 2015, highlighting the sub-measures completed and those that still needing compliance
- Envolve Vision's (OptiCare) HEDIS Outreach - Diabetic Retinopathy Exam sub-measure; monthly progress reports starting in July of 2016
- CentAccount Program Incentives
- Medical Management performs outreach to with non-compliant members and diabetic members in Care Management
- Member mailer postcards and letter with measure/test dates and reminders
- Customer Service and Medical Management training on measure to discuss care gaps with members on calls; reminders sent prior to care gap reports going out to members
- Use of KRAMES educational materials to educate members about diabetes care
- Member Newsletter containing detailed information on the importance of screenings, and proper diabetes care
- Quest Diagnostics providing outreach to non-compliant members and offering member lab draws in the member's home, as well as BMI and BP measurements
- Provider profiling report distributed to providers of non-compliant members and visits to providers as appropriate
- Provider newsletter articles related to plan performance and goals
- Include P4P measure review/discussion in DVO meetings with vendors who have the ability to assist members
- Partnership with FQHC to close member care gaps

The table provided below demonstrates results related to HEDIS measure. It is important to note that the final HEDIS 2017 rate is not available at the time of this report, therefore an administrative rate is provided.

HEDIS MEASURE	HEDIS 2015 (MY2014) Hybrid	HEDIS 2016 (MY2015) Hybrid	Achieved NCQA 2016 HEDIS 50th Percentile
Comprehensive Diabetes Care – Blood Pressure Control	53.88	56.86	No
Comprehensive Diabetes Care - Eye Care	61.42	67.92	Yes
Comprehensive Diabetes Care - HbA1c Testing	84.48	85.62	No
Comprehensive Diabetes Care – HbA1c Adequate Control (<8%)	40.13	45.58	No
Comprehensive Diabetes Care – HbA1c Poor Control	50.55	46.68	Yes
Comprehensive Diabetes Care – Monitoring for Nephropathy	77.83	92.48	Yes

**Awaiting final HEDIS 2017 hybrid rates*

Annual Dental Visit

The Annual Dental Visit (ADV) measure focuses on the members who are 2-20 years of age having had at least one dental visit during the measurement year. This measure continues as one of our Pay for Performance measures for the State of Kansas in 2016. Based on administrative data, Sunflower demonstrated a 61.84 from administrative data. Therefore, it is anticipated that Sunflower will achieve the 75th percentile on Quality Compass for measurement year 2016.

Annual Dental Visit Interventions for 2016 include the following:

- HEDIS Quick Reference Guide distribution to new providers and annual updates to existing providers with ICD-10 updates.
- Participate in Envolve Dental Delegated Vendor Organization meetings in order for Quality Manager to provide education on current ADV HEDIS rates and interventions.
- 32,794 Dental Reminder Postcards were mailed to 2015 non-compliant members in June reminding them to schedule an annual dental appointment.
- In May, Grace Med outreached to 1,917 of their members who were non-compliant for annual dental visits.
- Dental kits (including toothbrush, toothpaste, and floss) are sent to members ages 2 – 20 who have visited the Emergency Department for dental claims. The letter included in the dental kit encourages to the member to call Customer Service to find a dentist in their area for their dental needs.
- 28 electronic toothbrushes were distributed to members ages 2 – 20 who had the highest dollar dental claims in 2016 by Member Connections Representatives. During their visit, they stressed the importance of good dental hygiene and maintaining annual dental visits.

HEDIS MEASURE	HEDIS 2016 (MY2015) Hybrid	HEDIS 2017 * (MY2016) Admin.	Achieved NCQA 2016 HEDIS 50th Percentile
Annual Dental Visit	61.21	*61.84	Yes

**Awaiting final HEDIS 2017 hybrid rates*

Timeliness of Prenatal Care

Timeliness of Prenatal Care was a new Pay for Performance measures for Sunflower in 2016. Based on hybrid data, Sunflower didn't achieve the 50th Percentile on Quality Compass for measurement year 2015 but continued efforts to improve on this measure for the well-being of the expectant mothers and their babies. Sunflower identified several barriers, which included challenges for members to receive prenatal care within the first trimester or within 42 days of enrollment in the organization. This was likely complicated by those members made retroeligible after their first trimester had elapsed.

Timeliness of Prenatal Care Interventions for 2016 are noted below:

- Cent Account rewards are given to members who receive 3, 6, and 9 month prenatal visits. Members receive $15 per visit and also receive an additional $15 for completing a Notice of Pregnancy.

- HEDIS Quick Reference Guide distribution to new providers and annual updates to existing providers with ICD-10 updates.
- PLE Report is ran daily and is given to Member Connections Representatives to conduct outreach to recent pregnant members.
- Member Connections Representatives placed health promotion easels in FQHC's, pharmacies, and dollar stores creating awareness for pregnant ladies to obtain prenatal care. The easels have a "takeaway" piece of paper which offers Sunflower Health Plan contact information and stresses the importance of moms and babies health.
- Logisticare Transportation provided a report to Sunflower Health Plan of any members that they were transporting to a prenatal care appointment. Member Connections outreaches to these members to ensure they are receiving quality prenatal care and have completed a Notice of Pregnancy form.

HEDIS MEASURE	HEDIS 2015 (MY2014) Hybrid	HEDIS 2016 (MY2015) Hybrid	Achieved NCQA 2016 HEDIS 50th Percentile
Timeliness of Prenatal Care	72.38	71.84	No

**Awaiting final HEDIS 2017 hybrid rates*

Two additional measures that Sunflower focused on in 2016 were Breast Cancer Screenings and Cervical for the entire population served with anticipation of improvement for those waivers that these measures were a focus as a part of the state P4P measures. Those measures and their interventions are noted below.

Breast Cancer Screening (BCS) Interventions:

- Mailer to female members
- Mammogram post cards and "Healthy Reminders" mailing from Corporate office
- Provider Profile mailer
- Member education
- Customer Service and Medical Management reminders during member contacts to help close care gaps

Cervical Cancer Screening (CCS) Interventions:

- Mailer to female members
- "Healthy Reminders" mailing from Corporate office
- Care Gap Reports available on Provider Portal
- Member education
- Customer Service and Medical Management reminders during member contacts to help close care gaps

Behavioral Health HEDIS Measures

Two of the behavioral health measures that were the plan's focus this year were Follow-Up after Hospitalization for Mental Health and Initiation and Engagement of AOD Treatment. Since most of the measures listed below hover around the Quality Compass 75th percentile, the last column identifies the NCQA benchmark for this percentile.

Interventions for Follow-Up after Hospitalization for Mental Health:

- CM involvement during Hospital Discharge Planning, including assistance with appointments; referral is received by CM as soon as the authorization request is received by the health plan
- CMHCs and hospitals work together to ensure discharge planning occurs and follow-up appointments have been scheduled
- Educate CMHCs, Inpatient Hospital Administrators and Chief of Medical Staff as to the importance of this indicator while elevating awareness of the need to collaborate with the health plan's CM to ensure follow-up appointments are scheduled
- Staff training on measure and bridge appointments
- Work with major hospitals to make sure bridge appointments are being billed
- Analyses of data to determine what facilities are not billing these visits
- Provider mailers/reminders to bill 513 visits
- Provider profiling given to providers detailing their rates during annual visits
- Non-compliant list distributed to CBH for review as requested
- BH HEDIS Coordinator to manage clinical team interventions and track progress

The Initiation and Engagement of Alcohol and Other Drug Dependence Treatment measure had a Performance Improvement Project by SHP. The State of Kansas modified the HEDIS measure by adjusting the age group from the HEDIS standards. Both the HEDIS measure and the HEDIS-like modified measure were followed during the year. The table below only includes the actual HEDIS measure.

Interventions for Initiation and Engagement of AOD Treatment:

- Daily outreach and engagement of SUD members into Care Management to improve treatment compliance
- Interventions will then be generalized to all eligible study members
- Targeted SUD provider education; regular meetings scheduled throughout the year with providers; train on measures & review the HEDIS specifications
- Data collected on an on-going basis and reviewed monthly, quarterly and annually for volume & impact on measures

The table provided below demonstrates results for the HEDIS measures. It is important to note that the final HEDIS 2017 rates are not available at the time of this report, therefore the most current administrative rate is provided.

HEDIS MEASURE	HEDIS 2015 (CY2014) Final Admin.	HEDIS 2016 (CY2015) Final Admin.	HEDIS 2017 * (CY2016) Admin.	Achieved NCQA 2016 Quality Compass 75th Percentile
Follow-up after Hospitalization for Mental Illness - 7 day	59.54	67.20	66.55	Yes
Follow-up after Hospitalization for Mental Illness - 30 day	72.60	78.02	78.45	Yes
Initiation and Engagement of AOD Treatment: Initiation	44.22	39.44	38.11	No**
Initiation and Engagement of AOD Treatment: Engagement	15.47	11.45	12.91	No**

** HEDIS 2017 - Awaiting final administrative rates*

***Met 50th percentile Quality Compass but did not meet 75th percentile Quality Compass*

HEDIS Pharmacy Measures

Annual Monitoring for Patients on Persistent Medications continues as one of our Pay for Performance measures for the State of Kansas in 2016. Based on administrative data that is available pending final rates for HEDIS 2016, Sunflower achieved a 90.33% or 75th percentile on Quality Compass as anticipated for measurement year 2015. Sunflower worked to maintain this performance level and/or continue to demonstrate improvement in 2016.

Interventions for Annual Monitoring for Patients on Persistent Medications that were utilized in 2016 are noted here:

- Reminder faxes sent to providers throughout the year of members who need testing, with detail on specific members and the importance of this procedure; if records are received, they are given to Quality Department to enter into QSI as supplemental data
- In late 3rd quarter, member outreach begins by medical management to members who have not had testing since the beginning of the year; calls are made to prescribers to supplement the faxes for non-adherent Digoxin members; after that, the same process will be done for prescribers of ACE/ARB & Diuretics

The table provided below demonstrates results related to HEDIS measure. It is important to note that the final HEDIS 2016 rate is not available at the time of this report, therefore an administrative rate is provided that has not yet been determined to be final.

HEDIS MEASURE	HEDIS 2015 (CY2014) Final Admin	HEDIS 2016 (CY2015) Final Admin	HEDIS 2017 (CY2016) Admin*	Achieved NCQA 2015 HEDIS 75th Percentile
Annual Monitoring for Persistence Medications - Combined Rate	89.88	90.33	89.22	Yes

**Awaiting final HEDIS 2017 administrative rates*

PATIENT SAFETY

Quality of Care and Adverse Events

Sunflower monitors the safety of its members through identification of potential and/or actual quality of care (QOC) events and adverse incidents (AIRS). 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 five levels (None, 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, reviewed quarterly and reported as appropriate. 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 reviewed by the Credentialing Department for consideration at the time of provider 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

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 2016. Sunflower's data on QOCs demonstrates that the majority of the cases referred for review as potential QOC are determined to not meet the criteria for a QOC or received the lowest severity level of zero accounted for 212 cases in 2016. There were 5 cases noted to be given the highest severity level 4, with 12 cases receiving severity level of 3, 16 cases with severity level of 2 and 12 that were noted to have a severity level of 1. Sunflower provides a monthly report to the state advising of cases with high severity levels determined through the QOC process utilized internally at Sunflower and by the appropriate delegated vendors. The table below depicts the severity levels that resulted in the cases refered as potential QOC cases and their severity level based on review of records provided to Sunflower to allow for review to determine if there was a QOC concern and allow for severity level to be assigned accordingly. (See chart on next page)

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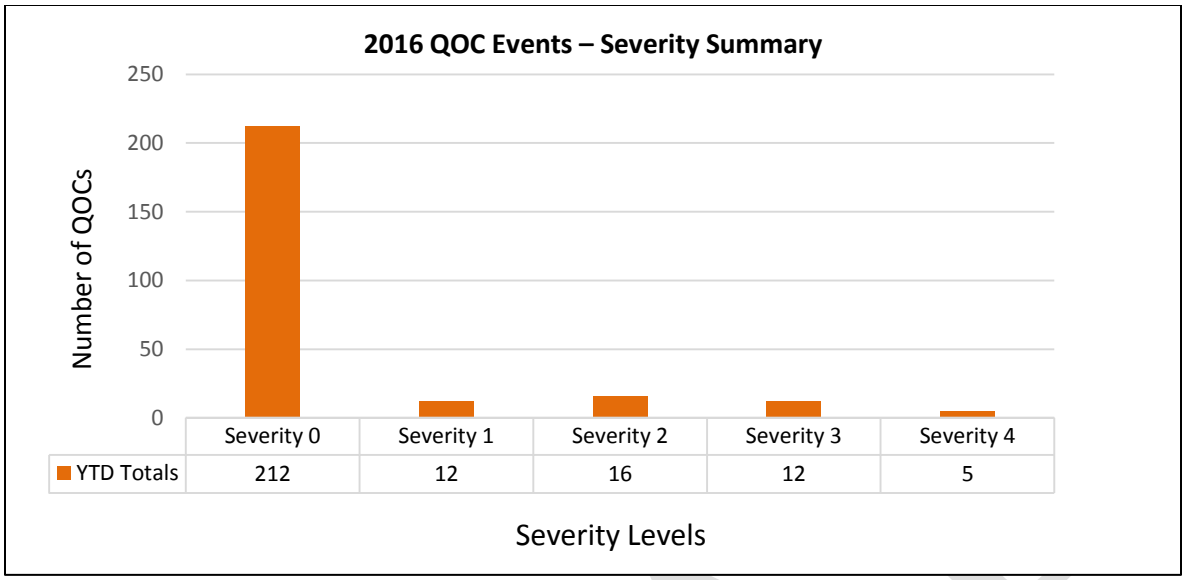
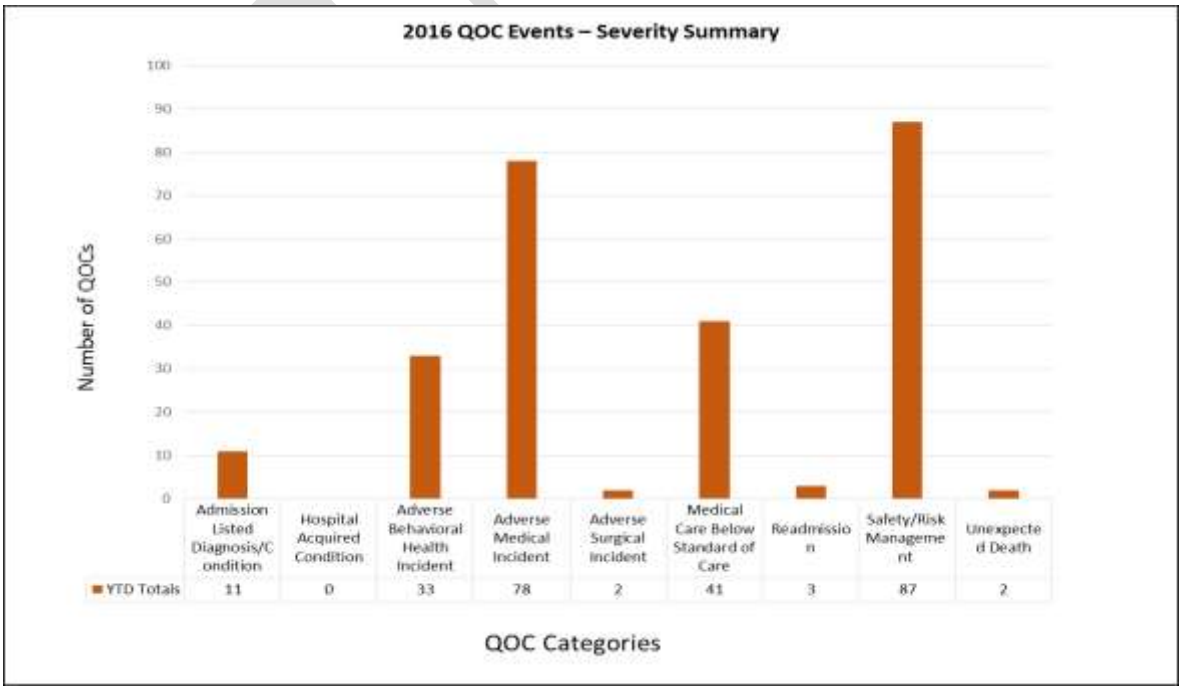


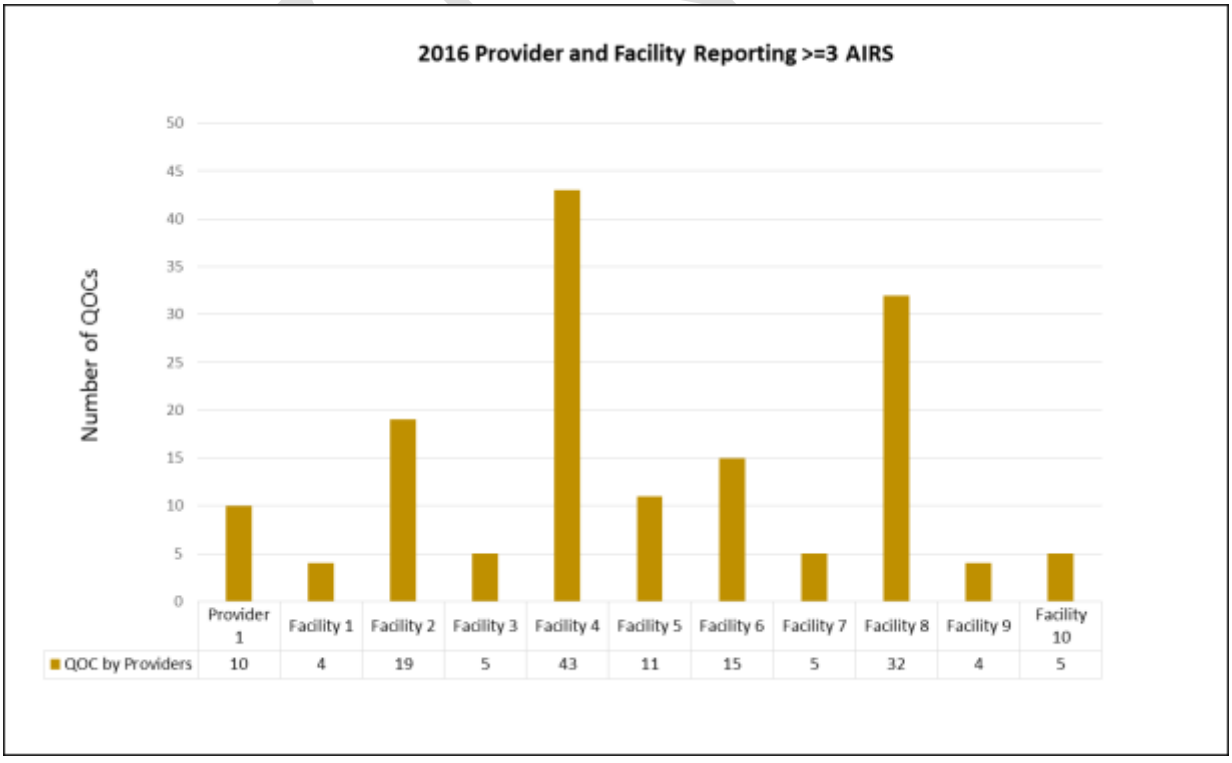
Sunflower also looks at QOC data to determine the most common types of QOC cases. Adverse Medical event was noted to be the highest type of QOC referral received in 2016. The next category was noted to be Safety Risk Management issues. The third highest typ of QOC case was Medical Care Below Standard. Sunflower utilizes the Peer Review Committee to review cases and make recommendations related to the next steps which can include requesting documentation from providers to demonstrate their actions that have already been implemented to prevent further occurences and may make recommendations for education to occur with staff responsible for specified care to members to help avoid future occurences that present risk to members served.



Review of the QOC concerns reported in 2016 resulted in trends of greater than or equal to 3 QOCs for 10 facilities and 1 provider. These 11 identified providers/facilities generated 147 potential QOCs to be investigated, of the 257 for the entirety of 2016. Of the cases referred for these 11 providers/facilities there were 2 providers who had more than 30 reports each. Upon further review of the potential QOCs that were reported for Facility #4, 39 of the 43 reported were noted to not be QOC concerns and were predominantly around hospitalizations and ED usage as well as behavorial incidents, some of which involved law enforcement. They had 1 Medium level QOC regarding a member being forcibly administered their medications after refusing, which resulted in two staff terminations and one staff receiving a written warning. This facility provided a CAP to Sunflower regarding this situation, which was accepted. The remining 3 QOCs for this facility were all Low level cases.

The second facility with greater than 30 QOCs reported in 2106 was Facility #8. Based on review of the potential QOCs, 30 of the 32 reported were not QOCs and 2 received a Low level rating. The majority of the cases that were deemed not to be QOCs were around hospitalizations and ED usage as well as a few behavioral health incidents, some involving law enforcement. One of the Low level cases involved a staff member yelling at a resident resulting in an immediate suspension pending an internal investigation. An APS report was also filed. The other Low level case for this provider was regarding a resident taking another resident's medications resulting in an overnight, observation stay in the CCU monitoring for any potential harm. Staff member involved was terminated and facility is currently being monitored for any similar incidents or trends.

There was a single provider whose prescribing practices generated 10 QOCs in 2016. 6 were Medium cases around the use of Codeine in pediatric patients and the other 4 were around the usage of Cromolyn and were assigned a Low level after review at the PRC.



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 the purpose 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. AIR system training was provided by the State in both Q3 and Q4 in 2016 which resulted in a dramatic increase in AIR reports as noted by volumes that doubled and tripled some months. Additionally, education with the health plan included the expectation that anyone can submit an AIR report including the health plan.

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)". As a result, Sunflower receives reported AIRS, completes initial review by the QOC nurse, then receives follow-up and input from a Care 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.

Sunflower's Quality Improvement team continues documenting and tracking AIR's within the automated clinical documentation system utilized by both Quality and the Medical Management teams. This process was refined in early 2015 and continues to be utilized to allow the two teams continue to work collaboratively to address needs or issues for the members to ensure member satisfaction as a result of the AIR reports received.

In 2016, Sunflower was notified of 1,169 individual AIRs, nearly double that which was reported in 2015. Each AIR reported was reviewed and processed as discussed previously. The following graphic demonstrates the categorization type of 2016 AIR reports. Hospitalized/ER visits represent the highest category, with 577 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 which could contribute to this being the most commonly received type of AIR.Threatening behavior/threatening suicide was the second highest report AIR with 201 followed by Abuse (sexual, emotional, physical and financial) at 140. These details are depicted in the chart on the following page.

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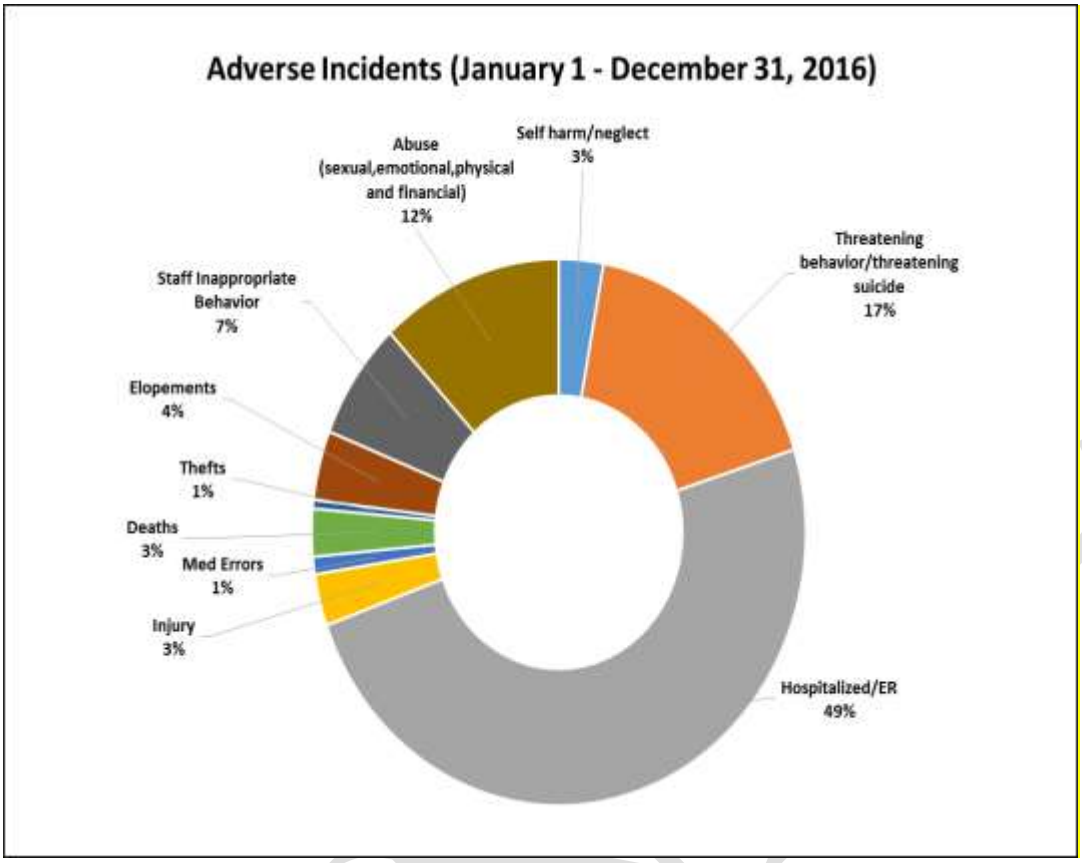

Education of providers in 2016 resulted in an increase in AIR reporting by nearly 300% in Q3 and Q4, over that of Q1 and Q2.

Recommendations for 2016 related to the quality of care and adverse incident reporting include continuing to monitor QOC and AIR data for provider trending, identification of opportunities for improvement which may include but not limited to educational opportunities, working with KDADS and providers to improve conditions for members, and provider follow up on AIR reporting. Plan is for there to be continued improvements for the state reporting system for AIRs which Sunflower actively participated in the meetings and as a partner in this process in 2016 and continues this partnered approach in 2017.

Practice Guidelines (CPG)

Sunflower utilized the following clinical and preventive health practice guidelines in 2016 review of policy. 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
- Anxiety Disorder
- Asthma
- Back Pain
- Diabetes
- CHF / Heart Failure
- CAD
- COPD
- Hyperlipidemia

- Hypertension
- Hypertension in Children
- Immunizations
- Lead Screening
- Pediatric Preventive
- Perinatal Care
- Sickle Cell
- Major Depressive Disorder
- Schizophrenia
- Substance Use Disorders
- Tobacco Cessation
- Weight Management

All Clinical Practice Guidelines (CPGs) and Preventive Health Guidelines (PHGs) are reviewed annually and updated accordingly. Opportunities in 2016 related to practice guidelines were to continue and expand provider profiles in 2016 to a larger provider group to help increase knowledge, awareness and compliance.

Efforts Undertaken in 2016:

- Continue annual review of CPGs and PHGs, review and update as appropriate based on the policy and procedure requirements. Goal met in 2016 and will continue efforts in 2017.
- Continue to notify practitioners about the guidelines via newsletter and website announcements. Goal met in 2016 and will continue in 2017.
- Continue member and provider outreach and education-based initiatives regarding all guidelines. Goal is related to provider profiles, partially met in 2016 due to provider profiles being revised based on provider feedback. Efforts continue for 2017.
- Continue to meet applicable NCQA Standards throughout 2016 and will continue in 2017 to meet standards.

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 to providers to providers.

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 is 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, 2016 through December 31, 2016, compared to calendar year 2015.

The table below displays grievance data by category and represents all member grievances resolved. All grievances are reviewed and analyzed; no sampling is used. Grievance categories were changed in April 2016 based on state reporting requirement changes and mapping was necessary to allow for optimal analysis of the data for internal purposes. Q1 2016 data is included on the table below comparing to 2015 data with additional tables reflecting the revised grievance categories as well as the mapping tool that was used to report annual and cumulative results to the Grievance and Appeal Committee in 2016.

The table below depicts the grievance categories as they were for timeframe January 1 through March 31, 2016 due to new state reporting categories initiated for 2Q2016.

Grievance Category	Jan 1 - Dec 31, 2015	Per 1000	Jan 1 - Mar 31, 2016	Per 1000
Accessibility of Office	7	0.05	4	0.03
Attitude/Service of Staff	151	1.10	42	0.30
Availability	167	1.22	30	0.22
Billing and Financial Issues	59	0.43	19	0.14
Criteria Not Met - DME	5	0.04	2	0.01
Criteria Not Met - Inpatient	3	0.02	0	0.00
Criteria Not Met - Med Proc	8	0.06	2	0.01
HCBS	3	0.02	0	0.00
Lack of Info from Provider	10	0.07	2	0.01
Level of Care Dispute	15	0.11	4	0.03
Other	55	0.40	13	0.09
Overpayments	0	0.00	1	0.01
Pharmacy	18	0.13	4	0.03
Prior or Post Authorization	16	0.12	0	0.00
Quality of Care	24	0.18	7	0.05
Quality of Office, Building	1	0.01	0	0.00
Sleep Studies	1	0.01	0	0.00
Sterilization	3	0.02	0	0.00
Timeliness	99	0.72	16	0.12
Totals	645	4.71	146	N/A*

*Annual per 1000 noted in next table

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The table below depicts the methodology for mapping the grievance categories to the new ones implemented effective April 1, 2016 per state reporting requirements.

Mapping old to new	
Accessibility of Office	Access to service or care
Attitude/Service of Staff	Customer service
Availability	Access to service or care
Billing and Financial	Billing and Financial or Transportation Issues
CNM - Med Procedure	Billing and Financial
HCBS	QOC HCBS
Lack of info from Provider	other
Level of Care Dispute	Billing and Financial
Other	other
Pharmacy	pharmacy issues
Prior or Post Auth	Billing and Financial
QOC	QOC non-HCBS (or HCBS)
Quality of Office, building	QOC non-HCBS (or HCBS)
Sterilization	QOC non-HCBS
Timeliness	Transportation Issues

The table below demonstrates the grievance categories implemented effective April 1, 2016 and remain in place.

Grievance Category	April 1 - Dec 31, 2016	Per 1000
Quality of Care (non-HCBS, non-transportation)	22	0.16
Customer Services	66	0.48
Member Rights Dignity	21	0.15
Access to Service or Care	137	0.99
Pharmacy Issues	21	0.15
Quality of Care HCBS	7	0.05
Transportation Issues (incl reimbursement, other than no-show or safety)	79	0.57
Transportation No Show	48	0.35
Transporation Safety	13	0.09
Value Added Benefits	14	0.10
Billing and Financial Issues (non-transport)	32	0.23
Other	25	0.18
Totals	485	4.54

The grievance category denoting the highest volume in 2016 was Access to Service or Care with 21.7% or 137 grievances out of 631 total for the year. Many of these in this category were due to members lacking access based on limitations in coverage or transportation difficulties. These have since been categorized for increased clarity in 2017 limiting Access to Service or Care for those grievances that directly relate to the network saturation, or lack thereof. Grievances secondary to Transportation Issues, excluding safety and no-shows accounted for 12.5% or 79 for Q2- Q4 2016. In the previous set of categories, which were used for Q1 2016 and all of 2015 we oftentimes saw transportation related grievances fall into the Attitude/Service of Staff and Timeliness categories which may account for the appearance of a reduction year over year in Transportation grievances. Sunflower continues to work very closely with our transportation vendor to ensure member satisfaction. Sunflower has established a goal of less than 4.50/1000 members annually in 2016. Sunflower nearly achieved that goal with 4.54/1000 for all grievances resolved in 2016, continuing to reduce grievance volume from 4.72/1000 in 2015. For 2017, Sunflower's grievance goal to achieve 4.5/1000 members will remain.

Member Appeals

Sunflower defines an appeal as a member's request for the health plan to review an action/adverse determination, in cases where the member is not satisfied with the previous decision made by Sunflower. Practitioners may appeal on behalf of a member as the member's authorized representative.

The Grievance and Appeal Committee and Quality Improvement Committee (QIC) review appeal data on a quarterly basis. Analysis is performed by the QIC which is composed of departmental leaders and network physicians, which enables Sunflower to initiate quality improvement initiatives to improve member satisfaction as needed.

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The table below reflects member appeals by category for 2016 as they compared to 2015. Appeal categories were changed beginning in Q2 2016 which is reflected in the two separate tables provided below.

Member Appeal Category	Jan 1 - Dec 31, 2015	Per 1000	Jan 1 - Mar 31, 2016	Per 1000
Criteria Not Met - Inpatient Admissions	23	0.17	10	0.07
Criteria Not Met - Durable Medical Equipment	73	0.53	18	0.13
Criteria Not Met - Medical Procedure	84	0.61	18	0.13
HCBS	78	0.57	13	0.09
Lack of Information from Provider	30	0.22	2	0.01
Level of Care Dispute	56	0.41	2	0.01
Other	4	0.03	0	0.00
Pharmacy	137	1.00	47	0.34
Prior or Post Authorization	48	0.35	24	0.17
Sleep Studies	1	0.01	1	0.01
Availability	0	0.00	1	0.01
Totals	534	3.89	136	N/A*

*Annual per 1000 noted in table on the following page

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Member Appeal Category	April 1 - Dec 31, 2016	Per 1000
Criteria Not Met - DME	34	0.24
Criteria Not Met - Med Proc	35	0.25
Criteria Not Met - Radiology	15	0.11
Criteria Not Met - Pharmacy	194	1.40
Criteria Not Met - Dental	7	0.05
Criteria Not Met or Level of Care - Home Health	15	0.11
Criteria Not Met - OT/PT/ST	50	0.36
Criteria Not Met - IP BH	52	0.37
Criteria Not Met - OP BH Svs and Testing	47	0.34
Level of Care - LTSS/HCBS	8	0.06
Other - Medical Necessity	7	0.05
Other - Non-Covered Service	15	0.11
Totals	479	4.61

For 2016, Pharmacy appeals were noted to be of highest occurrence, which was consistent with what was noted in 2015. This was attributed to changes of Prior Authorization criteria on specific medications and once additional documentation was provided on appeal approximately 62% of these were able to be overturned. Pharmacy appeals were followed by Criteria Not Met – Inpatient Behavioral Health and then by Criteria Not Met – Behavioral Health Outpatient Service appeals. Continued efforts at education occurred throughout 2016 with medication criteria to providers to assist them with an understanding of what is required as a result of the Prior Authorization changes. Sunflower set a goal of 3.5 appeals per 1000 members for 2016. Sunflower failed to meet that goal with 4.61 per 1000 members in 2016. For 2017, Sunflower's goal will remain to achieve 3.5 appeals per 1000 members. The annual per 1000 value was calculated from the annual total of member appeals in all categories of 640. The categories listed on this table are the top 12 appeal categories and contain 5 or more appeals in either 2015 or 2016 for each category.

Sunflower continues to note an increase in the number of appeals that were overturned on appeal secondary to documentation that was made available for inclusion in the appeal review process that was not provided with the initial Prior Authorization request for services throughout 2016. Pharmacy and DME have greater overturned to upheld ratios as compared to all other appeal categories. As a result, Sunflower will continue to educate providers and encourage them to submit required documentation with the initial request for services/authorizations that

will help in making these decisions in a more timely fashion potentially avoiding an appeal. This trend is noted in the following table.

Member Appeal Category	2016 Overturned	2016 Upheld
Criteria Not Met - Radiology	47%	53%
Criteria Not Met - Durable Medical Equipment	69%	31%
Criteria Not Met - Medical Procedure	41%	59%
Criteria Not Met – Pharmacy	62%	38%
Criteria Not Met - Dental	43%	57%
Criteria Not Met or Level of Care – Home Health	7%	93%
Criteria Not Met – OT/PT/ST	52%	48%
Criteria Not Met – Inpatient Behavioral Health	19%	81%
Criteria Not Met – Outpatient Behavioral Health Svc and Testing	26%	74%
Level of Care – LTSS/HCBS	43%	57%
Other – Medical Necessity	0%	100%
Other – Non-Covered Service	57%	43%

**Based on Q2-Q4 2016 totals*

Provider Appeals

Provider appeals consist of internal reviews of claim denials or payments made by Sunflower. These are monitored to assist in identifying opportunities to improve processes or assist providers in resolving claims issues. Sunflower reviews provider appeals data at the Grievance and Appeals Committee and Quality Improvement Committee (QIC) quarterly meetings. QIC includes departmental leadership which allows for discussion of the data, trends and allows for initiatives to be developed to help address trends identified in the provider appeals data. These initiatives can include but are not limited to provider education, education of plan staff, education of provider office staff and also review of internal plan processes for opportunities.

Sunflower established a goal of a 5% reduction in provider appeals for 2015. Sunflower noted a decrease in provider appeals from 1046 for 2015 to 738 in 2016. This reduction resulted in 29% decrease in provider appeals allowing Sunflower to meet the goal of reducing provider appeals by 5%. Sunflower's goal for 2017 will be to decrease provider appeals by 5%.

The table below depicts the provider appeals by category. Claims/billing issues combined with Claim Denied- Contained Errors (from Q2 onward) was by far the highest category with 148, accounting for 20% of provider appeals in 2016. The second highest provider appeal category was Criteria Not Met - Vision with 127 or 17%. The third highest category combines Authorizations from Q1 and Late Notification and No Authorization Submitted for the remainder of 2016. This accounted for 110 of the 738 provider appeals, or 15%. Authorization and claims processes work together in allowing for claims to be accurately processed. These two categories of provider appeals account for more than a third of the total annual 2016 provider

appeals. Sunflower performs analysis provider appeals data for trends that warrant evaluation of internal processes for potential opportunities for improvement or as opportunities to provide education for providers, their office staff and other areas for improvement opportunities as well.

Top 10 Provider Appeal Categories

Provider Appeals Category	Jan 1- Mar 31, 2016	Per 100,000 claims thru Oct 31, 2016
Authorizations	11	0.154
Claims/Billing Issue	53	0.740
Credentialing/Contracting	0	0.000
Provider Relations	2	0.028
Formulary	0	0.000
Customer Service	0	0.000
Health Plan Administration	0	0.000
Clinical/Utilization Management	5	0.070
Quality of Service or Care	8	0.112
Other	6	0.084

Provider Appeals Category	April 1- Dec 31, 2016	Per 100,000 claims thru Oct 31, 2016
Claim Denied - Contained Errors	95	1.326
Late Notification	58	0.810
No Authorization Submitted	41	0.572
Criteria Not Met - Vision	127	1.773
Criteria Not Met - Inpatient Admissions	102	1.424
Criteria Not Met - Medical Procedure	15	0.209
Criteria Not Met - Inpatient Behavioral Health	13	0.181
Critieran Not Met - BH OP Svcs and Testing	6	0.084
Ambulance	17	0.237
Other - Medical Necessity	8	0.112
Total (2016 provider appeals)	738	10.302

*5,969,518 claims received through October 2016. The entire year's data will not be available until mid-to- late April. The total appeals per 100,000 claims was calculated to account for 10 months' worth of claims data in arriving at these figures.

Member Satisfaction Survey

Sunflower conducts annual member satisfaction survey utilizing the Consumer Assessment of HealthCare Providers and Systems (CAHPS) 5.0H Medicaid Adult and Child Member Satisfaction Surveys to allow for evaluation and comparison of health plan ratings by members. This is also a requirement of our state contract and to support accreditation with the national Committee for Quality Assurance (NCQA).

The 2016 Summary Rate Composite and Key Question scores for Sunflower are presented in CAHPS Adult and Child survey results provided below. These tables also demonstrate

comparison of the survey results for 2016 against results for 2015 along with comparison to the Quality Compass® All Plans means and percentiles. The 2015 Quality Compass® All Plans is the mean summary rate from the Medicaid adult health plans that submitted data to NCQA in 2015. The Medicaid Child CAHPS is compared to the 2015 Quality Compass® All Plans benchmark; this benchmark includes approximately 143 samples of Medicaid child plans that submitted to NCQA.

Sunflower's summary rate results for 2016 Composites and Key Questions for the CAHPS Medicaid Adult Survey compared to the 2015 Quality Compass All Plans means and percentiles. Results for 2016 demonstrated improvement in Getting Need Care and How Well Doctors Communicate.

Medicaid Adult CAHPS Survey Results

Composite & Question Ratings	2015 Rate	2016 Rate	2016 Quality Compass All Plans Percentile (Met or Exceeded 50th percentile)
Getting Needed Care	**84.1%**	**87.1%**	**Yes**
• Ease of getting care, tests, or treatment needed	86.9%	86.3%	Yes
• Obtaining appointment with specialist as soon as needed	81.3%	87.9%	Yes
Getting Care Quickly	**83.9%**	**83.4%**	**Yes**
• Obtaining needed care right away	88.6%	86.5%	Yes
• Obtaining appointment for care as soon as needed	79.2%	80.3%	Yes
How Well Doctors Communicate	**90.6%**	**92.6%**	**Yes**
• Doctors explaining things in an understandable way	89.7%	92.6%	Yes
• Doctors listening carefully to you	91.2%	92.0%	Yes
• Doctors showing respect for what you had to say	92.4%	94.3%	Yes
• Doctors spending enough time with you	89.1%	91.5%	Yes
Customer Service	**92.2%**	**91.0%**	**Yes**
• Getting information/help from customer service	86.6%	86.1%	Yes
• Treated with courtesy and respect by customer service	97.8%	96.0%	Yes
Shared Decision Making	**82.2%**	**78.7%**	Yes
• Doctor/health provider talked about reasons you might want to take a medicine	93.2%	92.2%	Yes
• Doctor/health provider talked about reasons you might not want to take a medicine	71.7%	66.2%	No

Composite & Question Ratings	2015 Rate	2016 Rate	2016 Quality Compass All Plans Percentile (Met or Exceeded 50th percentile)
• Doctor/health provider asked you what you thought was best when talking about starting or stopping a prescription medicine	81.8%	77.6%	Yes
• **Health Promotion and Education**	67.8%	69.6%	No
• **Coordination of Care**	83.3%	87.8%	Yes
• **Providing Needed Information**	70.5%	74.6%	Yes
• **Ease of Filling Out Forms**	93.0%	94.5%	Yes
Ratings Items			
Rating of Health Care	74.5%	74.3%	Yes
Rating of Personal Doctor	81.5%	79.5%	No
Rating of Specialist	79.1%	81.7%	Yes
Rating of Health Plan	73.5%	75.4%	No

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Sunflower's 2016 summary rate results for Composites and Key Questions for the CAHPS Medicaid Child Survey by Title XIX and Title XXI compared to the 2015 Quality Compass All Plans. In 2016, Getting Care Quickly, Customer Services and Shared Decision Making, Rating of Personal Doctor and Health Plan all demonstrated improvement over the results for 2015 for both the Title XIX and Title XXI survey respondents. Getting Needed Care, Coordination of Care and Ease of Filing out Forms demonstrated a reduction for both populations as well as noted on the table below. Green text depicts where there was a noted increase from the previous year while red text indicates a decrease from previous year's results.

Medicaid Child CAHPS Survey Results

Child Composite & Question Ratings	2015 Rate Title XIX	2016 Rate Title XIX	2015 Quality Compass Met/Exceeded 50th Percentile	2015 Rate Title XXI	2016 Rate Title XXI	2015 Quality Compass Met/Exceeded 50th Percentile
Getting Needed Care	**88.1%**	**83.2%**	**No**	**90.9%**	**90.1%**	**Yes**
• Ease of getting care, tests, or treatment child needed	91.5%	92.4%	Yes	93.3%	93.1%	Yes
• Obtaining child's appointment with specialist as soon as needed	84.7%	74.0%	No	88.6%	87.1%	Yes
Getting Care Quickly	**92.3%**	**94.9%**	**Yes**	**90.0%**	**90.6%**	**Yes**
• Obtaining needed care right away	93.8%	97.4%	Yes	91.4%	91.7%	Yes
• Obtaining appointment for care as soon as needed	90.7%	92.3%	Yes	88.5%	89.6%	Yes
How Well Doctors Communicate	**93.0%**	**92.8%**	**No**	**95.0%**	**96.2%**	**Yes**
• Doctors explaining things in an understandable way	93.9%	93.9%	No	96.8%	96.2%	Yes
• Doctors listening carefully to you	94.9%	92.8%	No	95.3%	94.3%	No
• Doctors showing respect for what you had to say	95.5%	93.9%	No	96.1%	100.0%	Yes
• Doctors spending enough time with your child	87.8%	90.6%	Yes	91.8%	94.3%	Yes
Customer Service	**90.0%**	**90.5%**	**Yes**	**89.3%**	**94.8%**	**Yes**
• Getting information/help from customer service	86.6%	86.9%	Yes	84.6%	93.8%	Yes
• Treated with courtesy and respect by customer service staff	93.5%	94.2%	Yes	93.9%	95.7%	Yes
Shared Decision Making	**79.9%**	**81.2%**	**Yes**	**80.2%**	**83.1%**	**Yes**
• Doctor/health provider talked about reasons you might want your child to take a medicine	94.2%	99.0%	Yes	95.8%	95.2%	Yes
• Doctor/health provider talked about reasons you might not want your child to take a medicine	68.0%	66.3%	Yes	67.5%	70.7%	Yes

Child Composite & Question Ratings	2015 Rate Title XIX	2016 Rate Title XIX	2015 Quality Compass Met/Exceeded 50th Percentile	2015 Rate Title XXI	2016 Rate Title XXI	2015 Quality Compass Met/Exceeded 50th Percentile
• Doctor/health provider asked you what you thought was best for your child when starting or stopping a prescription medicine	77.5%	78.2%	Yes	77.2%	83.3%	Yes
Health Promotion and Education	66.6%	68.3%	No	66.3%	64.6%	No
Coordination of Care	83.3%	78.0%	No	81.5%	76.6%	No
Ease of Filling Out Forms	93.5%	93.0%	No	95.9%	95.4%	Yes
Rating Items						
Rating of Health Care	85.7%	89.2%	Yes	88.1%	85.4%	Yes
Rating of Personal Doctor	89.0%	89.4%	Yes	89.1%	92.2%	Yes
Rating of Specialist	81.8%	87.7%	Yes	85.0%	82.8%	No
Rating of Health Plan	86.5%	90.1%	Yes	89.1%	92.0%	Yes

Sunflower's goal for the 2016 CAHPS surveys was to meet or exceed the NCQA Quality Compass 50th percentile for both the Adult and Child surveys. Sunflower reached the 50th percentile on most measures and exceeded the 75th and the 90th percentile on several questions. Sunflower met the goal for most areas on the 2016 Adult and on the Child surveys. The areas not meeting Sunflower's goal of meeting the 50th percentile or above are the areas Sunflower is focusing improvement efforts on.

Medicaid Adult Survey – Sunflower's responses less than the 50th percentile:

- "Health Promotion and Education", "Rating of Personal Doctor", and "Rating of Health Plan" were less than the 50th percentile.
- "Doctor/Health Provider Talked about Reasons You Might Not Want to Take a Medicine" was the only key questions scoring less than the 50th percentile.

Medicaid Child Survey – Sunflower's responses less than the 50th percentile:

- "Health Promotion and Education" was less than the 25th percentile.
- "Ease of Filling out Forms" was less than the 50th percentile.

Some composites impact the members' responses to the rating questions more than others and are considered Key Drivers. SPH Analytics ran multiple linear regression analyses on the results to identify which composites were Key Drivers for both the Adult and Child Surveys.

The analysis of key drivers allows 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 2015 Key Drivers for the Medicaid Adult Survey identified as areas of opportunity or areas to monitor are identified in tables that follow.

Medicaid Adult Survey Opportunity Analysis

Key Driver of Health Plan Rating	**2015 Opportunity Analysis**	**2016 Opportunity Analysis**
Customer Service	98th, Strength	87th, Strength
Getting Needed Care	71st, Monitor	98th, Strength
Key Driver of Health Care Rating	**2015 Opportunity Analysis**	**2016 Opportunity Analysis**
Customer Service	N/A	87th Strength
Getting Needed Care	71st, Monitor	98th, Strength
How Well Doctors Communicate	48th, Opportunity	77th, Strength
Getting Care Quickly	82nd, Strength	N/A
Key Driver of Personal Doctor Rating	**2015 Opportunity Analysis**	**2016 Opportunity Analysis**
How Well Doctors Communicate	48th, Opportunity	77th, Strength
Coordination of Care	66th, Monitor	95th, Strength

To identify opportunities to improve performance, Sunflower examines all sources of member experience data to identify common issues across the various data sources. The sources utilized include grievance and appeal data and CAHPS survey results, including the key driver analysis, were reviewed by representatives from key Sunflower departments, including Provider Relations, Medical Management, Quality Improvement (including the Grievance and Appeal Coordinator), Network & Contracting, Customer Services, Compliance, Pharmacy, LTSS/Waiver, I/DD, and Behavioral Health. 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:

- Member lack of understanding of state benefits and limitations.
- Incomplete information received from providers to authorize services on initial request.
- Members unresponsive to health plan outreach via mail, phone, or text.
- Members unaware of process for scheduling transportation and that Sunflower can provide assistance with scheduling.
- Member lack of understanding of appointment standards.
- Expectations of member affecting perception of provider attitude or service.
- Inaccurate member demographic information used for outreach.

The opportunities identified for improvement involve the interventions aimed to impact those barriers are listed below:

- Increase member understanding of Medicaid benefits.
- Educate providers on documents and information needed for PA request.
- Increase member engagement in provided materials.
- Increase reliability of member demographic information.
- Member education regarding transportation benefit via the member newsletter.
- Increase member knowledge of standard/expected timeframes to obtain an appointment.

ACCESS & AVAILABILITY

Customer Service Call Statistics

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

The Customer Service Department has state contractual requirements to meet telephone access standards. In 2016, the Customer Service Department met Sunflower's performance goals for both member and provider inbound calls. Sunflower's Customer Service department had a total call volume of 101,719 for 2016. The average speed to answer was 18 seconds in 2016 and Sunflower successfully met the goal of 80% answered within 30 seconds or less. The 2016 abandonment rate was 2.2% which demonstrates meeting the goal of less than 4%. As a result of the performance goals having been met, there are no opportunities to improve Sunflower's telephone access at this time. However, Sunflower will continue monitoring and reporting telephone access on a monthly basis to allow for tracking, trending and identifying any opportunities while striving to continue to meet or exceed the requirements.

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 EPC, 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
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

Appointment Access Definitions - Standards and Methodology

Sunflower defines urgent care appointments as within 48 hours from the time of the request. Routine appointment accessibility for PCPs are not to exceed three weeks from the date of member requests. Access to a specialty care appointment within 30 days of request is the standard. Sunflower also monitors office wait times and defines an acceptable wait time as within 45 minutes from time member enters a practitioner office, for both PCPs and specialists.

Sunflower surveyed a sample of participating (in network) credentialed practitioners, both PCPs and specialists (includes OB/GYN), with Sunflower Health Plan as of July 17, 2015. No practitioners were excluded from the sample. Practitioner data was pulled from Sunflower's provider management system, Portico. Data is collected by standardized survey; a total of 1074 practitioners were included for the 2015 analysis. Sunflower Health Plan's appointment availability surveys request confirmation that the practitioner can accommodate members' appointment needs based on current practitioner availability for routine and urgent appointments.

The table below demonstrates the primary care and specialist standards and measurement methods by appointment type that Sunflower is contractually evaluating on an annual basis.

Appointment Type	Standard and Performance Goal	Measurement Method	Measurement Frequency
Primary care urgent appointments within 48 hours	90% of surveyed PCPs report availability of urgent appointment within defined timeframe	Survey sample of all PCP offices	Annually
Primary care routine appointments not to exceed three weeks from date of member request	90% of surveyed PCPs report availability of urgent and appointment within defined timeframes	Survey sample of all PCP offices	Annually
Specialist urgent care appointments within 48 hours	90% of surveyed specialists report availability of urgent appointment within defined timeframe	Survey sample of all specialist offices	Annually
Specialist routine appointments not to exceed 30 days from the date of member request	90% of surveyed specialists report availability routine appointment within defined timeframes	Survey sample of all specialist offices	Annually
Wait time not to exceed 45 minutes	90% of surveyed PCPs 90% of surveyed specialists	Survey sample of PCP offices and specialists offices	Annually

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The table below demonstrates the results from 2016 assessment of providers by types to include primary care, oncologists, and OB providers. Additionally, it demonstrates the results obtained from the survey results to determine waiting room times for those provider types along with volume of member grievances and appeals related to accessibility of service per 1000 members.

Measurement Results and Comparison to Performance Goal

Access Standard	Performance Goal	Results	Goal Met? (Yes/No)
Primary care urgent appointments within 48 hours	90% of surveyed PCPs report availability of urgent appointment within timeframe	99%	Yes
Primary care routine appointments not to exceed 3 weeks	90% of surveyed PCPs report availability of routine appointment within timeframe	1st available: 86% 2nd available: 79% 3rd available: 73%	No
Oncology care for urgent appointments within 48 hours	90% of surveyed high-impact specialists report availability of urgent appointment within timeframe	82%	No
Oncology care for routine appointments within 30 days	90% of surveyed high-impact specialists report availability of routine appointment within timeframe	1st available: 88% 2nd available: 76% 3rd available: 73%	No
OB care for routine appointments in the first trimester within 30 days	90% of surveyed high-volume specialists report availability of routine appointment within timeframe	1st available: 97% 2nd available: 100% 3rd available: 100%	Yes
OB care for routine appointments in the second trimester within 30 days	90% of surveyed high-volume specialists report availability of routine appointment within timeframe	1st available: 100% 2nd available: 100% 3rd available: 100%	Yes
OB for routine appointments in the third trimester within 30 days	90% of surveyed high-volume specialists report availability of routine appointment within timeframe	1st available: 100% 2nd available: 100% 3rd available: 100%	Yes
Wait time not to exceed 45 minutes	90% of surveyed PCPs 90% of surveyed oncologists 90% of surveyed OBs	94% 94% 100%	Yes Yes Yes
Volume of member grievances regarding accessibility of services	Complaint volume of less than .75/1000 members	0.01	Yes
Volume of member appeals regarding accessibility of services	Appeal volume of less than .75/1000 members	Zero (0)	Yes

Measurement Results and Comparison to Performance Goal

Access Standard	Performance Goal	Results	Goal Met? (Yes/No)
Adult Survey: *Getting Care Quickly* Composite	2015 Quality Compass All Plans Rate 80.7%	83.4%	Yes
Q4 Adult Survey: Percent of members who responded always or usually to "Obtained needed care right away"	2015 Quality Compass All Plans Rate 83.3%	86.5%	Yes
Q6 Adult Survey: Percent of members who responded always or usually to "Obtained appointment for care as soon as needed"	2015 Quality Compass All Plans Rate 78.2%	80.3%	Yes
Q61 (custom question) Adult Survey: In the last 6 months, when you phoned after regular office hours, how often did you get the help or advice you needed?	Internal Goal – Summary Rate of 80% or greater	75.0%	No
Child Survey: *Getting Care Quickly* Composite	2015 Quality Compass All Plans Rate 88.6%	93.7%	Yes
Q4 Child Survey: Percent of members who responded always or usually to "Child obtained needed care right away"	2015 Quality Compass All Plans Rate 90.2%	95.8%	Yes
Q6 Child Survey: Percent of members who responded always or usually to "Child obtained appointment for care as soon as needed"	2015 Quality Compass All Plans Rate 87.2%	91.6%	Yes
Q85 (custom question) Child Survey: In the last 6 months, when you phoned after regular office hours, how often did you get the help or advice you needed	Internal Goal – Summary Rate of 80% or greater	83.1%	Yes

Sunflower chose to assess the first, second, and third appointment availability to more thoroughly determine accessibility of routine appointments, as depicted in the table titled "Measurement Results and Comparison to Performance Goal" above. The goal was not met for

routine appointments, with a rate of 86% compliance (for first available appointment), a slight decrease from the 2015 rate of 87.86%. The survey of a sample of PCPs for accessibility of urgent care appointments found that the Sunflower goal of 90% compliance with appointment standards was met for urgent appointments at 99% (improved from 91.33% in 2015). Sunflower will strive to meet or exceed the 90% goal for compliance with appointment standards in 2017.

Sunflower also chose to survey high-impact specialists (i.e. oncologists) and high-volume specialists (i.e. OB/GYNs). The survey of oncologists for accessibility of routine and urgent care appointments found that the Sunflower goal of 90% compliance with appointment standards was not met for both urgent appointments at 82% and routine appointments at 88% (for first available appointment). The survey of OBs for accessibility of routine appointments found that the Sunflower goal of 90% compliance with appointment standards was met for routine appointments (97% to 100%), depending upon which trimester the member was requesting an appointment for.

The survey results for wait time not to exceed 45 minutes found that the Sunflower's goal of 90% compliance was met for all PCPs (94%), high-impact specialists/oncologists (94%), and high-volume specialists/OBs (100%).Sunflower will continue to strive for this performance upon assessment in 2017 to meet or exceed compliance with 90%.

After-Hours Care

In 2016, the After-Hours Survey was completed for primary care physicians in December of 2016. The results demonstrated that 100% of PCP offices who were successfully contacted were determined have an acceptable method of providing after-hours access for members. Of the 342 total providers in the sample, 253 offices were assessed and found to be compliant with the passing criteria outlined in Table 3 above; 89 of the office did not have a working phone number/wrong number so could not be assess for compliance with the after-hours access standard.

The 2016 CAHPS survey included questions addressing After-Hours Care; Q#60 on the Adult Survey Supplemental Questions "In the last 6 months, did you phone your personal doctor's office after regular office hours to get help or advice for yourself?", Q#61 "In the last 6 months, when you phoned after regular office hours, how often did you get help or advice you needed?"; Q#84 on the Child Survey Supplemental Questions "In the last 6 months, did you phone your child's personal doctor's office after regular office hours to get help or advice for yourself?", Q#85 "In the last 6 months, when you phoned after regular office hours, how often did you get help or advice you needed?"

CAHPS Survey Questions for After Hours	Title XIX 2015 Rate	Title XIX 2016 Rate	Title XXI 2015 Rate	Title XXI 2016 Rate	Adult 2015 Rate	Adult 2016 Rate
Child Q84/Adult Q60. In last 6 months, did you phone your child's or your personal doctor's office after regular office hours to get help/advice?	16.1%	15.1%	13.0%	9.8%	16.3%	14.0%
Child Q85/Adult Q61. In the last 6 months, when you phoned after regular office hours, how often did you get the help/advice you needed for your child or yourself?	81.7%	82.1%	74.2%	86.7%	74.1%	75.0%

**Rate provided demonstrates those who responded with always/usually.*

The CAHPS data revealed that there is a small percentage of members who call providers offices after hours for help/advice. As noted, those who called their providers office after hours in the previous six months ranged from 9.8% to 15.1% in 2016 for both child populations and the adult population. All three populations noted a decrease in the number which had called their providers office after hours for help/advice in the last six months when compared to 2015 results. Of those who did call for help/advice after hours were able to get the help or advice they needed for their child or their self by responses indicating always or usually. All three populations demonstrated an increase in getting the help or advice needed after hours for 2016 compared to 2015. Sunflower will continue to monitor this data on an annual basis to assess for opportunities for improvement from our membership.

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 2016, Sunflower utilized additional CAHPS questions to capture data for more providers to more globally assess primary care access information.

The table below demonstrates the Sunflower rates for CAHPS Adult member satisfaction survey results comparing 2016 to 2015. Also, the tables demonstrates the plans ranking per the 2015 Quality Compass ranking.

Composite & Question Ratings	2015 Rate	2016 Rate	2015 Quality Compass Plan Ranking Exceeded 50th Percentile
Getting Care Quickly	**83.9%**	**83.4%**	Yes
• Obtaining needed care right away	88.6%	86.5%	Yes
• Obtaining appointment for care as soon as needed	79.2%	80.3%	Yes

Below, the table that demonstrates Sunflowers Child CAHPS survey results for comparison of 2016 results with 2015 survey demonstrated by Title XIX and Title XXI member satisfaction survey results specific to Getting Care Quickly.

Child Composite & Question Ratings	2015 Rate Title XIX	2016 Rate Title XIX	Title XIX 2015 Quality Compass Met/Exceeded 50th Percentile	2015 Rate Title XXI	2016 Rate Title XXI	Title XXI 2015 Quality Compass Met/Exceeded 50th Percentile
Getting Care Quickly	**90.9%**	**94.9%**	**Yes**	**90.0%**	**90.6%**	Yes
• Obtaining needed care right away	93.8%	97.4%	Yes	91.4%	91.7%	Yes
• Obtaining appointment for care as soon as needed	90.7%	92.3%	Yes	88.5	89.6%	Yes

*The 2015 Quality Compass benchmark is the mean summary rate from Medicaid Child samples submitted to NCQA 2015 approximately 143 samples.

To identify opportunities to improve performance, Sunflower examines all sources of member experience data to identify common issues across the various data sources. These resources include grievance and appeal data and CAHPS survey results, including the key driver analysis, were reviewed by representatives from key Sunflower departments, including Provider Relations, Medical Management, Quality Improvement (including the Grievance and Appeal Coordinator), Network & Contracting, Customer Services, Compliance, Pharmacy, LTSS/Waiver, I/DD, and Behavioral Health. The Sunflower workgroup met and discussed barriers, opportunities to address these barriers to increase member satisfaction, and potential interventions.

Network Access

Sunflower reviews data to evaluate practitioner access to members which includes cultural and linguistic capabilities with regard to meeting the needs of Sunflower's membership. Additionally, practitioner availability with respect to members living in urban and rural areas.

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, EPC, 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.

Standards and Measurement Methods by Practitioner Type

Practitioner Type	Standard	Measurement Method	Measurement Frequency
PCPs: All Types	95% of urban members have at least 1 PCP within 20 miles. 95% of rural members have at least 1 PCP within 30 miles. At least 1 PCP per 2000 members	Quest Analytics Quest Analytics Ratio of PCPs to members	Annually
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	Quest Analytics Quest Analytics Ratio of FPs or GPs to members	Annually
PCPs: Internal Medicine	95% of urban members ≥19 years have at least 1 internist within 20 miles. 95% of rural members ≥19 years have at least 1internist within 30 miles. At least 1 internist per 2000 adult members	Quest Analytics Quest Analytics Ratio of internists to members	Annually
PCPs: Pediatrics	95% of urban members ≤18 years have at least 1 pediatrician within 20 miles. 95% of rural members ≤18 years have at least 1 pediatrician within 30 miles. At least 1 pediatrician per 2000 members ≤18	Quest Analytics Quest Analytics Ratio of pediatricians to members	Annually

Standards and Measurement Methods by Practitioner Type

Practitioner Type	Standard	Measurement Method	Measurement Frequency
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	Quest Analytics Quest Analytics Ratio of NPs to members	Annually
PCP Extenders: Physician Assistants	95% of urban members have at least 1 PA within 20 miles. 95% of rural members have at least 1 PA within 30 miles. At least 1 PA per 2000 members	Quest Analytics Quest Analytics Ratio of PAs to members	Annually
Obstetrics and Gynecology	95% of urban female members have at least 1 OB/GYN within 15 miles. 95% of rural female members have at least 1 OB/GYN within 60 miles. At least 1 OB/GYN per 2000 members	Quest Analytics Quest Analytics Ratio of OB/GYN practitioners to members	Annually
Hematology/ Oncology	95% of urban members have at least 1 Hematology/Oncology provider within 25 miles. 95% of rural members have at least 1 Hematology/Oncology provider within 100 miles. At least 1 Hematology/Oncology provider per 5000 members	Quest Analytics Quest Analytics Ratio of Hematology/ Oncology providers to members	Annually
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	99.9% 99.9% 1:42	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	99.9% 99.9% 1:119	Yes Yes Yes

Standards and Measurement Methods by Practitioner Type

Practitioner Type	Standard	Measurement Method	Measurement Frequency
PCPs: Internal Medicine	95% of urban members ≥19 have at least 1 internist within 20 miles	99.6%	Yes
	95% of rural members ≥19 have at least 1internist within 30 miles.	83.8%	**No**
	At least 1 IM per 2000 adult members	1:78	Yes
PCPs: Pediatrics	95% of urban members ≤18 years of age have at least 1 pediatrician within 20 miles	99.5%	Yes
	95% of rural members ≤18 years of age have at least 1 pediatrician within 30 miles.	73.2%	**No**
	At least 1 Pediatrician per 2000 members under age 19	1:324	Yes
PCP Extenders: Nurse Practitioners	95% of members have at least 1 NP within 20 miles	98.9%	Yes
	95% of rural members have at least 1 NP within 30 miles.	99.6%	Yes
	At least 1 NP per 2000 members	1:205	Yes
PCP Extenders: Physician Assistants	95% of members have at least 1 PA within 20 miles	99.9%	Yes
	95% of rural members have at least 1 PA within 30 miles.	97.6%	Yes
	At least 1 PA per 2000 members	1:410	Yes
Obstetrics and Gynecology	95% of urban female members have at least 1 OB/GYN within 15 miles.	97.5%	Yes
	95% of rural female members have at least 1 OB/GYN within 60 miles.	95.4%	Yes
	At least 1 OB/GYN per 2000 members	1:203	Yes
Hematology/ Oncology	95% of urban members have at least 1 Hematology/Oncology provider within 25 miles.	91.5%	**No**
	95% of rural members have at least 1 Hematology/Oncology provider within 100 miles.	83.0%	**No**

Geographic analysis of provider availability entails comparing results to the standards for primary care for members residing in urban areas (95% of members having at least 1 PCP within 20 miles) and rural areas (95% of members have at least 1 PCP within 30 miles).

Availability for all PCP types combined and by specific type for family/general practitioners, internists, and pediatricians met Sunflower's standards for members residing in urban areas. Two standards were not met for Sunflower members residing in rural areas. The two that failed to meet the standard were internal medicine and pediatricians. However, it is noted that for those rural areas there are family and general practitioners demonstrating access to primary care. This may indicate that the primary care providers available in the rural area do not specialize in the care of adult, children or adolescents specifically. Sunflower also measures availability for PCP-Extenders, i.e. nurse practitioners and physician assistants, which both met the standards for urban members in 2016. Availability of physician assistants and nurse practitioners for members residing in rural areas did meet the standard of 95%, for 2016. This was an improvement as in 2015, physician assistants in the rural area failed to meet the 95% standard. All PCP types exceeded the numeric/ratio standards established by Sunflower: 1:2000 for all types of PCPs again in 2016.

Sunflower's standards for OB/GYN practitioners are that 95% of female members have access to at least 1 OB/GYN within 15 miles for urban areas and within 60 miles for rural areas; both standards were met for OB/GYNs in 2015. In addition to OB/GYNs, high-volume specialty care practitioners are defined as any provider greater than 150 encounters per 1,000 members. Sunflower also evaluated high-impact specialists, identified as hematology and oncology specialists, it was determined that they did not meet the urban (95% of members have at least 1 specialist within 25 miles) or the rural (95% of members have at least 1 specialist within 100 miles) geographic standards. The results of the 2016 practitioner availability analysis for hematology and oncology access for urban members was 91.5%. Therefore, Sunflower has identified this as an opportunity and will target these counties for further investigation and outreach to improve access for urban members: Butler, Crawford, Geary, Leavenworth, Miami, and Reno. The results for hematology and oncology access for rural members was 83%. Sunflower will target these counties for further investigation and outreach to improve access for rural members: Finney, Seward, Grant, Sherman, Stevens, Kearney, Thomas, Rawlins, Hamilton, Haskell, Gray, and Meade. Of the counties listed above, Crawford, Finney, Geary, Grant, Gray, Hamilton, Haskell, Kearney, Meade, Rawlins, Reno, Seward, Sherman, Stevens and Thomas are all designated as Health Professional Shortage Areas (HPSAs) by the U.S. Department of Health and Human Services (DHHS).

Sunflower's rural standards include both rural areas and "frontier" areas. Much of the state of Kansas is considered rural or frontier. While definitions of "frontier" vary, estimates based on the definition of frontier as counties having a population density of six or fewer people per square mile show that approximately three-fourths of the state is considered frontier. Per the US Department of Agriculture, the term "frontier and remote" describes territory characterized by a combination of low population size and a high degree of geographic remoteness, and are defined in relation to the time it takes to travel by car to the edges of nearby Urban Areas (UAs). Based on this definition, over 58% of the Kansas population is considered living in "frontier and remote" areas. The large percentage of the state 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 services through Quest Analytics reporting. Sunflower believes that despite not meeting the geographic standards for internists, pediatricians, and physician assistants and Hematologists/Oncologists per Quest Analytics reporting, members in rural and frontier areas of the state do have adequate access to primary and specialty care when considering the overall availability of all PCPs, including PCP-Extenders and known primary care and specialty services available through hospitals, as Sunflower is contracted with all available hospitals in the rural and frontier areas.

Sunflower has identified gaps through analysis of network adequacy from Geo Access maps of all contracted PCPs, specialists, key ancillary services and hospitals. As a result, it was determined there were opportunities in access for PCPCs and high volume specialists which includes hematology, internal medicine and pediatric specialists.

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

- Approaching PCPs and other providers with limited or closed panels, and request that they open their panels to new members or members (or if applicable, to a relative of a member already in their panel).
- Identifying potential providers through sources such as listing from the local medical societies and provider associations, case managers, MemberConnections representatives, established community relationships, internet resources and personal recommendations from network providers in the area.
- Utilizing listings of newly-licensed providers and state reports of providers issued new NPI numbers which may include identifying providers through sources such as Kansas Board of Healing Arts and local Medical Societies.
- Identifying out of network providers utilized by Sunflower members in the past.
- Maintaining relationships with providers who have declined to join the network.
- Identifying sources of provider dissatisfaction and strengthening retention strategies.
- Sunflower may also enroll other providers, who meet the credentialing requirements, to the extent necessary to provide covered services to members through gap analysis and intervention.

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 Envolve People Care (EPC). Centene utilizes SPH Analytics formerly known as The Meyers Group (TMG), a National Committee for Quality Assurance (NCQA) Certified Survey Vendor, to conduct the provider satisfaction survey for all Centene health plans.

SPH Analytics followed a one-wave mail and internet with phone follow-up survey methodology to administer the provider satisfaction survey from September to October 2015. Sunflower's sample size was 1,500. SPH Analytics collected 377 surveys (145 mail, 58 internet, and 174 phone) from the eligible provider population. After adjusting for ineligible providers, the mail/internet survey response rate was 14.0%, and the phone survey response rate 17.0%. A

response rate is only calculated for those providers who are eligible and able to respond. The methodology demonstrating the response rates for mail, internet and phone survey responses is depicted below as well as shows how the ineligible provider responses are addressed.

Mail/Internet Component
145 (mail) + 58 (Internet) / 1,500 (sample) – 47 (ineligible) = 14.0%
Phone Component
174 (phone) / 1,139 (sample) – 116 (ineligible) = 17.0%

For the 2016 survey, Sunflower expanded those who could participate in providing feedback to include HCBS providers and nursing facilities. The 2016 survey results demonstrated the following: 46.0% of the responses were from HCBS providers, followed by 33.0% nursing facilities, 19.7% primary care providers and, 20.3% of the responses were from specialty practices. Of those who responded to the survey, 51.2% were responses from the office manager, 47.7% nurse/other staff responding, and 1.1% were physicians who responded on the survey.

Composites	2016 Summary Rate	2015 Summary Rate	2014 Summary Rate
Overall Satisfaction	58.9%	53.2%	43.8%
Comparative Rating of Sunflower compared with all other contracted health plans	32.2%	24.0%	13.9%
Finance Issues	33.8%	22.9%	18.0%
Utilization & Quality Management	26.7%	18.1%	17.9%
Network/Coordination of Care	21.6%	22.0%	18.4%
Pharmacy	14.7%	12.7%	10.2%
Health Plan Call Center Service Staff	29.7%	22.1%	21.0%
Provider Relations	36.1%	25.0%	26.5%

Sunflower has demonstrated year over year improvement for all the composite areas except for Network/Coordination of Care which demonstrated a slight decrease in 2016 compared to 2015. The Network/Coordination of Care focuses on the number and quality of specialists in the Sunflower provider network, timeliness of feedback/reports from specialists, timeliness of exchange of information/communication/reports from behavioral health providers and also how frequently behavioral health providers provide verbal/written communications to other providers on their patients. This is also an area identified for opportunity from the CAHPS survey results for Sunflower in 2016.

Continuity and Coordination of Care between Medical and Behavioral Healthcare

Sunflower's Medical Management team works in collaboration with Envolve People Care (formerly EPC Behavioral Health), Sunflower's behavioral health delegate and sister organization. Sunflower annually assesses the following areas of collaboration between medical and behavioral healthcare:

- Exchange of information between behavioral health care and primary care practitioners and other relevant medical delivery system practitioners or providers;
- Appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care;
- Appropriate use of psychotropic medications;

- Management of treatment access and follow-up for patients with coexisting medical and behavioral disorders;
- Implementation of a primary or secondary preventive behavioral health program;
- Special needs of members with severe and persistent mental illness.

The table below demonstrates how Sunflower specifically monitors these areas.

Specific Area Monitored	Description of Monitor
Exchange of Information	Rate of practitioner satisfaction with behavioral health practitioner communication as reported through the annual provider satisfaction survey.
Appropriate Diagnosis, Treatment and Referral of BH Disorders Commonly Seen in Primary Care & Appropriate Use of Psychotropic Medications	Antidepressant Medication Management (AMM) HEDIS Measure: Acute Phase & Continuation Phase.
Screening and Management of Coexisting Disorders	Number of members identified, screened and engaged in behavioral health services for perinatal depression.
Preventive Behavioral Program	Number of members identified and screened for perinatal depression.
Special Needs of Members with Serious and Persistent Mental Illness	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) HEDIS Measure.

Exchange of Information between Behavioral Health and Primary Care

Sunflower collects data and identifies opportunities to improve the exchange of information through the annual provider satisfaction survey, which includes evaluation of satisfaction with communication between behavioral health practitioners and primary care practitioners. Levels of primary care practitioner satisfaction with behavioral health practitioner communication are collected through the annual provider satisfaction survey, and shared with Envolve People Care.

Intentionally Left Blank

In the standardized survey tool administered by SPH Analytics for Sunflower's 2016 Provider Satisfaction Survey, two questions measure the timeliness and the frequency of communication from behavioral health practitioners to primary care practitioners. Responses for the specific questions are noted in the table below for 2016. The response for question 4E demonstrated an increase from 10.4% in 2015 to 17.8% for 2016. For question 4F, there was a noted increase from 33.7% in 2015 to 37.7% in 2016.

Provider Satisfaction Questions	2015 Percent Satisfied*	2016 Percent Satisfied	2016 Responses Composite/Attribute
4E: Please rate the timeliness of exchange of information/feedback /reports from the behavioral health providers?	10.4%	17.8%	Excellent – 4.1% Very Good – 13.7% Good – 49.3% Fair – 26.0% Poor – 6.8% (n=146)
4F: How often do you receive verbal and/or written communication from behavioral health providers regarding your patients?	33.7%	37.7%	Always – 8.2% Usually – 29.5% Sometimes – 20.5% Rarely – 28.8% Never – 13.0% (n=125)

** Summary Rates represent the most favorable response percentage(s).*

Sunflower was unable to compare performance on the 2016survey against a benchmark, as SPH Analytics does not provide Medicaid Book of Business benchmarks for the two relevant questions since these are custom questions. Similarly, the composite for the Network/Coordination of Care section of the survey does not include these custom questions so was not reviewed for this report. Sunflower identified these as opportunities for improvement and has demonstrated improvement from 2015 to 2016. For question 4E there was a 71.2% increase and 4F demonstrated 11.9% increase. Sunflower's goal for the 2016 provider satisfaction survey was an increase of 5%on each survey question. Sunflower achieved the goal for both of these questions. However, Sunflower will continue to work on improvement here as it is imperative to the members and their overall health.

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

Sunflower and EPC staff have identified the following barriers related to the exchange of information between medical and behavioral healthcare providers and continue to work to address these:

- Members do not have an established relationship with a PCP.
- Staff unable to identify the member's PCP, therefore cannot facilitate exchange of

information.
- Member knowledge deficit regarding importance of and process for providing consent to share treatment records that include HIV/AIDS or substance abuse treatment information.
- Physicians are unaware their patients are seeing behavioral health clinicians and/or who the behavioral health providers are.
- Physicians are unaware their patients are seeing behavioral health clinicians and/or who the behavioral health providers are.
- Behavioral health clinicians are not aware of who the member's assigned PCP is.
- Members leaving acute inpatient for psychiatric care maintain the stigma of mental illness and often do not want their other providers or support systems to know they were hospitalized for behavioral health issues.
- Members with acute psychosis are difficult to coordinate services as they are resistant to others outside of their perceived support group.
- Sunflower identified that members in Foster Care can be a challenge with moving and are working to bridge the gaps between providers including behavioral health.

Sunflower continues to work on the following opportunities were identified to address the barriers with regard to making impact on improving communication between behavioral health providers and primary care:

- Member education to help establish relationship with a PCP.
- Staff education and ongoing auditing of inpatient cases.
- Member education regarding providing consent for information to be shared to allow for communication of treatment including HIV/AIDS and substance abuse treatment for improved coordination of care
- Education of medical providers regarding a member's behavioral health providers.
- Member education regarding importance of sharing information between providers.
- Education of behavioral health providers regarding a member's PCP.
- Member education regarding importance of sharing information between providers.
- Treatment record review for all high volume behavioral health providers to identify attempts to coordinate care and provide technical assistance to providers who do not meet the standards.
- Work with members to understand that mental health also impacts all areas of their health and quality of life and encourage coordination of care with other providers.
- Minimize the number of people who are contacting the member to one case manager that will coordinate with other members of the care team.
- Educational brochure developed on Foster Care and importance of communication between providers to include behavioral health.

Appropriate Diagnosis, Treatment and Referral of Behavioral Disorders Commonly Seen in Primary Care & the Appropriate Use of Psychotropic Medications

Sunflower collects and analyzes data regarding appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care, and appropriate use of psychotropic medications through assessment of the Antidepressant Medication Management (AMM) HEDIS measure. Sunflower and Envolve People Care collaborate on this HEDIS measure as practitioners from both primary care health and behavioral health treat members with depressive disorders and prescribe antidepressant medications.

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.

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

AMM Indicator	HEDIS 2014	HEDIS 2015	HEDIS 2016	Achieved QC 50th Percentile
Effective Acute Phase Treatment	57.14% (115/203)	49.09% (834/1699)	50.06 (874/1746)	No
Effective Continuation Phase Treatment	37.44% (76/2013)	33.78% (574/1699)	34.48 (602/1746)	No

Sunflower's HEDIS 2016 (measurement year 2015) rate for the *Effective Acute Phase Treatment* measure did not meet the goal of reaching or exceeding the Quality Compass 50th percentile. However, this did demonstrate an increase of 0.97 percentage points. The *Effective Continuation Phase Treatment* rate for HEDIS 2015 also did not meet the goal to meet or exceed the Quality Compass 50th percentile but did demonstrate an increase of 0.7 percentage points. Therefore, Sunflower will continue to work to increase performance in 2017.Both AMM HEDIS 2016 rates demonstrate an increased performance rate from HEDIS 2015.

Sunflower and EPC provide Depression Disease Management (DM) to members with depression. Outreach is made to members identified with a diagnosis of depression to engage them in the DM program, and referrals are made by Sunflower staff. Adherence to treatment plans, including antidepressant medications, is a primary focus of the program. Sunflower and EPC also identified barriers and opportunities related to the appropriate diagnosis, treatment, and referral of behavioral disorders and the appropriate use of psychotropic medications, displayed in the table below.

Analysis of the data lead to the identification of the following barriers that were focused on with continued efforts:

- Member knowledge deficit regarding importance of adherence, ways to manage side effects, etc.
- The treating provider may not be aware the member is not consistently taking their

prescribed medication.
- Treating providers not familiar with the depression clinical practice guideline.
- Providers unaware of available behavioral health services such as the Depression DM program.

The opportunities identified as interventions to address the barriers are noted below and continue to be area of focus:
- Targeted outreach to members with a depression diagnosis and recently prescribed/fill of a new antidepressant prescription.
- Utilize pharmacy data to identify members who are non-adherent and distribute letter to prescribers to notify of member non-adherence.
- Article in the provider newsletter, educated providers about Sunflower's adopted clinical practice guidelines, including the depression guideline.
- Mailers sent to members starting in 2016 containing educational information on AMM measure that include common side effects, encourage compliance, keeping appointments and feelings/thoughts to share with provider.

Management of Treatment Access and Follow-up for Members with Coexisting Medical and Behavioral Disorders & Primary or Secondary Preventive Behavioral Healthcare Program

Sunflower provides a preventive behavioral health program targeting early identification of pregnant members at risk for depression as a means to assure treatment access and follow-up for these members with coexisting conditions. The program, through collaboration with EPC, allows for early co-management of cases where a member may be experiencing depression along with their pregnancy. The collaborative efforts to identify members at risk for perinatal depression involve identifying all pregnant members and those who recently delivered Start Smart member mailings, and involves screening of members to identify those at risk or with depression, Depression education materials are provided to the mothers who are expecting and those who have delivered along with an Edinburgh Depression Scale and a self-addressed envelope. Education is provided to practitioners about the program to allow for referrals. Efforts also utilize case management and disease management as opportunities to identify members early with depression.

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 and nurturing of the newborn can be optimal through the goals provided below.

- Educate members in the perinatal period about the risks of depression;
- Educate members regarding the signs and symptoms of depression;
- Educate the member about accessing services for treatment of depression;
- Educate the member's provider if the member demonstrates depression using the Edinburgh Scale; and,
- Identify members at moderate or high risk for depression and engage them in preventative care to avoid adverse outcomes.

Returned screenings/surveys are scored and assigned as high, moderate, or low risk; outreach is performed for each member regardless of their score. Results for Q3 2015 - Q2 2016 are noted below, stratified by prenatal and post-partum periods. As evidenced in the table, the response rate was 5.4% for prenatal and 2.1% for post-partum members. Of the 206 surveys returned to EPC, 54 were scored at moderate or high risk of depression.

	Number Sent	Number Returned	Response Rate	Number Low	Rate Low	Number Moderate /High	Rate Moderate /High
Prenatal	2606	141	5.4%	99	70.2%	42	18.5%
Post-Partum	3142	65	2.1%	53	81.5%	12	26.2%
Total	5748	206	3.6%	152	73.8%	54	26.2%

The EPC clinical team is notified of all moderate or high risk members within two business days of receipt of completed surveys and outreaches to these members within 24 hours. Successful outreach was completed for 83.3% (45 of 54) at-risk prenatal and post-partum members. Of those 54 members scored as moderate or high risk, 25.9% (14/54) had successful outreach and a paid claim for services. The rate for the current measurement period represents a decrease of 7.1 percentage points from the previous measurement period (67 members scored as moderate or high risk, with 33% having a successful outreach and a paid claim for services for measurement period 3Q 2014 - 2Q 2015) and did not meet Sunflower's goal of 38% (i.e. an increase of 5 percentage points from the baseline measurement period) of members identified at risk for perinatal depression engaged in behavioral health services. Sunflower's goal for the next re-measurement period (3Q 2016 - 2Q 2017) will again be to improve the rate by 5 percentage points (i.e. 30.9%/5 percentage points above the current measurement period rate of 25.9%).

The following barriers and opportunities were identified regarding management of members with coexisting medical and behavioral health disorders and the Perinatal Depression Screening Program. These continue to be encountered and efforts continue to address these.

- Members at risk for perinatal depression cannot be identified due to low response rates to survey.
- Member knowledge deficit about the Start Smart program and benefits of the program (i.e. depression screening) and availability of behavioral health services.
- Provider knowledge deficit regarding services Sunflower can provide to members with perinatal depression.
- Provider perception that depression screening is time consuming and office lacks staff to do screening.
- Member and provider knowledge deficit about the Start Smart program and benefits of the program (i.e. depression screening) and availability of behavioral health services.

The opportunities identified were as follows and continue to methods utilized to improve upon:

- Sunflower care management staff complete depression screenings in real time with members during calls.
- Member and provider education related to Start Smart program and benefits as well as availability of behavioral health services
- Provider education related to Sunflower services available to members with Perinatal Depression
- Provider education related to importance of taking the time to complete the screening

Coordinating Special Needs of Members with Serious & Persistent Mental Illness

Sunflower collects data on challenges surrounding coordination and continuity of care for members with serious and persistent mental illness through assessment of the HEDIS *Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications (SSD)* measure. The SSD measures assesses the percentage of members 18-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. Use of this measure as a monitor for coordination of care is key to ensuring members with high acuity special healthcare needs are receiving the proper monitoring and service coordination for both their behavioral and physical health conditions.

The SSD measure is a new measure for HEDIS 2015. Sunflower's HEDIS 2015 final rate serves as the baseline for this monitoring performance. For Sunflower's Health's baseline year (HEDIS 2015, Measurement Year 2014) the goal was to achieve the NCQA Quality Compass HMO Medicaid 50th percentile of 79.38%. Sunflower's final rate of 72.69% failed to meet that goal. HEDIS 2016 demonstrated improvement of 2.58 percentage points over HEDIS 2015 with a rate of 75.27%, however this rate fell short of the NCQA Quality Compass Medicaid 50th percentile, not meeting Sunflower's goal for 2016.

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Rate	Achieved Quality Compass 50th Percentile
HEDIS 2015	72.69% (953/1311)	No
HEDIS 2016	75.27% (1239/1646)	No

Barrier analysis was performed and Sunflower recognized the following barriers to coordination of care for members with special needs including those with serious and persistent mental illness:

- Knowledge deficit of members with SPMI regarding the risk of diabetes and the importance of diabetic screening
- Member confusion regarding involvement of both medical and behavioral health case managers/care coordinators
- PCPs are unaware their patients are seeing behavioral health clinicians or who the behavioral health provider is that the member is seeing.

- Members do not have an established relationship with a PCP.
- Health plan staff unable to identify the member's PCP, therefore cannot facilitate exchange of information.
- Treating providers not familiar with the depression clinical practice guideline.
- Member knowledge deficit regarding importance of adherence, ways to manage side effects, etc.

The collaborate efforts of Sunflower and EPC demonstrate efforts to overcome barriers that were initiated back into 2014 which were carried through for 2015 and new action as were added as well in 2015 based on analysis of data. Below are the actions taken with regard to overcoming and assisting members with improved health and quality of life.

- Member and provider newsletter articles about the availability of behavioral health services through EPC
- Discharge assessments faxed to member PCP to advise of inpatient behavioral health admission to ensure proper follow up appointments with appropriate clinicians
- Full integration of medical and behavioral health care management services – one primary lead care manager/care coordinator. Primary care manager addresses medical and behavioral health issues concurrently.
- EPC staff re-trained regarding discharge assessment process and how to effectively identify the member's PCP. Monthly audits by EPC QI staff continue, and include ongoing staff education regarding successful facilitation of the exchange of information.
- Enhance post-discharge outreach call script for medical inpatient admissions, to include addressing behavioral health treatment and encouraging members to share information between providers and provide consent if needed.
- Provider newsletter article regarding availability of behavioral health services and resources available through EPC/Sunflower
- Provider newsletter article regarding Sunflower's practice guidelines and how to access the guidelines.
- Implementation of pilot program with inpatient facility with Sunflower representative to provide support with communication and discharge planning to improve coordination of care with medical and behavioral health providers

UTILIZATION MANAGEMENT PROGRAM

Purpose

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

Authority

The Plan Board of Directors (BOD) has ultimate authority and accountability for the oversight of the quality of care and services provided to members. The BOD oversees development, implementation and evaluation of the Quality Improvement Program. The Plan BOD delegates the daily oversight and operating authority of the utilization management (UM) activities to the Plan's Quality Improvement Committee (QIC), which, in turn, delegates responsibility for the UM Program to the UM Committee (UMC), including the review and appropriate approval of medical necessity criteria and protocols and utilization management policies and procedures. The UMC is responsible for reviewing all utilization management issues and related information and making recommendations to the Plan's QIC, which reports to the BOD. The UM Program is reviewed and approved by the Plan's BOD on an annual basis.

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

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

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

Program Integration

The UM Program, Pharmacy and Therapeutics (P&T) Program, Quality Improvement (QI), Credentialing, and the Fraud and Abuse Programs are closely linked in function and process. The UM process utilizes quality indicators as a part of the review process and provides the results to the Plan's QI department. As case managers perform the functions of utilization management, 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.

Complex Case/Care 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. Care 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.

Members identified who will potentially benefit from care management 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. In order to optimize the outcome for all concerned, case management services are best offered in a climate that allows direct communication between the Case Manager, the member, and appropriate service personnel, while maintaining the member's privacy, confidentiality, health, and safety through advocacy and adherence to ethical, legal, accreditation, certification, and regulatory standards or guidelines.

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, and Sunflower's protocol for complex case management will remain essentially the same in 2017 as no material changes in the membership relative to product line, age/gender, language, and race and ethnicity were identified. However, there have been many changes made to the overall case management services provided by Sunflower as the health plan moves into the third year of operations. Some of the improvements include:

- Two new post-discharge nurse positions to contact all members not in case management after they have been discharged from the hospital.
- Implementation of a dedicated Transplant Case Manager (2) 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.

- Continuation of the holistic integrated care model (ICM) based on the primary pillar a one case/care manager owner model. In doing so, behavioral health was integrated into the health plan operations as opposed to a contracted service from our sister company. This resolved the silo effect with working as one team 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 continued weekly rounds on inpatient members. Sunflower also continued integration with Complex Case Management Rounds, Long Term Service and Supports (LTSS) rounds, behavioral health and physical health integrated rounds to discuss, coordinate care/services with contracting providers and vendors.
- Sunflower has a wide range of member materials, including diabetes materials that are brightly colored and easy to read.
- Sunflower continues using the Krames Patient Education materials database which contains patient education materials for thousands of diagnoses, medications, and medical procedures.

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
- Hypertension
- Heart disease

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

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

1. Envolve People Care (EPC, formerly EPC-CBH) - Sunflower's managed behavioral health care vendor. EPC provides utilization management, network development and maintenance, case management, credentialing of their network, and claims payment data.
2. Envolve Vision (formerly OptiCare) - Sunflower's vision care provider. Envolve Vision provides utilization management, network development and maintenance, credentialing of their network, and claims payment data.
3. Envolve Pharmacy (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. Envolve People Care (EPC, formerly Nurtur) - Sunflower's disease management provider. EPC provides disease management for the following programs: Asthma, Coronary Artery disease, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, Hypertension, Hyperlipidemia and Tobacco Smoking Cessation.
5. Envolve People Care (EPC, formerly NurseWise) - Sunflower's after-hours call center and nurse advice line. EPC is a bilingual care line of registered nurses which complete health screenings and after hours nurse advice.
6. 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.
7. Logisticare - Sunflower's transportation vendor.
8. Alere - Assists Sunflower in obtaining risk assessment information on pregnant members and facilitating utilization of 17P.
9. Envolve Dental (formerly Dental Health and Wellness) - They provide prior 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 Quality Improvement Director reviews the results with the Vendor Manager and the Compliance Manager to identify any necessary interventions. All potential interventions are discussed with a multi-disciplinary 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.

The following table contains the results of vendor audits conducted in 2016 and scope of the review.

Vendor and Type	Date of Audit	Areas Audited	Scored Below 90%/QIP Implemented
NIA	May 2016	UM: P&Ps & UM Program Description; denial files; appeal files	Yes
		Credentialing: P&Ps & Credentialing Program Description, credentialing/recredentialing file review	No
		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
Envolve Vision	November 2016	Claims: P&Ps; claims file review	No
		Complaints: 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
		Network Management:	Yes
		Quality Improvement: P&Ps & QI Program Description	No
		UM: P&Ps & UM Program Description; denial files	No

Vendor and Type	Date of Audit	Areas Audited	Scored Below 90%/QIP Implemented
Logisticare Transportation	October 2016	Claims:	Yes
		Compliance: P&P's; 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	No
		Safety & Security: sample provider agreement; provider materials; sample inspection form	No
		Vehicle Equipment Requirements & Maintenance: sample vehicle inspection form/report	No
Envolve Pharmacy Solutions	April 2016	Claims: P&Ps; claims file review	Yes
		Customer Service: Call Handling	Yes
		Compliance: P&Ps; Compliance Program Description; sample reports; staff interviews	No
		Credentialing: P&Ps & Credentialing Program Description, credentialing/recredentialing file review	Yes
		Member Rights & Responsibilities: applicable P&Ps	Yes
		Network Management	Yes
		Performance Standards: P&P; reports	No
		Quality Improvement: P&Ps & QI Program Description	No
		UM: P&Ps & UM Program Description; denial file review	Yes

Vendor and Type	Date of Audit	Areas Audited	Scored Below 90%/QIP Implemented
Envolve People Care (CBH)	Aug/Sept 2016	Case Management: P&Ps; file review	Yes
		Claims: P&Ps; claims file review	Yes
		Complaints: file review	Yes
		Compliance: P&Ps; Compliance Program Description; sample reports; staff interviews	Yes
		Credentialing: P&Ps & Credentialing Program Description, credentialing/recredentialing file review	Yes
		Quality Improvement: P&Ps & QI Program Description	Yes
		UM: P&Ps & UM Program Description; denial file review; appeal file review	Yes
Envolve People Care (STRS)	Aug/Sept 2016	Case Management: P&Ps; file review	No
		Claims: P&Ps; claims file review	No
		Complaints: file review	Yes
		Compliance: P&Ps; Compliance Program Description; sample reports; staff interviews	No
		Credentialing: P&Ps & Credentialing Program Description, credentialing/recredentialing file review	Yes
		Members Rights & Responsibilities: applicable P&Ps	No
		UM: P&Ps & UM Program Description; denial file review; appeal file review	Yes

Vendor and Type	Date of Audit	Areas Audited	Scored Below 90%/QIP Implemented
Envolve Dental	October 2016	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
		Customer Service Standards: P&Ps; Reports, Performance Standards; Training	No
		Member Rights & Responsibilities: applicable P&Ps	No
		Network Management:	Yes
		Quality Improvement: P&Ps & QI Program Description	No
		UM: P&Ps & UM Program Description; denial file review; appeal file review	No
Envolve People Care (Nurtur & NurseWise)	August 2016	NCQA Disease Management standards: Care Coordination, Clinical Quality, Evidence-based Programs, Patient Services, Practitioner Services & Program Operations - applicable P&Ps, sample reports, etc.	No
		Compliance: P&Ps; Compliance Program Description; training documents; sample reports	No
		URAC Core Standards: applicable P&Ps, program descriptions/work plans, meeting minutes	No
		Complaints/concerns: file review	No
		Triage calls: file review	No

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 continuation in 2016 were reviewed and continued as needed for measures requiring continued improvement.

Strengths:

- Member satisfaction results
- Continued steady improvement in HEDIS scores year over year
- Access and Accessibility
- Re-design of Care Management with integration of physical and behavioral health
- Revised UM processes, strength of new executive leadership
- Provider satisfaction survey results

Opportunities for Improvement:

- Physical and behavioral health provider integration
- Continue efforts to promote provider and specialist communication to improve coordination of care
- Provider education to increase efficiencies

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 three years of complete data, Sunflower is in a position to continue to analyze data for trends that allow identification of processes that have opportunities for improvement while assessing for statistically significant changes. The findings from the analysis completed for 2016 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 on the gains achieved in 2016, and will take the necessary steps to continue to make improvements on the areas identified as priorities for improvement in 2017 with the aim to improve the health and well-being of our membership and increase partnership approach with providers