Medicaid Quality Assessment and Performance Improvement (QAPI) Program Evaluation

January 1 - December 31, 2018

*Data as available by 3/22/2019

Introduction

The purpose of this evaluation is to provide a systematic analysis of Sunflower Health Sunflower's performance of the Quality Improvement (QI) activities and to evaluate the overall effectiveness of the Quality Assessment and Performance Improvement (QAPI) Program. The QI Department has established reporting QI activities as outlined in the QI Work Plan. This evaluation is focused on activities and interventions completed during the period of January 1 - December 31, 2018. 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'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. Sunflower, as an agent of the Kansas Department of Health and Environment (KDHE) and the Kansas Department of Aging and Disability Services (KDADS) and by collaborating 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 and improving Quality of Life;
- Improve access to necessary specialty services;
- Encourage quality, continuity, and appropriateness of medical care;
- Provide medical coverage in a cost-effective manner.

All 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 utilizing the Plan-Do-Study-Act (PDSA) method for rapid cycle process improvement to drive continuous Quality Improvement across Plan for both members and providers.

Member Demographics and Service Area

Plan began operation as a managed care health plan serving the Kansas Medicaid population on January 1, 2013. Sunflower has made efforts since that time and 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 occurred annually from 2013 through 2018. 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 sixth year of operations providing Medicaid services to members in Kansas. Annually, TANF and CHIP members consistently make up the majority of the Sunflower membership. These two groups together made up 75% of Sunflower membership in 2018. The children ages 0-10 continues to comprise the largest age group, with 44% of the membership for 2018 which is slightly higher than 2017. Those members of the ages 0-20 years make up 71% of the members served by Sunflower. Males and females remained consistent in distribution from for the last three years. Sunflower saw a small reduction in TANF while noting a similar increase in CHIP membership for 2018. Sunflower's membership by month data demonstrates there were increases in multiple products by the end of 2018. From January 2018 to December 2018, there was an increase of approximately 13% in overall Sunflower membership.

Sunflower's membership characteristics for comparative purposes for 2016, 2017 and 2018 are shown in the tables below:

Percentage of Member Population by Product

Product	% of Population for 2016	% of Population for 2017	% of Population for 2018
CHIP	10%	10%	12%
Foster Care	4%	4%	4%
IDD	3%	3%	3%
LTC Dual	4%	4%	4%
LTC Non-Dual	2%	2%	2%
SSI Dual	4%	4%	4%
SSI Non-Dual	7%	8%	8%
TANF	66%	65%	63%
Total**	100%	100%	100%

*IDD not previously broken out

**Rounding results in some totals >100%

Member Age Breakdown

Age Group	2016	2017	2018
0-10	46%	43%	44%
11-20	27%	27%	27%
21-30	7%	8%	8%
31-40	6%	6%	6%
41-50	3%	4%	4%
51-60	4%	5%	4%
61-70	3%	3%	3%
71-80	2%	2%	2%
81-90	1%	2%	1%
91+	1%	1%	1%

Gender Breakdown

Gender	2016	2017	2018
Male	46%	46%	46%
Female	54%	54%	54%

The table below depicts the membership for each product throughout 2018. 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. CHIP membership noted an increase of 17%. Foster Care, IDD and LTC non-dual membership noted small membership increases over the twelve-month period. Consistency was noted for Foster Care, IDD, LTC Dual and Non-Dual and both SSI products. LTC Dual was the only product that noted a lower membership in December compared to January.

Medicaid Member Enrollment

Product	18-Jan	18-Feb	18-Mar	18-Apr	18-May	18-Jun	18-Jul	18-Aug	18-Sep	18-Oct	18-Nov	18-Dec
CHIP	13,532	13,496	13,677	13,696	13,730	13,743	13,852	13,860	13,981	14,504	15,063	15,877
Foster Care	5,742	5,750	5,843	5,873	5,918	5,839	5,793	5,836	5,823	5,857	5,873	5,962
IDD	4,191	4,200	4,207	4,218	4,226	4,211	4,222	4,214	4,211	4,208	4,202	4,205
LTC Dual	5,847	5,822	5,807	5,761	5,725	5,717	5,670	5,675	5,723	5,628	5,585	5,622
LTC Non-Dual	2,480	2,512	2,551	2,584	2,594	2,590	2,645	2,650	2,672	2,815	2,993	2,983
SSI Dual	5,330	5,334	5,313	5,325	5,335	5,395	5,358	5,368	5,362	5,405	5,459	5,486
SSI Non-Dual	10,068	10,061	10,095	10,223	10,292	10,360	10,391	10,463	10,430	10,485	10,532	10,553
TANF	86,312	86,774	86,355	85,437	84,576	84,288	83,816	83,977	84,179	84,684	85,215	86,859
Total	133,502	133,949	133,848	133,117	132,396	132,143	131,747	132,043	132,381	133,586	134,922	137,547

Sunflower membership experienced an increase in total memberships from January of 2018 to December of 2018 as evidenced in the table provided above. 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 anticipated some member movement to be reflected in 2018 with respect to one of the other Medicaid MCOs leaving the Kansas market with a new MCO entering the market for the new contract that went into effect on 1/1/2019.

An additional look at membership data evaluated the top five diagnoses for adults and children by physical and behavioral health. For children the top physical health diagnosis was *Routine Health Exam Without Abnormal Finding*, followed by *Immunization Encounter*, *Acute Respiratory Infection*, *Bilateral Nearsightedness*, and *Acute Pharyngitis*. For adults, *Primary Essential Hypertension* was the top diagnosis. However*, Immunization Encounter* was number two, similar to child results. The third top adult diagnosis was *Long Term Concurrent Use of*

Drug Therapy followed by a more general and broad diagnosis of *Other General Symptoms and Signs*. *Gastroesophageal Reflux without Esophagitis* rounded out the top five adult diagnosis.

From a behavioral health standpoint, both the adult and child population had anxiety diagnoses for two out of both of their top five. The ADHD diagnosis, however, was in the top two diagnoses for children followed by *Oppositional Defiant Disorder*, and then two anxiety disorder diagnoses are listed. While *Anxiety Disorder Unspecified* was the top adult diagnosis for behavioral health followed by *Major Depressive Disorder*, *Nicotine Dependence Cigarettes*, and *Generalized Anxiety Disorder with Nicotine Dependence Unspecified Uncomplicated* coming in fifth. One opportunity identified is to explore the use of R6889, *Other General Symptoms and Signs,* for evaluation of trends and potential provider education. These details are provided in the tables on the following page.

2018 Top Diagnosis

Top 5 Medical Diagnosis Child (Ages 0 - 19) Range: January 1, 2018-December 31, 2018		
Diagnosis Code	**Diagnosis**	**# Unique Member**
Z00129	ENC RTN CHLD HLTH EX W/O ABNRM FIND	44,960
Z23	ENCOUNTER FOR IMMUNIZATION	40,731
J069	ACUTE UP RESPIRATORY INFECTION UNS	17,613
H5203	HYPERMETROPIA BILATERAL	15,598
J029	ACUTE PHARYNGITIS UNSPECIFIED	13,157

Top 5 Medical Diagnosis Adult (Ages 20+) Range: January 1, 2018-December 31, 2018		
Diagnosis Code	**Diagnosis**	**# Unique Member**
I10	ESSENTIAL PRIMARY HYPERTENSION	17,011
Z23	ENCOUNTER FOR IMMUNIZATION	12,164
Z79899	OTH LONG TERM CURRENT DRUG THERAPY	11,237
R6889	OTHER GENERAL SYMPTOMS AND SIGNS	9,401
K219	GERD WITHOUT ESOPHAGITIS	8,889

Top 5 Behavioral Health Diagnosis Child (Ages 0 - 19) Range: January 1, 2018-December 31, 2018		
Diagnosis Code	**Diagnosis**	**# Unique Member**
F902	ADHD COMBINED TYPE	7,151
F909	ADHD UNSPECIFIED TYPE	3,352
F913	OPPOSITIONAL DEFIANT DISORDER	3,191
F411	GENERALIZED ANXIETY DISORDER	3,165
F419	ANXIETY DISORDER UNSPECIFIED	3,037

Top 5 Behavioral Health Diagnosis Adult (Ages 20+) Range: January 1, 2018-December 31, 2018		
Diagnosis Code	**Diagnosis**	**# Unique Member**
F419	ANXIETY DISORDER UNSPECIFIED	8,990
F329	MAJ DEPRESS D/O SINGLE EPIS UNS	8,864
F17210	NICOTINE DEPEND CIGARETTES UNCOMP	8,334
F411	GENERALIZED ANXIETY DISORDER	5,674
F17200	NICOTINE DEPEND UNS UNCOMPLICATED	4,302

Languages Spoken by Sunflower Members

Sunflower assesses members' linguistic needs based on the state eligibility files, which query members on their primary language spoken. Sunflower noted an increase in those speaking *English* from 88.67% in 2017 to 94.05% in 2018. The number that *did not report a primary language* demonstrated a decrease from 7.72% for 2017 to 2.9% for 2018. Those who speak *Spanish* demonstrated a decrease from 3.12% in 2017 to 2.7% in 2018. A detailed breakdown of other less common languages is also noted in the table. Members reporting their language as *Other* was 0.12% in 2017, which dropped to zero in 2018. This information is provided in the following table.

Languages Spoken by Sunflower Medicaid Members

Language	Member Count	% of population
Sudanese	0	0%
Arabic	140	0.1%
Chinese	42	0.03%
German	8	0.005%
English	128,700	94.05%
French	25	0.01%
Guajarati	2	0.001%
Hindi	17	0.01%
Italian	1	0.001%
Korean	18	0.01%
LAO	35	0.03%
Other	0	0%
Persian	10	0.007%
Portuguese	3	0.002%
Russian	52	0.04%
Serbo-Croatian	9	0.006%
Somali	5	0.003%
Spanish	3,705	2.7%

Language	Member Count	% of population
Tagalog	5	0.004%
Thai	5	0.004%
Unknown	3,927	2.9%
Urdu	10	0.007%
Vietnamese	113	0.08%
Total	136,832	100.00%

Sunflower offers language assistance services to members who require translation services. Services are available for both telephonic and on-site interactions. Plan Care Management, Customer Service, or Provider/Practitioner staff for member interactions with both Sunflower staff and network providers can arrange these services. The following table provided represents the top languages for which members have requested translation services by unique interactions during the evaluation of 2018. Sunflower also has Spanish-speaking staff represented in Care Management, Customer Services Representatives and Quality Improvement available. The Sunflower Customer Service Supervisor and Call Quality Analyst are also Spanish speaking to ensure Spanish-speaking members are served well by the health plan. Spanish speaking is noted to be the highest utilizer followed by Nepali, Swahili, and Burmese. The table below depicts the Language Service Line Requests that occurred from January 1, 2018 through December 31, 2018.

Member Languages from Language Line Use

Language	# of Calls	% of Population
Amharic	5	0.10%
Arabic	75	1.46%
Bengali	11	0.21%
Brazilian Portuguese	4	0.08%
Burmese	117	2.28%
Cambodian	4	0.08%
Cantonese	1	0.02%
Chin	1	0.02%
Chin (Falam)	5	0.10%
Chin (Hakha)	9	0.18%
Croatian	15	0.29%
Dari (Afghanistan)	1	0.02%
Farsi	21	0.41%
Filipino	1	0.02%
French	17	0.33%
Gujarati	7	0.14%
Hindi	5	0.10%
Hmong	10	0.19%
Iraqi Arabic	1	0.02%
Italian	2	0.04%
Japanese	1	0.02%
Karen	25	0.49%
Karenni	2	0.04%

Language	# of Calls	% of Population
Kinya/Rwanda	19	0.37%
Kirundi	5	0.10%
Korean	3	0.06%
Kunama	1	0.02%
Kurdish (Sorani)	1	0.02%
Lao	6	0.12%
Mandarin	21	0.41%
Neapolitan	1	0.02%
Nepali	225	4.38%
Oromo (Ethiopia)	4	0.08%
Persian	2	0.04%
Punjabi	2	0.04%
Rohingya	1	0.02%
Russian	58	1.13%
Somali	73	1.42%
Spanish	4182	81.43%
Sudanese Arabic	1	0.02%
Swahili	119	2.32%
Swedish	1	0.02%
Tigrigna (Eritrea)	7	0.14%
Twi	1	0.02%
Urdu	5	0.10%
Vietnamese	58	1.13%

Race/Ethnicity

The tables below reflect race and ethnicity based on member responses on race and ethnicity to the 2018 CAHPS Adult and Child member satisfaction surveys. The data provided allows for comparison to the designated race/ethnicity provided on the 2017 CAHPS member satisfaction surveys as well. The Child survey noted for both 2017 and 2018 represents an aggregated report of two separate Child surveys completed for Title XIX and Title XXI. Results provided below for both the General Child Population as well as the Child with Chronic Conditions (CCC).

CAHPS Child Race and Ethnicity

Child Race / Ethnicity Category	2017 Child General Population CAHPS	2018 Child General Population CAHPS	2017 Child With Chronic Conditions CAHPS	2018 Child With Chronic Conditions CAHPS
White	77%	74%	82%	81%
Black /African American	10%	8%	14%	13%
Hispanic / Latino**	35%	40%	21%	24%
Asian	4%	4%	2%	2%
Hawaiian / Pacific Islander	1%	1%	1%	1%
American Indian / Alaskan	5%	3%	5%	4%
Other	12%	14%	9%	10%

CAHPS Adult Race and Ethnicity*

Adult Race / Ethnicity Category	2017 Adult CAHPS	2018 Adult CAHPS
White	75%	72%
Black /African American	13%	12%

Adult Race / Ethnicity Category	2017 Adult CAHPS	2018 Adult CAHPS
Hispanic / Latino**	11%	15%
Asian	2%	3%
Hawaiian / Pacific Islander	1%	1%
American Indian / Alaskan	5%	6%
Other**	7%	10%

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

Sunflower noted an increase in those responding as *Hispanic/Latino* for the General Child Population from 35% in 2017 to 40% in 2018 and for the Child with Chronic Condition also noted a slight increase with those noted to be *Hispanic/Latino* from 21% in 2017 to 24% in 2018. Both of the sample groups of respondents noted a decline in those reporting as *White*, again, in 2018, which was consistent with what results demonstrated in the 2017 results. The remainder of the race/ethnicity categories stayed relatively the same for the General Child and Child with Chronic Conditions respondents. The adult survey respondents demonstrated a small decline in both the *White* and *Black/African American* groups while the *Hispanic/Latino* respondents increased from 11% in 2017 to 15% for 2018. The *Asian*, *American Indian/Alaskan* populations saw minimal increases in 2018 over 2017. All three respondent populations noted an increase in respondents in 2018 reported as *Other* in comparison to 2017.

Overall, the results from the 2018 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 2017 to 2018, as there were no significant changes noted. The majority of Sunflower adult membership is *White* followed by *Hispanic/Latino*, which was formerly the third and then by *Black/African* respondents dropped to third highest. The child survey results demonstrated consistency in comparison to previous years. This was evidenced as the majority of respondents for Child General Population indicated their race/ethnicity as white, followed by Hispanic/Latino and then Other which was higher than Black/African American as it was previously the third highest in past years. The Child with Chronic Conditions demonstrated consistency again in 2018 compared to 2017 where White, Hispanic/Latino and then Black/African American remained as the top three respondent categories.

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 that 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.

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 Sunflower 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;
- Sunflower services will meet industry-accepted standards of performance;
- Fragmentation and/or duplications of services will be minimized through integration of quality improvement activities across Sunflower 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). Sunflower

will measure compliance with clinical practice guidelines until 90% or more of relevant network providers are consistently in compliance;
- Compliance with all applicable state/federal regulatory requirements and accreditation standards.

Objectives

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 and providers. To this end, Sunflower has established various committees, subcommittees, and ad-hoc committees to monitor and support the QAPI Program. The Board of Directors holds ultimate authority for the QAPI Program. 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 compliance with program objectives, and recommending adjustments when necessary.

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

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

The QIC is composed of Plan's CEO/President, Chief Medical Director, Associate Medical Director, and QI senior leadership, along with other Plan 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 occurred December 19, 2012, prior to implementation of KanCare, and the committee continues to meet on a quarterly basis, at a minimum. For 2018, QIC met a total of five (5) times which included the quarterly meetings and one ad hoc meeting.

Credentialing Committee
The Credentialing Committee is a standing subcommittee of the QIC and is responsible for administering the daily oversight and operating authority of the Credentialing Program. The QIC is the vehicle through which credentialing activities 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(s), Centene's Corporate Credentialing Director, network

physicians, and other Sunflower QI staff. The Credentialing Committee met twelve (12) times in 2018. 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 2018 Credentialing report for Sunflower.

Sunflower's number of practitioners in network for 2018 was 16,571 which included that which is delegated for dental and vision providers. In 2018, 1,499 Sunflower practitioners completed the re-credentialing process. Of those re-credentialed, 99.8% of those were re-credentialed successfully and timely. The number of those re-credentialed in 36-month timeframe was 3,358. It is important to note that a system limitation resulted in credentialing turnaround time only being available from April to December. That system limitation has been resolved. The credentialing details are depicted in the table that follows. Provider credentialing turnaround time averaged 8.6 days from application completion to committee, which is down from 11.3 days for 2017 as noted in the table that follows.

2018 Credentialing Statistics As of 12/31/2018	
Total number of practitioners in network (includes delegated providers)	16,571*
Initial Credentialing (excludes delegated)	
Number initial practitioners credentialed	1,217
Average Credentialing TAT from Complete Application to Committee (Days)	8.6 days**
Re-credentialing	
Number of practitioners re-credentialed	1,499
Number of practitioners re-credentialed within a 36 month timeline	3,358
% re-credentialed timely	99.8%
Terminated/Rejected/Suspended/Denied	
Number with cause	1
Number denied	1

** Includes Medicaid, Envolve Vision and Dental*
***TAT data is only for April through December*

Pharmacy and Therapeutic Committee

The Pharmacy and Therapeutics (P&T) Committee is a standing subcommittee of the QIC and is responsible for administering the routine oversight and operating authority of the Pharmacy Program. The QIC is the vehicle through which pharmacy monitoring and reporting activities are 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 Associate Medical Director, Pharmacy Director, network physicians, and other executive staff. For 2018, P&T met two (2) times.

Utilization Management Committee
Routine and consistent oversight and operating authority of utilization management activities is delegated to the Utilization Management Committee (UMC) which reports to the QIC and ultimately to the Sunflower Board of Directors. The UMC is responsible for the review and appropriate approval of medical necessity criteria, protocols, and utilization management policies and procedures. Additionally, the UMC monitors and analyzes relevant data to detect and correct patterns of potential or actual inappropriate under- or over-utilization, which may impact health care services, coordination of care, appropriate use of services and resources as well as member and practitioner satisfaction with the UM process. Examples of utilization information reported to UMC includes but is not limited to the following: under/over-utilization, notice of pregnancy, high utilizer review, ED diversion, etc. and this allows for network provider and Plan departments to provide input on interventions targeting continuous quality improvement for utilization. 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. Network physicians also participate in this committee to provide input on process, policies and data. For 2018, UM Committee met four (4) times. Typically, the UM Committee meets quarterly.

HEDIS Steering Committee
The HEDIS Steering Committee oversees 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, Medical Directors, and Senior Leadership of Medical Management, with representation from Contracting/Network Management, Member/Provider Services, and Pharmacy. The HEDIS Steering Committee meets quarterly and met four (4) times in 2018.

Grievance and Appeals Committee
The Grievance and Appeals Committee (GAC) is a subcommittee of the QIC and is responsible for tracking and analysis of member grievances and appeals including type, timeliness of resolution, performing barrier and root cause analysis, and making recommendations regarding corrective actions as indicated. The GAC is composed of Sunflower's Chief Medical Director, Medical Directors, 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 occur quarterly or more frequently as needed. The GAC met four (4) times in 2018.

Peer Review Committee
The Peer Review Committee (PRC) is an ad-hoc committee of the QIC. It is responsible for reviewing inappropriate or aberrant service by a provider including alleged quality of care concerns, adverse events, and sentinel events where initial investigation indicates a significant potential or a significant, severe adverse outcome has occurred, or other cases as deemed

appropriate by the Chief Medical Director. This committee includes participation by both network physicians and health plan medical directors. The PRC 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 2018, PRC for Physical Health met on fifteen (15) occasions to review cases and make recommendations as appropriate. For the Behavioral Health PRC, that group met five (5) in 2018.

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 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, Community Health Services, Contracting, Customer Services, Network Development, Prior Authorization, Provider Relations, Quality Improvement or other members as determined by the topic under discussion. The PIT met twelve (12) times in 2018, with several subcommittee meetings of the PIT to address items such as the CAHPS survey results and Pay for Performance (P4P) activities. The PIT typically meets monthly.

Nine (9) subcommittees report to the PIT as noted below in the descriptions for the committees as they are detailed out below.

CAHPS/Member Experience Workgroup
The focus of the CAHPS/Member Experience team serves as a work group that reviews the CAHPS or member satisfaction survey results, identify the opportunities for improvement, barriers and methods to mitigate the barriers. The goal of this committee is to continue to make strides improving the member experience as evidenced through improved survey results while utilizing PDSA. The committee will meet quarterly and more often as necessary. A Senior Quality leader or the designated Member Experience lead from the Quality team leads the committee. Members of the committee consist of representatives from Member and Provider Services, Vendor Management, Quality Improvement, Medical Management, Pharmacy, Marketing, LTSS, Network Development/Contracting and Member Connections (Community Health Services). This workgroup typically meets on a quarterly basis but may have Ad Hoc meetings as needed. In 2018, the work group met on eight (8) occasions.

Medicaid Member Advisory Committee (MAC)
The goal of the Member Advisory Committee (MAC) is to solicit member input into the Quality Improvement Program, operations, and services that are provided to members. The scope of the MAC is to act as a focus group to facilitate member and community perspective on the quality of care and services offered by Plan and to offer recommendations for improvement to member services and community engagement. MAC responsibilities may include review of member satisfaction survey results, Member Services telephone performance levels, member

education materials for relevance, understanding and ease of use, and/or other topics as defined by the Plan.

The MAC includes members, community members, parents/foster parents/guardians of children who are Plan members including those in foster care and Children with Special Healthcare Needs (CSHCN) to allow them to provide feedback to the Plan, and Plan staff, as appropriate. The Sunflower's senior leader of Member Services chairs the Committee. The MAC met four (4) times in 2018.

Sunflower Vendor Joint Operations Committees

The Vendor Joint Operations Committees (JOCs) are active sub-committees of the PIT. The JOC 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 Vendor JOCs is to provide oversight and assess the appropriateness and quality of services provided on behalf of Sunflower to members. The Vendor JOCs includes representation from each Plan functional area as well as representation from the delegated vendors. These meetings typically occur on a quarterly basis but may occur more frequently as needed.

Vendor	Number of Meetings in 2018
National Imaging Association	46
Envolve Pharmacy	32
Logisticare	50
EPC DM / NAL	28
Envolve Dental	54
USMM	3
Optum	3
LifeShare	1
Envolve Vision	53
EPC (CBH)	43
EPC (STRS)	6

Long Term Support and Services Advisory Committee

The Long Term Support and Services (LTSS) Advisory Committee is an active subcommittee of the PIT. The focus of the LTSS Provider Advisory Committee is to allow the LTSS Providers and member advocates the forum to provide feedback and suggestions to the health plan on opportunities to impact the LTSS members. This committee meets quarterly and different health plan departments present on items that impact the LTSS membership. Senior Director of Medical Management chairs the committee. This committee was implemented in 2017 and met 5 times which was comprised of the typical quarterly meetings and one ad hoc meeting secondary to legislative initiatives.

Sunflower Provider Joint Operations Committees (JOCs)

The Provider Joint Operations Committees (JOCs) are active provider committees that occur at least quarterly and report to PIT. These committees are with high volume providers whose primary function is to allow the providers to provide input on the following: Sunflower policies, clinical programs and processes; payment and UM activities; provider satisfaction and profiling activities, provide assistance to identify concerns and provide input for improvement of provider

relations and support. Additionally, from time to time, Sunflower may engage providers to provide input on implementation of new policies, processes, and tools. In 2018, there were 35 Provider Joint Operations Committee meetings held.

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

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

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 2018. 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 - 2)
- Senior Director, QI (Nurse)
- Managers, QI
    - Accreditation (Social Worker)
    - Grievances and Appeals (Nurse)
    - Performance Improvement (Nurse)
    - HEDIS (Social Worker)
- EPSDT Coordinator (Nurse)
- Grievance Coordinator (2 total)
- Accreditation Specialist
- Supervisor, Clinical Appeals (Nurse)
- Clinical Appeals Coordinator (Nurse – 3)
- QI, Project Manager (2)
- QI, Care Manager (1)
- QI, Specialist (3)
- QI, Coordinator (3, one is a Nurse, one is a Social Worker)

- Senior QI Specialist
- RA, Coding Analyst
- RA, Member Coordinator (2)
- Centene Corporate support

Quality Leadership in 2018
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 2018 in the QI Department. The turnover was attributed to two staff members who left Sunflower; three of those seized opportunities to join our corporate team. Additionally, an Accreditation Specialist was added to the team. All of these positions were filled with new team members in 2018. Additionally, three team members were promoted from within the Quality team. Two of those were promoted to Managers and one was promoted to a Supervisor. Two Risk Adjustment team members were integrated into the Operations team in 2018. Quality continues to conduct routine assessments of work volume and progress on plan priorities to allow for reallocation of staff resources to address needs encountered in work volume trends and also to address priority areas to ensure the member and provider needs are met as integral parts of the business all while driving continuous quality improvement. In December of 2018, the Chief Medical Director accepted an opportunity to serve as Chief Medical Director with a larger Centene Plan. Therefore, two Medical Directors were delegated the responsibilities of the CMD until a new CMD is appointed. In the timeframe for a new CMD to be named, Quality started reporting up to the Plan CEO and President while working in close contact with both of the Medical Directors.

In 2018, the employment positions at Sunflower have remained relatively consistent as the plan membership experienced some change nearing the end of the year given changes with MCOs in the market and the new contract. Staffing needs continue to be assessed on an ongoing basis to ensure the plan is able to accommodate member needs, contractual requirements, improve quality, and 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 2018, Sunflower underwent the BBA/state audit, and KDADS member quarterly files. Additionally, in 2018 KFMC, our EQRO, performed validation of HEDIS measures and other measures included in the state Pay for Performance along with the following surveys: CAHPS, Provider Survey, and Mental Health Survey. CAHPS surveys include both adult, Title XIX, and Title XXI surveys. Plan anticipates the start of the 2018 Performance Measure Validation in June of 2019. Plan complied with record requests for quarterly Home and Community Based Services (HCBS) documentation audit requests; Sunflower is awaiting the final results of HCBS audits from the state.

QAPI Program Effectiveness
Throughout 2018, the QI Department continued its collaboration with all organizational departments to facilitate continuous improvement in performance by empowering all

stakeholders through education, communication, utilizing the PDSA methodology with regard to data analysis, interventions and outcomes. Sunflower has continued to improve the quality of care and services provided to the membership through continuous assessment of patterns, trends, identification of barriers to desired outcomes and then adjusting to better meet the needs of those served and through the implementation of innovation and feedback.

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

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

The 2018 QI Work Plan defines the activities, the person(s) responsible for the activity, the date of expected task completion and the monitoring techniques that 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. Additionally, the work plan is presented to the Board of Directors at least annually but more often as needed. The 2019 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.

2018 Quality Improvement Strengths and Accomplishments:

- Quality Improvement leadership expanded to include four nurses and two social workers with Quality Improvement experience
- Quality Improvement reports up to the Chief Medical Director, who is directly involved in Quality initiatives as the SEQI
- Continued 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 continues to evaluate revised and functional support activities.
- Network providers actively participating in various Quality committees to provide input and feedback to drive continuous Quality Improvement across the organization
- Quality improvement initiatives and focus studies identified, using data trends starting to take more shape with plan experience

- 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. Continued development of comprehensive plans for future improvement opportunities using multidisciplinary team approach.
- Continued use of skill and experience in HEDIS operations to allow for the plan to increase year round abstractions/over-reads and also over-reads during hybrid season,
- Continued efforts in place for optimization of data captured through state immunization registry, member outreach to optimize collection of supplemental data, including records from in-home assessments and other opportunities for potential impact on HEDIS measures for MY2018.
- Increased supplemental records that were abstracted and over-read for HEDIS
- Utilized PDSA to improve process for documenting and reporting successful warm call outreaches on HPV PIP to reduce reporting errors and increase use of automation
- Continued evaluation and updates to systems to incorporate state reporting criteria to reduce reporting errors and automate some reporting functions.
- Increased medical records provided to the health plan related to Provider Profiles sent out to engage providers on closing care gaps.
- Ongoing evaluation, modification, and update of templates for trending of Grievances, Appeals, and Quality of Care issues data for more in depth analysis and display for team members and Committee, allowing improvement opportunities to be more easily identified.
- Ongoing efforts to review all Sunflower and vendor grievance and appeals documentation, revising and creating more consistency to reduce member confusion.
- Added an auditor to the Quality Improvement team to focus on contractual requirements for UM, appeals and grievances to include notices, manuals and process compliance.
- Continued collaboration with vendors to look through opportunities to improve efficiencies and satisfaction through education of providers, health plan staff and members
- Continued development and use of reports for monitoring and identification of 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 Adverse Incident Reporting System (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.
- PDSA process on SFH documents utilizing SharePoint as a means to share materials internally with witnesses in preparation for the hearing to increase efficiencies through avoiding delays with large attachments
- Continued partnership with Sunflower Data Analytics team to improve data integrity, revise provider profiles and accuracy related to member outcomes, strategic initiatives and to meet state reporting requirements.

- Implemented revisions to the Grievance Appeals Report (GAR) through collaboration with the Data Analytics team
- Implemented Contract Amendment 33 on 4/1/18 related to appeals, grievances and State Fair Hearings, which included health plan trainings to increase knowledge and understanding of requirements through collaboration with UM, QI, Vendor Management and Claims. Sunflower completed eight (8) trainings in 2018 on Appeals and Grievances.
- Medicaid Member grievance resolution TAT for 2018 was 98.9%, while acknowledgment was at 99.1%
- Medicaid Member standard appeal resolution TAT for 2018 was 99.4% and acknowledgment was at 96.5%
- Care Management worked with 15,486 members in 2018 for Medicaid.
- Envolve People Care Nurse Advice Line handled 1,617 total calls in 2018.
- Participated in approximately 196 member outreach health fairs/community events.
- Participated in approximately 123 provider conferences and seminars, presenting and providing information or as a conference participant.
- Envolve People Care's Disease Management demonstrated a monthly average for active health coaching is 941 members, and for Education is 2,309 for 2018.
- The Medicaid call center in Lenexa answered 154,844 calls, had an average speed of answer of 19 seconds, with a service level of 87.92% and an abandonment rate of 1.81%.
- 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 2,977 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 record request burden for providers, which included use of records received via the secure Provider Portal, in-home vendor assessments and utilization of KHIN.
- Continued utilization of WebIZ, state immunization registry to improve capture of immunization data for HEDIS Childhood and Adolescent Immunizations.
- Provided $1.95M in value added services to our membership and approximately $602,276 for in-lieu of services.
- For 2018, achieved an overall claims payment average TAT of 9.94 days on over 324,000 claims a month (excluding pharmacy claims).
- Continued to collaborate 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.
- Continued utilization of Provider Profiles/scorecards for monitoring of health plan rating scores and P4P that incorporate both CAHPS and HEDIS data as appropriate, allowing for current year trends to previous year and gap to meet thresholds and rating score.
    - Provider profiles sent for nine Medicaid HEDIS measures
- Added Provider Profile Reminders as an 'end of year push' initiative focusing on six measures for Medicaid
- Continued and expanded Pay for Performance arrangements with providers to impact preventive and disease management of members including partnerships with CMHCs, primary care providers, pediatricians, and OB/GYN providers; positive feedback included that the Primary Care/Pediatric and OB/GYN models were noted to be "User Friendly"
- Pediatric PCP Provider P4P programs revealed:

  - Childhood Immunizations Combo 10 – 2 out of 4 providers met/exceeded the 75th Quality Compass Percentile
  - Immunizations for Adolescents Combo 2- 3 out of 4 providers met/exceeded the 75th Quality Compass Percentile
  - Medication Management for members with asthma 75% of treatment period for 5-11 year olds – 2 out of 4 met/exceeded the NCQA 75th percentile, one met the NCQA 50th percentile.
  - Medication Management for members with asthma 75% of treatment period for 12-18 year olds – 3 out of 4 met or exceeded the NCQA 75th percentile, 1 met/exceeded the Quality Compass 50th percentile.
  - Of PCP providers on P4P, eight of 15 met/exceeded the Quality Compass 75th percentile on Immunizations for Adolescents Combo 2.
- Continued partnership with Quest/ExamOne to help close care gaps with in home visit option for Hemoglobin A1c testing, Monitoring for Nephropathy, BMI measurements and Blood Pressure measurements.
- Implemented mail-in test kits for Hemoglobin A1c testing demonstrating a 23% return rate in pilot for 2018 with Lab2U
- Medicaid Switched from CRM to PRIME for non-vendor Clinical Appeals, Grievances and SFH. PRIME data is stored in EDW (Enterprise Data Warehouse) and allows greater access to member demographics data for deeper analysis over CRM.
- Implemented and automated GAC based reporting including UM denial and AIRS (Adverse Incident Reporting).
- Incorporated member region specific data and implement member LOC data into internal weekly Grievance and Appeals reporting.
- Reporting Case Management HEDIS notes data from our TruCare system for any notes regarding medical records.
- AMM Antidepressant monthly mailing list for monthly letter campaign.
- HEDIS A1c outreach campaign with Case Management without continuous enrollment requirements for all business lines to identify members early for opportunity to engage to close care gaps.

2018 Quality Improvement Opportunities:

- HEDIS rates continue to be an area of focus through member outreach, education and collaboration with various partners including providers, health departments, schools and organizations; Plan continues to explore and evaluate resources and opportunities for education and incentives to improve rates with goal to meet or exceed the 75th Quality Compass Percentile.
- Implement text messaging technology to engage members and assist in care gap closure
- Sunflower continues to work on P4P interventions for 2019.
- Continuously evaluating data and exploring new interventions to continuously improve Member and Provider satisfaction with Plan services, care and operations based on survey results and other avenues of feedback including both member and provider appeals and grievances.
- Continued efforts to develop and expand trending reports for data analysis and focused intervention to be used as a part of PDSA within all health plan departments.
- Continued HPV PIP efforts to strive for improvement in the HPV vaccination compliance for adolescents

- Interventions continue to increase Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications
- Implement additional outreach to internal and external partners to share results of quality improvement activities and open doors for feedback.
- Continue to work with the other Kansas Medicaid MCOs on issues to improve care to Medicaid beneficiaries as necessary.
- Continue efforts to improve processes, provide education and work to improve appeals and grievances for both members and providers which will also impact satisfaction for both
- Continue to explore opportunities to expand P4P partnerships with network providers to improve the quality of care members receive including innovation;

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 a contractual requirement that one of those is related to behavioral health. Sunflower's PIPs for 2018 were continued from 2017 and were related to HPV Vaccination Rates for Adolescent and the newly initiated PIP focusing on Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD).

Human Papilloma Virus (HPV) Vaccination

Because of the state requirement for collaborative performance improvement projects, Sunflower worked in collaboration with the other two MCOs to focus on a PIP to increase 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 turned 13 years of age during 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. This left one quarter in 2015 to implement and focus interventions on this PIP. Member and provider facing interventions were part of the PIP design.

Each of the MCOs had proposed a separate goal for 2015 performance that was based on their HEDIS 2015 final rate for the measure. Upon evaluation by the State and EQRO, this was not utilized as the baseline year performance since the project began in late 2015. HEDIS 2017(MY2016) was identified as the baseline. Those final rates are depicted in the table below. Combined rate for males and females was 19.23%. Based on this performance, the MY2017 goal for Sunflower's combined rate is 20.19%, which would demonstrate a 5% increase from the previous years' performance. The HEDIS Technical Specifications changed in 2016 to include males. During 2017, the HEDIS Technical Specifications were updated again requiring two doses versus three in specific circumstances to offer protection against HPV. However, for measurement year 2016, performance will be measured on females only. HEDIS 2017(MY2016) provided the baseline for combined males/females and males rates.

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. A three-month phone outreach campaign to the guardians of

members was implemented to promote the vaccine, educate guardians on the importance of the vaccine, assist in scheduling appointments, and arranging transportation for appointments as needed. Sunflower offered one provider educational opportunity on October 17, 2018. This CME event included a partnership with the American Cancer Society and Kansas University School of Medicine. Additionally, Sunflower continued to collaborate with health departments to engage members and promote the vaccine. Member lists of those identified as non-compliant in completing the HPV series were provided to the health departments. The health departments made outreach attempts to members and scheduled appointments as appropriate. Sunflower collaborated with the one local health department and a middle school to promote and offer the vaccine during the school day to members who attend that school. Gap in care information is on Sunflower's provider portal. Providers are able to go into the portal and access a list of their members who have an HPV vaccination gap in care. Although the HPV rate is not yet final for MY2018, the preliminary rate shows improvement. MCOs continue to explore ways to increase collaboration with more provider types beyond Primary Care to explore and continue efforts to address missed opportunities.

The following table provided demonstrates the year over year results on final HEDIS rates as well as the HEDIS administrative rates for HEDIS 2019 since the final results are not yet available.

HEDIS Measure	HEDIS 2017 (MY2016) Hybrid	HEDIS 2018 (MY2017) Hybrid	HEDIS 2019 (MY2018) Admin*	Met/Exceeded NCQA MY2017 Quality Compass 50th Percentile
Meningococcal	66.59	74.21	73.17	No
Tdap	82.69	84.91	82.43	No
HPV (male and female)	19.23	31.14	32.5	No

*Awaiting final HEDIS 2019 rates

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications

In 2017, Sunflower began a new Performance Improvement Project (PIP) for Medicaid members in the state of Kansas. This PIP continued in 2018 and was designed around the HEDIS measure Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD). The PIP focuses on the relationship between use of antipsychotic medications within the defined population and the possible risk of developing diabetes as a result. The main focus was to encourage members 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication to complete annual diabetic screening through glucose or HbA1c testing. The goal is for earlier identification and treatment of diabetes.

Interventions implemented:

1. Referred non-compliant members to the CM team for education and support in completing their screening.
2. Mailed letters to members to educate them on the importance of screening and to offer support as needed.
3. Sunflower engaged Community Mental Health Centers (CMHC) providers in a pay for performance program related to appropriate diabetes screening of members at risk. In addition, Community Mental Health Centers (CMHC) were provided a monthly data set

of attributed members who fell within the PIP. This data set informed CMHCs of each member's compliance status with the screening. CMHCs were asked to support members in completing the screening.

4. Internal trainings among behavioral health and physical health staff are provided annually. The training discussed diabetes, antipsychotic medications, and the importance of annual screenings.

The performance goal for MY2017 (79.91%) was a 5% improvement over the MY2016 rate. This goal was exceeded in MY2017. Again, a goal of 5% improvement was set for MY2018 performance. The MY2018 PIP performance will be measured when the final HEDIS rates are reported.

HEDIS Measure*	HEDIS 2017 (MY2016) Admin	HEDIS 2018 (MY2017) Admin	HEDIS 2019 (MY2018) Admin*	Met/Exceeded NCQA MY2017 Quality Compass 50th Percentile
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications	76.1	80.66	76.38	No

*Awaiting final HEDIS 2019 rates

NCQA Accreditation

Sunflower received an initial upgraded commendable accreditation status from the National Committee for Quality Assurance (NCQA) effective August 31, 2016. Plan achieved commendable status again on August 31, 2017 following completion of the most recent NCQA survey onsite on April 18, 2017. Plan maintained commendable status effective August 31, 2018, following completion of annual HEDIS/CAHPS scoring.

The results from the 2017 renewal survey revealed the following overall strengths:

- Knowledgeable and committed staff
- Very strong survey documentation and preparation
- Good use of NCQA Accredited and Certified organizations
- Effective Corporate support
- Breadth of member programming

NCQA's 2017 Accreditation renewal noted the following QI strengths, specifically:

- Strong and well developed QI program that demonstrates plan continuous improvement
- Excellent Complex Case Management system and well-documented and complete files
- File review results 8/8
- Comprehensive care coordination between medical to medical and medical to behavioral health

Strengths were also noted for other areas of the organization include Network, Utilization Management, Credentialing, Member Rights & Responsibilities, and Member Connection. Network was noted to have a strong process for monitoring and improvement of network adequacy. Utilization Management was noted to have done well on file reviews for Medical, Pharmacy, and Appeal file reviews with 8/8 or 100% performance. It was also noted that the denial notification letters were well designed and thorough. Credentialing was recognized for having well organized and documented files for credentialing and re-credentialing of providers. They were also noted for strong delegate oversight and very knowledgeable credentialing staff

with 8/8 on file reviews as well. Sunflower's member materials were noted to be compliant and easy for members to use.

Sunflower continues to work on noted opportunities identified by NCQA during the 2017 Accreditation Renewal. Those opportunities for improvement revolved around physician information transparency, hospital directory data on the organization's web page, and hospital information transparency. Sunflower continues to work with corporate resources to improve performance in these domains.

Sunflower strives for continuous readiness, which involves ongoing review of 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 2018 readiness reviews/audits, and ongoing health plan NCQA education, and reminders continued. Sunflower continues preparing for LTSS Distinction and confirming Behavior Health integration, which took place late 2017. Sunflower has a lead for NCQA accreditation efforts to ensure the plan has a focus on continued readiness. Sunflower also works very closely with corporate resources to maintain NCQA compliance. Sunflower will undergo NCQA Accreditation renewal in beginning of 2020.

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 Sunflower'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. Sunflower continues to submit HEDIS data annually in accordance with the performance measure technical specifications. Sunflower also continued to design and implement key interventions to increase the Sunflower'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. Focus is placed on 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 continued to track progress on these measures on a monthly basis throughout 2018 while actively working interventions throughout 2018. 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 2019 results are available, which will likely be in July of 2019. The 2018 HEDIS work-plan focused on the NCQA and state recognized P4P measures. Sunflower's performance

on HEDIS measures in MY2017 contributed to the achievement of remaining at 'Commendable' status by NCQA.

Childhood Immunizations

Much of Sunflower'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
- Implemented warm phone calls to parents/guardians of the children and adolescents with care gap needs for immunizations and well exams
- 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
- Proactive Outreach Management (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
- 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
- Well child provider profile based first of provider attribution then assignment to augment immunizations by children getting necessary well child visits
- Provider EPSDT Reference Kit developed and distributed to high volume providers
- Obtaining WebIZ Immunization Registry data, Web-IZ data pulls for CIS were completed in January, February, May, July, August, September, October, November and December.
- Engaged network physicians in Pay for Performance program rewarding providers for ensuring members complete required infant and adolescent immunization.

For 2018, the P4P measure tied to Childhood Immunization focused in on Comb 10, which is compliance for all 10 of the vaccinations. The final HEDIS rate for CIS, Combo 10 for HEDIS 2018 (MY2017) was 38.44% and the administrative rate for Sunflower is 31.92% pending the final HEDIS 2019 results anticipated in July of 2019.

The table provided on the following page demonstrates results related to HEDIS measures on Childhood Immunizations. Combo 10 evaluates compliance with completion of all 10 of the immunizations, which is a Sunflower Pay for Performance measure. It is important to note that the final HEDIS 2019 rate is not available at the time of this report, therefore an administrative rate is provided.

HEDIS MEASURE*	HEDIS 2017 (MY2016) Hybrid	HEDIS 2018 (MY2017) Hybrid	HEDIS 2019 (MY2018) Admin Rate*	Met/Exceeded NCQA 2017 Quality Compass 50th Percentile
DTaP Immunizations	77.40	79.08	71.63	Yes
H Influenza Type B Immunizations	87.98	87.10	83.13	No
Hepatitis A Immunizations	87.74	88.56	85.62	Yes
Hepatitis B Immunizations	91.35	93.19	86.66	Yes
Influenza Immunizations	40.38	47.69	43.03	Yes
Measles, Mumps and Rubella Immunizations	88.94	88.81	86.29	No
IPV Immunizations	89.90	89.54	86.56	No
Pneumococcal Conjugate	79.57	80.20	73.41	Yes
Rotavirus Immunizations	72.12	73.97	68.45	Yes
Chicken Pox (VZV)	87.98	88.56	85.95	No
Combo 10	31.01	38.44	31.92	Yes

***Awaiting HEDIS2019 Final Hybrid Rates*

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

Adolescent Immunizations

Immunizations for Adolescents continues to be a priority for Sunflower Health Plan. This measure continued as one of our Pay for Performance measures for the State of Kansas in for 2018 with the focus being on Combo 2, which is the demonstration of completion of the Tdap, Meningococcal and HPV vaccination series. The HPV immunization exceeded the 50th percentile, however, Tdap and Meningococcal did not exceed the 50th percentile. Sunflower continued with direct outreach to members and/or their parents.

Immunizations for Adolescents Interventions for 2018 were:

- A CentAccount reward of $15 for adolescent members who complete the HPV series prior to their 13th birthday.
- Provider Care Gaps shared on members who were non-compliant for immunizations.
- Implemented warm phone calls to parents/guardians of adolescents needing immunization by QI staff
- 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.
- 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 was updated and available to providers via Sunflower Health Plan Website.
- Obtaining KDHE Immunization Registry data. Web-IZ data pulls completed for IMA in January, February, May, July, August, September, October, November, and December.
- In June, letters were sent to non-compliant members alerting them to nearby clinics that would administer immunizations via walk-in or providers in their area who provide these.
- Telephonic outreach to non-compliant members were made by Sunflower Health Plan, Johnson and Sedgwick County Health Departments, First Care Clinic, and Grace Med in April, August, October, and November encouraging members to obtain immunizations.
- Engaged network physicians in Pay for Performance program rewarding providers for ensuring members complete required infant and adolescent immunization.
- Partnered with a local health department and middle school for immunization clinic during school

The following table depicts the previous final rates for HEDIS 2018 and the administrative rate for HEDIS 2019 for the Adolescent Immunizations individually and then also by the Combo 2 which assesses compliance with completion of all three of the Adolescent Vaccinations per HEDIS technical specifications. Final rates for HEDIS 2019 are not yet available. The notable increase in HPV vaccinations is anticipated to be secondary to the changes with the HEDIS technical specifications that require 2 doses instead of 3 in specific circumstances to consistent with dosing recommendations.

HEDIS MEASURE*	HEDIS 2017 (MY2016) Hybrid	HEDIS 2018 (MY2017) Hybrid	HEDIS 2019 (MY2018) Admin.*	Met/Exceeded NCQA 2017 Quality Compass 50th Percentile
Meningococcal	66.59	73.33	73.17	No
Tdap	82.69	83.84	82.43	No
HPV	19.23	32.20	32.50	Yes
Combo 2	17.79	30.61	30.74	Yes

**Awaiting HEDIS 2019 Final Hybrid Rates*

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

Comprehensive Diabetes Care

Sunflower continued to work on this HEDIS measure and its sub measures in 2018 to help members garner a better understanding of Diabetes, importance of routine monitoring, proper diet, and exercise all aimed at helping to improve their management of diabetes and potentially lessen or avoid complications that result from Diabetes. These efforts included continued partnership with Envolve Vision Care for the Eye Exam sub measure. Sunflower continued the venture, as was established in fourth quarter of 2015, with Quest/ExamOne in 2018. 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 172 members referred to Quest/ExamOne for in-home visits. Out of those contacted 66 in-home visits were completed and resulted in success rate of 38%. Plan also proceeded with follow up of the members who were not interested in the in-home visits by the Medical Management team to help members find a provider, make appointments, arrange transportation, educate the members on the importance to have these tests done annually, and even referred members as appropriate for the Disease Management services available to them via Nurtur.

The P4P measure on CDC was changed to Hemoglobin A1c Control of <8%. However, due to the significance of overall diabetic care reflected in the other sub-measures, Plan continued focus interventions on all of these and not limit efforts to the just the P4P measure.

Interventions for Comprehensive Diabetes Care:

- Envolve Vision's HEDIS Outreach - Diabetic Retinopathy Exam sub-measure; monthly progress reports starting in July of 2016 and continued through 2018
- 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
- Revised the provider profiling report based first on attribution then assignment were distributed to providers of non-compliant members
- 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 on eye exams, diabetes education and disease management
- Continued partnerships with FQHCs to close member care gaps
- Engaged network physicians in Pay for Performance program rewarding providers for ensuring diabetic members complete recommended screening with Hemoglobin A1c.

For HEDIS 2018, all the sub measures demonstrated improvement. Hemoglobin A1c control <8% saw an increase of 3.25% from the previous year while the poor control sub measure noted a reduction of 5.64%. The following table provided demonstrates results related to Comprehensive Diabetes Care HEDIS measure. It is important to note that the final HEDIS 2019 rate is not available at the time of this report. Those results are expected in July of 2019.

HEDIS MEASURE*	HEDIS 2017 (MY2016) Hybrid	HEDIS 2018 (MY2017) Hybrid	HEDIS 2019 (MY2018) Admin*	Met/Exceeded NCQA 2017 Quality Compass 50th Percentile
Comprehensive Diabetes Care - Blood Pressure Control	54.88	59.12	2.35	No
Comprehensive Diabetes Care - Eye Care	70.70	64.79	61.89	Yes
Comprehensive Diabetes Care - HbA1c Testing	87.44	85.64	77.79	No
Comprehensive Diabetes Care - HbA1c Adequate Control (<8%)	53.26	54.99	6.35	Yes
Comprehensive Diabetes Care - HbA1c Poor Control	40.23	37.96	92.30	Yes
Comprehensive Diabetes Care - Monitoring for Nephropathy	87.91	88.56	80.22	No

**Awaiting HEDIS 2019 Final Hybrid Rates*

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

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 2018. Based on administrative data, Sunflower demonstrated a 62.40 from administrative data. Therefore, it is anticipated that Sunflower will achieve the 75th percentile on Quality Compass for measurement year 2018.

Annual Dental Visit Interventions for 2018 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.
- Grace Med and Health Partnership Clinic outreached to 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.
- In June, POM calls went to 12,998 members who had not received a dental visit since 1/1/2017.

The following table depicts the HEDIS measure final results for ADV for HEDIS 2018 and the administrative data on this measure for HEDIS 2019 since the final results are not yet available.

HEDIS MEASURE*	HEDIS 2017 (MY2016) Hybrid	HEDIS 2018 (MY2017) Hybrid	HEDIS 2019 (MY2018) Admin.*	Met/Exceeded NCQA 2017 Quality Compass 50th Percentile
Annual Dental Visit	63.49	65.15	62.40	YES

**Awaiting final HEDIS 2019 rates*

With continued year over year improvement, Sunflower continues to analyze data for opportunities for improvement on ADV. Member knowledge and understanding continues to be barriers that Sunflower focuses efforts on to ensure members know the recommendations and the services available to promote the annual dental visits for overall health promotion. Therefore, Sunflower will continue to utilize interventions from 2018 while also exploring opportunities to expand for demonstrating continued improvement.

Timeliness of Prenatal Care

Timeliness of Prenatal Care continued as a Pay for Performance measure for Sunflower in 2018. Based on hybrid data, Sunflower did not achieve the 50th Percentile on Quality Compass for measurement year 2018but, has continued efforts to improve on this measure for the well-being of the expectant mothers and their babies. Plan 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. Those members made retro eligible after their first trimester had elapsed likely complicated this. However, Plan continues efforts to improve the compliance with the Timeliness to Prenatal Care measure.

Timeliness of Prenatal Care Interventions for 2018 as listed below:

- Implemented a Provider Pay for Performance arrangement with select providers based on completion of the Notice of Pregnancy and timely first prenatal visit being completed
- Cent Account rewards are given to members who receive three, six, and 9-month prenatal visits. Members receive $15 per visit and 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.
- Daily PLE Report utilized by Quality Improvement Representatives to conduct outreach to newly pregnant members to assist with completion of the Notice of Pregnancy, establishing care, providing resources, assisting with appointments, transportation and information.
- 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.
- Pregnant members who are interested are enrolled in Start Smart for your Baby, Centene's healthy pregnancy and family program.

The following table depicts data for Timeliness of Prenatal Care for final rates for HEDIS 2017 and 2018, but the administrative rate for HEDIS 2019 since the final rates are not yet complete and available for HEDIS 2019.

HEDIS MEASURE*	HEDIS 2017 (MY2016) Hybrid	HEDIS 2018 (MY2017) Hybrid	HEDIS 2019 (MY2018) Admin	Met/Exceeded NCQA 2017 Quality Compass 50th Percentile
Timeliness of Prenatal Care	70.29	67.64	29.06	No

**Awaiting final HEDIS 2019 rates*

Sunflower continues to explore opportunities for improvement to impact the Timeliness of Prenatal Care, which includes addressing barriers like member knowledge deficits, provider opportunities and transportation issues. Plan will continue to monitor the impact of the Prenatal Care Provider Payment Incentive arrangement, for impact on completion of the Notice of Pregnancy and timely completion of the first prenatal visit. This intervention was new in 2017 and continued in 2018. In addition, Sunflower will continue to utilize a variety of interventions in 2019 with the goal of furthering timeliness completion of the first prenatal visits. Additionally, Sunflower is working to implement text messaging as another option to engage members to close care gaps and prenatal care is a measure that is planned for this intervention in 2019.

Sunflower focused on in 2018 four additional HEDIS measures. These measures were Breast Cancer Screenings, Cervical Cancer Screening, Statin Therapy for Patients with Cardiovascular Disease, and Statin Therapy for Patients with Diabetes, for the entire population served. Cervical Cancer Screening is also a state P4P measure. Those measures and their interventions are noted on the following page.

Breast Cancer Screening (BCS) Interventions:

- Mailer to female members
- Provider Profile mailer
- Member education
- Customer Service and Medical Management reminders during member contacts to help close care gaps
- Medical Management outreach to gather information and records to support members who are compliant on this measure utilized then for supplemental data purposes

Cervical Cancer Screening (CCS) Interventions:

- Mailer to female members
- Care Gap Reports available on Provider Portal
- Member education
- Customer Service and Medical Management reminders during member contacts to help close care gaps
- Medical Management outreach to gather information and records to support members who are compliant on this measure utilized then for supplemental data purposes

Statin Therapy for Patients with Cardiovascular Disease (SPC) Interventions:

- Provider Profile Mailer
- Pharmacy outreach to educate members and providers on the importance of taking and prescribing the Statins.

Statin Therapy for Patients with Diabetes (SPD) Interventions:

- Provider Profile Mailer
- Pharmacy outreach to educate members and providers on the importance of taking and prescribing the Statins.

Based on Provider feedback from the two provider profiles sent on Statin Therapy for Patients with Cardiovascular Disease and also those with Diabetes, it was determined that the cover letter that goes with the profiles needed revision to indicate that medical records are not necessary to send to demonstrate compliance. Instead, it was noted that this letter should reflect that this profile is based off claims data from when the medication is filled at the pharmacy so the member is not compliant with this medication, which is important as an evidence based practice for those with cardiovascular disease and diabetes. This is evidence of utilizing the PDSA method and tweaking based on the analysis after initiating a new or modifying an existing process on a smaller scale.

The table below depicts final HEDIS rates for HEDIS 2017 and HEDIS 2018 along with the administrative rate for HEDIS 2019 for Breast Cancer Screening, Cervical Cancer Screening, Statin Therapy for Patients with Cardiovascular Disease, and Statin Therapy for Patients with Diabetes. The final HEDIS 2019 rates will be available in June of 2019. While Plan did not achieve the 50th percentile, year over year improvement is noted from 2017 to 2018. Cervical Cancer Screening demonstrated a 14.34% improvement, while Breast Cancer Screening had a 2.61% improvement. Plan continues efforts to improve on both of these measures for the members served.

The following table provided demonstrates the year over year final HEDIS results on these two measures as well as the administrative data for HEDIS 2019. Those final results are anticipated in June of 2019.

HEDIS MEASURE*	HEDIS 2017 (MY2016) Final	HEDIS 2018 (MY2017) Final	HEDIS 2019 (MY2018) Admin Rate*	Met/Exceeded NCQA 2017 Quality Compass 50th Percentile
Cervical Cancer Screening	49.15	56.20	50.74	No
Breast Cancer Screening	47.84	49.09	49.31	No
Statin Therapy for Patients with Cardiovascular Disease- Total Statin Therapy	N/A	42.26	43.85	No
Statin Therapy for Patients with Cardiovascular Disease- Total Adherence	N/A	56.95	55.05	No
Statin Therapy for Patients with Diabetes- Received Statin Therapy	N/A	35.48	35.28	No
Statin Therapy for Patients with Diabetes- Statin Adherence	N/A	58.53	57.07	No

**Awaiting final HEDIS 2019 rates*

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

Behavioral Health HEDIS Measures

The behavioral health measures that were the Sunflower's focus for 2018 were Follow-Up after Hospitalization for Mental Health, Initiation and Engagement of AOD Treatment and Diabetic Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications.

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
- Education to the CMHCs as to the importance of this indicator while elevating awareness of the need to collaborate with the health Sunflower's CM to ensure follow-up appointments are scheduled
- Staff training on measure
- BH HEDIS Coordinator to manage clinical team interventions and track progress
- Engaged Community Mental Health Center (CMHC) provider in Pay for Performance program rewarding providers for ensuring members complete appropriate follow up after hospitalization for mental health.

The Initiation and Engagement of Alcohol and Other Drug Dependence Treatment measures had a Performance Improvement Project by SHP that ended in 2016. Sunflower followed the HEDIS technical specifications on this measure in 2018 after the PIP ended and continued interventions.

Interventions for Initiation and Engagement of AOD Treatment:

- Referral of pregnant/using members going into residential treatment
- 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

Interventions for Diabetic Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication:

- Outreach and engagement of non-compliant members into Care Management to complete the recommended screening and treatment as needed
- Member mailer to educate and encourage glucose or HbA1c screening
- Provide CMHCs with monthly reports to include a list of their members and the compliance status of diabetic screening

- Internal staff trainings on diabetes and use of antipsychotic medications Engaged
- Community Mental Health Center (CMHC) provider in Pay for Performance program rewarding providers for ensuring members complete recommended diabetes screening test.

The following table demonstrates results for the HEDIS measures. It is important to note that the final HEDIS 2019 rates are not available at the time of this report, therefore the most current administrative rate is provided.

HEDIS MEASURE*	HEDIS 2017 (MY2016) Final Admin.	HEDIS 2018 (MY2017) Final Admin.	HEDIS 2019 (MY2018) Admin. *	Met/Exceeded NCQA 2017 Quality Compass 50th Percentile
Follow-up after Hospitalization for Mental Illness - 7 day	68.62	59.72	54.11	Yes
Follow-up after Hospitalization for Mental Illness - 30 day	81.04	77.40	71.43	Yes
Initiation and Engagement of AOD Treatment: Initiation	39.13	34.60	37.57	No
Initiation and Engagement of AOD Treatment: Engagement	13.69	9.87	11.23	No
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications	76.10	80.66	76.99	No

** Awaiting final HEDIS 2019 rates*

Sunflower plans to continue interventions from 2018 in 2019, while also utilizing feedback to determine opportunities and barriers to be addressed. Member education is key and continues to be a barrier to focus on. Member compliance with these HEDIS measures relies on member understanding of the need and significance for follow up visits and screening for successful management of their mental illness and overall health. Therefore, Sunflower plans to explore how to further partner with providers, expand member education and demonstrate improvement on these measures in 2019.

HEDIS Pharmacy Measures

Sunflower focused on multiple Pharmacy measures in 2018 with the goal to demonstrate improvement on these. Those measures were: Use of Multiple Concurrent Antipsychotics in Children/Adolescents, Metabolic Monitoring for Children/Adolescents, Antidepressant Medication Management and Follow up ADHD. The aim was to continue to demonstrate improvement with compliance on the use of medications, compliance with appropriate monitoring secondary to antipsychotic use and then compliance with taking medications to help ensure optimal outcomes for the members as appropriate with an overall goal of helping them to achieve their own personal goals.

Interventions for Use of Multiple Concurrent Antipsychotics in Children/Adolescents:

- Care Management team utilized care alerts on assigned members and addressed identified gaps with members to facilitate the appropriate care
- Referred members identified as being on 2+ antipsychotic meds to LifeShare for outreach and support as needed based on member specific needs and circumstances
- Psychiatric Medication Utilization Review program used algorithm to identify members

on multiple concurrent or high dose antipsychotic medication regimens with outreach to prescribers if needed based on prescribing information
- BH CM and UM teams were trained on the measure and to look for members who may fall into the measure. If a member was identified on their caseload, they were to work with the member and the member's care team to ensure other needed supports and treatment were in place or to assist with access as appropriate.

Interventions for Metabolic Monitoring for Children/Adolescents on Antipsychotics & Follow up ADHD listed below:
- Care Management team reviewed care alerts on assigned members and addressed identified gaps with members to facilitate appropriate care

Interventions for Antidepressant Medication Management:
- CM team reviewed care alerts on assigned members and addressed identified gaps with members
- Referred members to Disease Management

The following table provides data on all of these measures. Sunflower demonstrated improvement from HEDIS 2017 to HEDIS 2018 on Use of Multiple Concurrent Antipsychotics in Children/Adolescents by 3.53%. Sunflower also noted YOY improvements on Metabolic Monitoring for Children/Adolescents on Antipsychotics, and Antidepressant Medication Management – Continuation Phase. However, there was a drop noted for Antidepressant Medication Management – Acute Phase, Follow up ADHD for both the Initiation and Continuation and Management. Efforts are planned to continue on these measures in 2019 as well to help ensure member needs are being met.

HEDIS MEASURE	HEDIS 2017 (MY 2016) Final Rate	HEDIS MY 2017) Final Rate	HEDIS 2019 (MY 2018) Admin Rate*	Met/Exceeded NCQA 2017 Quality Compass 50th Percentile
Use of Multiple Concurrent Antipsychotics in Children/Adolescents	4.81	4.64	3.90	No
Metabolic Monitoring for Children/Adolescents on Antipsychotics	38.00	47.18	47.43	Yes
Antidepressant Medication Management - Acute Phase	51.02	49.66	51.89	No
Antidepressant Medication Management - Continuation Phase	33.76	32.03	33.22	No
Follow Up ADHD - Initiation	53.47	52.78	53.53	Yes
Follow Up ADHD - Continuation & Management	62.01	62.53	59.28	Yes

**Awaiting final HEDIS 2019 data*

Sunflower utilizes data to determine opportunities for improvement, potential barriers and then adapts the interventions as appropriate. With the measures noted above, relationships with providers and members provide opportunities for feedback to identify where there maybe individual member needs that can be addressed to help ensure compliance, e.g. transportation challenges, and member knowledge deficits and in some instances even provider opportunities related to prescribing information. Sunflower will continue to utilize interventions from 2018 in 2019 while also exploring additional opportunities to further partner with providers and expand education to members as appropriate based on data and feedback.

PATIENT SAFETY

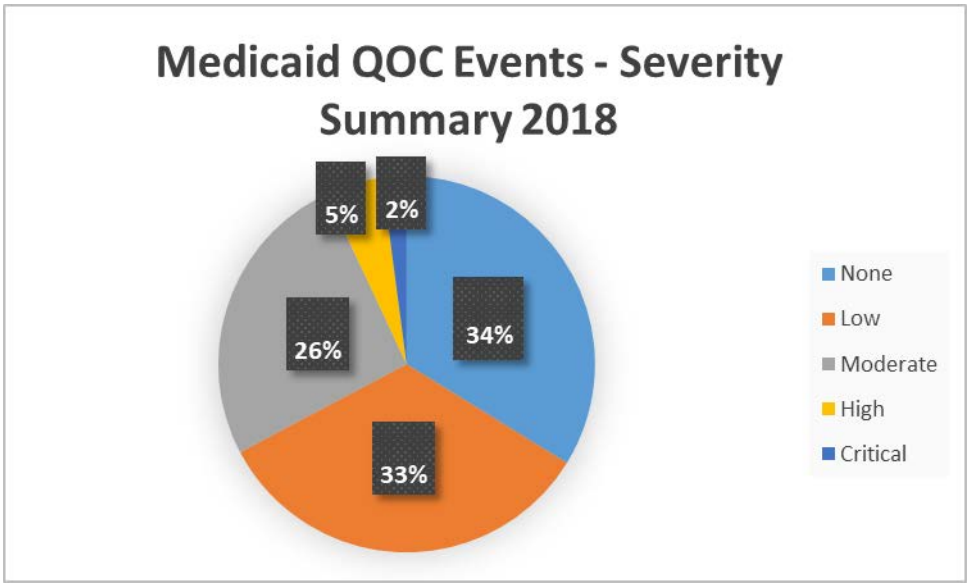
Quality of Care and Adverse Incidents

Sunflower monitors the safety of its members through identification of potential and/or actual quality of care (QOC) events and adverse incident reports (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 quarterly and to 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 2018. 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. The following table provided depicts the severity level results from the cases refered as potential QOC events. Their severity level was based on the review of records provided to Sunflower. This allowed for the reviewer to determine if there was a QOC concern and subsequently assign a severity level.

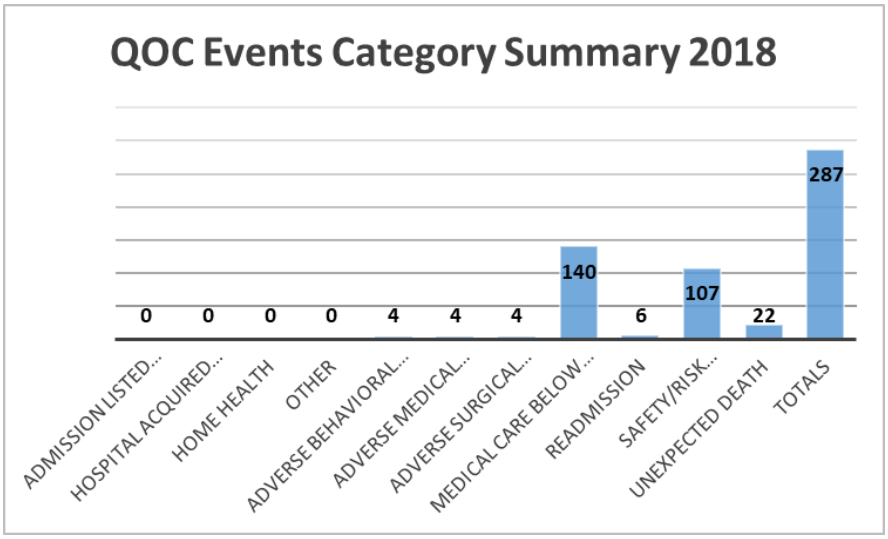


For 2018, there were a total of 287 QOC events completed which was noted to be a decrease of 11.5% from 2017. Sunflower's Quality team continued to provide education throughout 2018 with health plan staff on their role and responsibility to report potential Quality of Care concerns to the Quality team to allow for appropriate investigation. Of those, 97 resulted in categorized as "None" which comprised 34% of those for 2018 which was a noted decrease by 9% from 150 for 2017. "Low" accounted for 96 events, comprising 33% for the year which was up slightly from 32% in 2017. "Moderate" accounted for 74 or 26% for 2018 compared to 16% for 2017 and demonstrated the greatest increase from 2017. There was an increase in the volume of severity of "High," thought the percentage remained the same; total of 14 or 5% for 2018 compared to 17/5% the previous year. The total for "Critical" was noted to be 14 or 2% which was the rate same as 2017. The results are depicted in the table below, showing 2017 and 2018 totals for comparison.

Severity Level	QOC Events Severity Summary 2017	QOC Events Severity Summary 2018
None	150	97
Low	104	96
Moderate	52	74
High	17	14
Critical	7	6
Totals	330	287

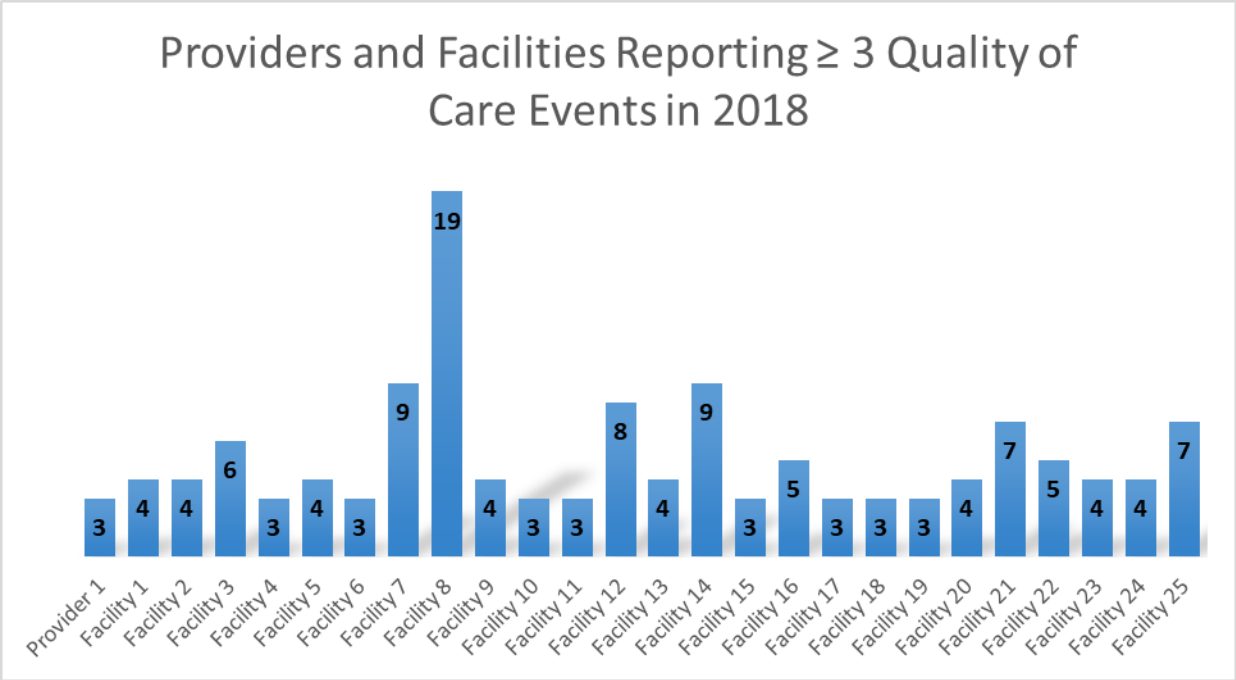
Sunflower also looks at QOC data to determine the most common types of QOC cases. Medical Care Below Standard of Care events were noted to be the highest type of QOC referral received in 2018. The next category was noted to be Safety/Risk Management. The third highest type of QOC case was Unexpected Death. 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. Sunflower noted an increase in Medical Care Below Standard of Care events in the cases reviewed in 2018 of 144 which was up from 97 in 2017, while in 2018 there was also an increase of referrals for unexpected death from 21 in 2017 to 22 in 2018. Cases referred for Readmission increased from 4 to 6 from the previous year.



Sunflower's review of the QOC concerns reported in 2018 resulted in trends of greater than or equal to 3 QOCs for 25 facilities and 1 practitioner. These 25 identified facilities and 1 practitioner generated 134 potential QOCs that were investigated, of the 292 for the entirety of 2018. Upon further review of the potential QOCs that were reported for Facility #8, 1 of the 19 reported were noted to not be QOC concerns. They had 10 with severity level of Medium. The remaining 8 QOCs for this facility were all determined to be of Low severity level.

There were 2 facilities noted to have 9 total QOCs and these were Facility #7 and Facility #14. Based on review of the potential QOCs for Facility #7, 5 of the 9 reported were not QOCs, 2 received a Low level rating, 1 received a Medium Severity level and 1 was deemed to be of a High Severity level. Based on review of the potential QOCs for Facility #14, 8 of the 9 received a Low Severity level and 1 received a Medium Severity level. The data points are depicted on the table following this paragraph. Sunflower will continue to evaluate both facility and provider trends with QOCs for opportunities to improve upon.



The State of Kansas has defined, and developed a system of provider reporting for events considered “Adverse Incidents”. Selected providers are required to report the defined events into a state developed portal and these reports are named Adverse Incident Report(s) or AIRs. The AIR policy and processes were refined through collaborative efforts that Sunflower actively participated in with the State and fellow MCOs in 2018.

Adverse Incidents include potentially serious events or outcomes these definitions were updated through the collaborative efforts of the State and MCOs, as defined below:

A. Abuse**:** Any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to a participant, including:

1) Infliction of physical or mental injury;
2) Any sexual act with a participant that does not consent or when the other person knows or should know that the participant is incapable of resisting or declining consent to the sexual act due to mental deficiency or disease or due to fear of retribution or hardship;
3) Unreasonable use of a physical restraint, isolation or medication that harms or is likely to harm the participant;
4) Unreasonable use of a physical or chemical restraint, medication or isolation as punishment, for convenience, in conflict with a physician's orders or as a substitute for treatment, except where such conduct or physical restraint is in furtherance of the health and safety of the participant or another individual;
5) A threat or menacing conduct directed toward the participant that results or might reasonably be expected to result in fear or emotional or mental distress to the participant;
6) Fiduciary abuse; or
7) Omission or deprivation by a caretaker or another person of goods or services

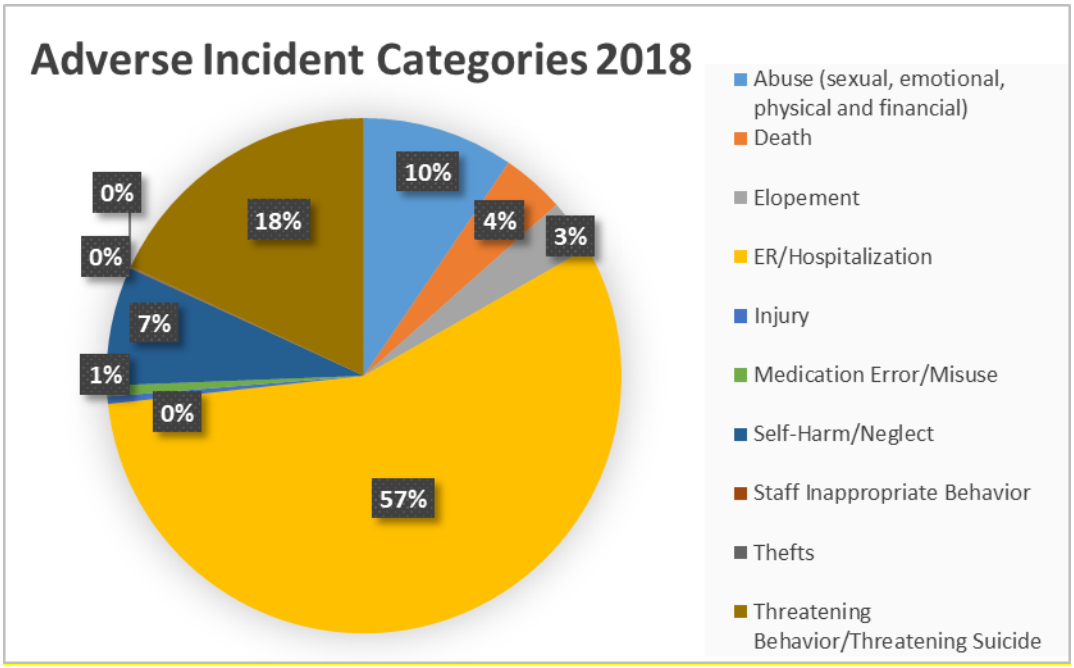
which are necessary to avoid physical or mental harm or illness.
B. Death: Cessation of a participant's life
C. Elopement: The unplanned departure from a unit or facility where the participant leaves without prior notification or permission or staff escort.
D. Emergency Medical Care: The provision of unplanned medical services to a recipient in an emergency room or emergency department. The unplanned medical care may or may not result in hospitalization.
E. Exploitation: Misappropriation of the participant's property or intentionally taking unfair advantage of a participant's physical or financial resources for another individual's personal or financial advantage by the use of undue influence, coercion, harassment, duress, deception, false representation or false pretense by a caretaker or another person.
F. Fiduciary Abuse: A situation in which any person who is the caretaker of, or who stands in a position of trust to, a participant, takes, secretes, or appropriates their money or property, to any use or purpose not in the due and lawful execution of such person's trust or benefit.
G. Law Enforcement Involvement: Any communication or contact with a public office that is vested by law with the duty to maintain public order, make arrests for crimes and investigate criminal acts, whether that duty extends to all crimes or is limited to specific crimes.
H. Misuse of Medications: The incorrect administration or mismanagement of medication, by someone providing a KDADS Community Services and Programs service which results in or could result in serious injury or illness to a participant.
I. Natural Disaster: A natural event such as a flood, earthquake, or tornado that causes great damage or loss of life. Approved emergency management protocols are to be followed, documented and reported as required by the policy in the AIR system. A separate AIR report shall be made for all HCBS participants in the area who are impacted by the natural disaster.
J. 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.
K. Seclusion: The involuntary confinement of a participant alone in a room or area from which the participant is physically prevented from leaving.
L. Restraint: Any bodily force, device/object, or chemical used to substantially limit a person's movement.
M. Serious Injury: An unexpected occurrence involving the significant impairment of the physical condition of a participant. Serious injury specifically includes loss of limb or function.
N. Suicide: Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.
O. 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.

The State of Kansas/KDADS has developed parallel reporting mechanisms for providers to report Adverse Events to the state and MCOs through an "Adverse Incident Reporting System". As a result, Sunflower receives reported AIRs via the KDADS system. The QI Designee completes an initial review, then requests 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 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 AIRs 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 safety as a result of the AIRs received.

In 2018, Sunflower was notified of 3,669 individual AIRs, which demonstrated an increase when compared to 3,129 from 2017. This increase equated to 14.7%. Each AIR reported was reviewed and processed as discussed previously. The following graphic demonstrates the categorization type of 2018 AIRs. Hospitalized/ER visits represent the highest category, with 2,073 AIRs which is consistent with what was noted as the top category for 2017. 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 continued to be second highest category for 2018 at 662 which demonstrated an increase of 11.4%. Abuse (sexual, emotional, physical and financial) was noted as the third highest category at 349 which was an increase from 2017 17.7%. The top three categories denoted for 2018 were consistent with what was evidenced in 2017 AIR data. These details are depicted in the following chart provided.



Recommendations for 2019 related to the quality of care and adverse incident reporting include continuing to monitor QOC and AIR data for provider trending, identifying opportunities for improvement which may include but not limited to educational opportunities for providers, health plan staff and others as identified from data, working with KDADS and providers to improve conditions for members, and provide follow up on AIR reporting. Sunflower's plan is to maintain

partnership with KDADS in use and improvement of the state reporting system for AIRs as Plan was an active participant in its development in 2018. Sunflower will continue to hold quarterly LTSS Quality Assurance Committee meetings, in which AIR trends are reviewed and discussed in order to identify concerns or opportunities for improvement.

Clinical Practice Guidelines (CPG)
Sunflower utilized the following clinical and preventive health practice guidelines in 2017 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. Below are the CPGs are provided:

- 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 2017 related to practice guidelines were to continue and expand provider profiles in 2018 to a larger provider group to help increase knowledge, awareness and compliance.

Efforts Undertaken in 2018:
Sunflower continues to complete annual review of CPGs and PHGs, review and update as appropriate based on the policy and procedure requirements. Goal was met in 2017 and Sunflower will continue efforts in 2018:

- Continue to notify practitioners about the guidelines via newsletter and website announcements. Goal met in 2017 and continued in 2018.
- Continue member and provider outreach and education-based initiatives regarding all guidelines. Goal is related to provider profiles, partially met in 2017 due to provider profiles being revised based on provider feedback. Efforts continued for 2018.
- Continue to meet applicable NCQA Standards throughout 2017 and continued in 2018 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.

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 and 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, 2018 through December 31, 2018, compared to calendar year 2017 for the Medicaid line of business.

The following table included represents the grievance totals by category in accordance with state reporting requirements and then per 1000 members for the years 2017 and 2018. Sunflower saw an increase in the number of member grievances for 2018 of 16.2%. This is likely attributed to education provided in 2018 by the Quality to the health plan staff. Training included definition and examples of a member grievance, who can report a grievance, and instruction on how other departments should report a grievance to the Quality team for proper processing. Training also focused on the importance of accurate identification of all expressions of member dissatisfaction as grievances, with proper referral to Quality for accurate processing and reporting. Accurate identification and reporting of member grievances enables Sunflower to have the ability to accurately assess where opportunities exist to improve the experience and satisfaction of members. These opportunities also allow us to educate the members on their right to file a grievance as well.

Member Grievance Category	2017	2017 Per 1000	2018	2018 Per 1000
Quality of Care (non HCBS provider)	42	0.26	80	0.58
Quality of Care – Pain Medication	*	*	9	0.06
Customer service	115	0.71	97	0.70
Member rights dignity	13	0.08	8	0.06
Access to service or Care	24	0.15	47	0.34
Non-Covered Services	*	*	6	0.04
Pharmacy Issues	30	0.18	18	0.13
Quality of Care HCBS provider	31	0.19	32	0.23
Value Added Benefits	15	0.09	17	0.12
Billing and Financial issues (non-transportation)	37	0.23	31	0.23
Transportation Issues- Billing and Reimbursement	93	0.57	26	0.19
Transportation- No Show	71	0.44	49	0.35
Transportation- Late	89	0.55	84	0.61
Transportation- Safety	30	0.18	36	0.26
Transportation - No Driver Available	71	0.44	49	0.35
Transportation- Other	13	0.08	92	0.67

Member Grievance Category	2017	2017 Per 1000	2018	2018 Per 1000
MCO Determined No Applicable	*	*	2	0.01
Other	7	0.04	7	0.05
Total	617	3.78	641	4.66

Three new grievance categories were added during 2018, and definitions for some grievance categories changed during the course of the year as well. Sunflower was able to accommodate changing instructions from KDHE related to categorization of grievances, but these changes do affect the ability to compare year-to-year or even quarter-to-quarter grievance volume trends by category. The grievance category denoting the highest volume in 2018 was Customer Service with 15.1% or 97 grievances out of 641 total for the year. These grievances related to Customer Service can encompass providers, their office staff, Sunflower staff and staff from vendors. Grievances in the category of Transportation Issues - Other were the second leading category, and accounted for 14.3% or 92 for 2018. This was closely followed by Transportation – Late grievances which accounted for 84 or 13.1% for 2018. The Plan monitors grievances both on a monthly and quarterly basis to identify trends as early as possible to allow further review to determine where opportunities for improvement exist. Then efforts are made to provide education aimed at preventing reoccurrences while improving the experience and quality of care and services members receive. Sunflower expanded focus with our transportation vendor to ensure member satisfaction and experience improves to include monthly reviews and follow up on grievance trends, tracking, and actions taken by the vendor to drive up the quality. Sunflower has established a goal of fewer than 4.50 member grievances per 1000 members annually. The Plan did not achieve that goal with 4.66/1000 for all grievances resolved in 2018. For 2019, Sunflower's grievance goal remains to be less than 4.50 member grievances per 1000 members.

Member Appeals

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

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

The following table demonstrates the Member Appeals resolved by category for entire year of 2017 and 2018 as well as the per 1000 calculation. The categories noted below are consistent with the state reporting requirements and account for any adjustments to those made throughout the year.

Member Appeal Reasons	2017 Total Resolved	2017 Per 1000	2018 Total Resolved	2018 Per 1000
MEDICAL NECESSITY DENIAL	669	4.10	687	4.99
Criteria Not Met - Durable Medical Equipment	94	0.58	119	0.86

Member Appeal Reasons	2017 Total Resolved	2017 Per 1000	2018 Total Resolved	2018 Per 1000
Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	3	0.18	4	0.03
Criteria Not Met - Medical Procedure (NOS)	64	0.39	60	0.43
Criteria Not Met - Radiology	45	0.28	101	0.73
Criteria Not Met - Pharmacy	244	1.50	278	2.02
Criteria Not Met - PT/OT/ST	32	0.20	25	0.18
Criteria Not Met - Dental	20	0.12	8	0.06
Criteria Not Met - Home Health	8	0.05	10	0.07
Criteria Not Met - Hospice	0	0.00	0	0.00
Criteria Not Met - Out of network provider, specialist or specific provider request	1	0.01	2	0.01
Criteria Not Met – Inpatient Behavioral Health	82	0.50	13	0.09
Criteria Not Met – Behavioral Health Outpatient Services and Testing	35	0.21	11	0.08
Level of Care - LTSS/HCBS	25	0.15	22	0.16
Level of Care - WORK	0	0.00	0	0.00
Level of Care - LTC NF	0	0.00	0	0.00
Level of Care - Mental Health	0	0.00	0	0.00
Level of Care - HCBS (change in attendant hours)	3	0.18	0	0.00
Ambulance (include Air and Ground)	0	0.00	0	0.00
Criteria Not Met - Other	23	0.14	34	0.25
Change in attendant hours	0	0.00	*	*
NONCOVERED SERVICE DENIAL	67	0.41	121	0.88
Noncovered service - Dental	4	0.02	6	0.04
Noncovered service - Home Health	0	0.00	0	0.00
Noncovered service - Pharmacy	4	0.02	6	0.04
Noncovered service - Out of Network providers	0	0.00	1	0.01
Noncovered service - OT/PT/Speech	0	0.00	0	0.00
Noncovered service - Durable Medical Equipment	22	0.13	28	0.20
Noncovered service - Behavioral Health	0	0.00	10	0.07
Noncovered service - Other	35	0.21	68	0.49
LOCK IN	2	0.01	2	0.01
BILLING AND FINANCIAL ISSUES	0	0.00	0	0.00
TRANSPORTATION TIMELINESS	0	0.00	*	*
Transportation No Show	0	0.00	*	*
Transportation Late	0	0.00	*	*
AUTHORIZATION DENIAL	2	0.01	7	0.05
Late submission by member/provider rep	1	0.01	4	0.03
No authorization submitted	1	0.01	3	0.02

Member Appeal Reasons	2017 Total Resolved	2017 Per 1000	2018 Total Resolved	2018 Per 1000
MCO TIMELINESS	0	0.00	0	0.00
Noncompliance with PA Authorization timeframes	0	0.00	0	0.00
Noncompliance with resolution of Appeals and issuance of notice	0	0.00	0	0.00
Denials of Authorization (Unauthorized by Members)	*	*	0	0.00
Total	**748**	**4.59**	**815**	**5.92**

For 2018, overall Medical Necessity Denials per Criteria Not Met made up the majority of member appeals at 687 or 84% of the total member appeals. When broken down further, Pharmacy continues to be the area with the highest volume, which is consistent with what was noted for 2016 and 2017. The volume from 2017 was 244 while in 2018 it was 278, showing a change of 12%. Sunflower exhibited an increase in the overturn rate of the Criteria Not Met Pharmacy from 35.7% in 2017 to 58.6% for 2018. There were multiple new medications added by KDHE to the Prior Authorization required list, which contributed to subsequent Pharmacy appeals during 2018. The Pharmacy appeals were followed by Criteria Not Met – Durable Medical Equipment and Criteria Not Met – Radiology appeals. Continued efforts at education occurred throughout 2018 with changes on medication criteria communicated to providers to make the authorization process more efficient for both members and providers while also aiming to decrease the number of appeals that resulted. Sunflower's goal at the beginning of 2018 was to complete 98% of standard member appeals within 30 calendar days from receipt. Plan was successful in meeting this goal in each quarter of 2018. Additionally, Sunflower's goal for expedited member appeals was to resolve 98% within 72 hours of receipt. This goal was met in three of 4 quarters of 2018. For 2019, Sunflower's goal is to resolve 100% of standard member appeals within 30 calendar days and to resolve 100% of expedited member appeals within 72 hours of receipt.

In 2018, Plan noted a change to the appeal decisions that were overturned or reversed which exhibited an increase from 2017. The reversed appeals for 2018 was noted at 49.94% compared to 45.1% in 2017. As a result, Sunflower will continue to provide education to 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 and efficient fashion to potentially avoid an appeal. This trend of appeals upheld, overturned or withdrawn is noted in the following table. The number of those that were withdrawn stayed relatively consistent.

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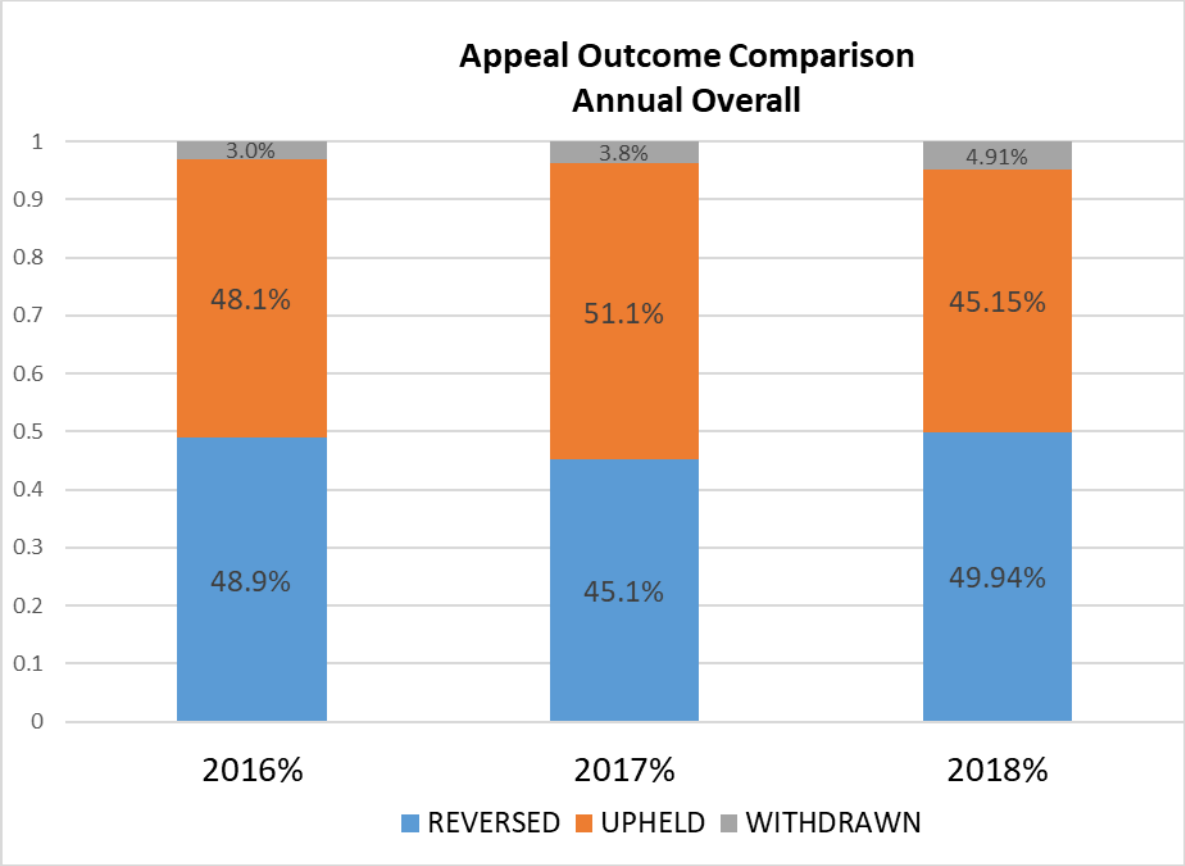

Provider Appeals

Provider appeals consist of internal reviews of partial or whole claim denials 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 and network physicians, which allows for discussion of the data, trends and allows 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 2018. Plan noted an increase in provider appeals from 1,266 in 2017 to 2,378 in 2018. This increase was noted to be significant at 47%. Provider appeal rights changed in May 2017 consistent with KDHE policy, which allowed the providers to skip the reconsideration step and proceed directly to appeal. Prior to 5/1/17, the reconsideration step was required prior to requesting an appeal. Upon implementation of this change, we saw an immediate increase in provider appeal volume. An additional change made was for provider appeal rights in April 2018, in which a request, which was not clearly noted as a reconsideration, should be treated as a provider appeal by default, rather than a reconsideration. Again, Sunflower saw an increase in provider appeal volume shortly after implementation of this change. During 2018, Sunflower's goal was to resolve 98% of provider appeals within 30 calendar days of receipt. The Plan did not meet this goal in any

quarter of 2018. A variety of factors contributed, including inaccurate processing of provider appeals by the behavioral health claims team, claims system changes resulting in appeal misrouting, and mailroom backlogs causing a delay in scanning of mail received. The Quality team worked collaboratively with members of the claims, mailroom, UM, and other teams involved in the processing/review of provider appeals in order to improve the timeliness. Additionally, the Quality team has provided education to each of the teams involved in order to ensure those involved in handling provider appeals understand the turnaround time requirements. The goal for 2019 remains to resolve 98% of provider appeals within 30 calendar days of receipt.

The following table depicts the provider appeals by category allowing for comparison of 2017 to 2018. Hospital Outpatient (Non-Behavioral Health) was by far the highest category with 707, accounting for 30% of provider appeals in 2018. The second highest provider appeal category was Hospital Inpatient (Non-Behavioral Health) with 400 17%. The third highest category Radiology comprising 8% for 2018. Together the top three provider appeal categories accounted for 1,294 of the 2,378 provider appeals, or 54%. Sunflower performs analysis of provider appeals data for trends that warrant evaluation. This evaluation may reveal processes with potential opportunities for improvement and may result in education for providers, their office staff and other areas on what records could fulfill medical necessity with the claim submission to lessen their need to file an appeal. Another example would be when there are errors on claims where education is an opportunity to alleviate administrative burden for providers and/or their staff. Sunflower works to collaborate with vendors, providers and their office staff to improve processes and opportunities to increase efficiencies and lessen the burden.

Provider Appeals Categories	Number Resolved 2017	Per 100,000 Claims	Number Resolved 2018	Per 100,000 Claims*
CLAIM DENIALS	**648**	**9.01**	**2157**	**41.80**
Hospital Inpatient (Non-Behavioral Health)	137	1.91	400	7.75
Hospital Outpatient (Non-Behavioral Health)	0	0.00	707	13.70
Pharmacy	2	0.02	5	0.10
Dental	41	0.57	40	0.76
Vision	164	2.28	85	1.65
Ambulance (include Air and Ground)	11	0.15	18	0.35
Medical Professional (Physical Health not Otherwise Specified)	21	0.29	136	2.64
Nursing Facilities - Total	14	0.19	18	0.35
HCBS	11	0.15	2	0.04
Hospice	4	0.06	12	0.23
Home Health	23	0.32	18	0.35
Behavioral Health Outpatient and Physician	11	0.15	136	2.64
Behavioral Health Inpatient	28	0.39	67	1.30
Out of network provider, specialist or specific provider request	2	0.02	91	1.76
Radiology	23	0.32	187	3.62

Provider Appeals Categories	Number Resolved 2017	Per 100,000 Claims	Number Resolved 2018	Per 100,000 Claims*
Laboratory	0	0.00	79	1.53
PT/OT/ST	7	0.10	19	0.37
Durable medical Equipment	42	0.58	97	1.88
Other	107	1.49	40	0.78
BILLING AND FINANCIAL ISSUES				
Recoupment	2	0.02	22	0.43
ADMINISTRATIVE DENIALS				
Denials of Authorization (Unauthorized by Members)	196	199	846	2378
Total	2.73	3.86	11.77	46.08

*7,190,820 claims received in 2017. 5,160,410 claims received through October 2018. The entire year's data will not be available until mid-to-late April. The total appeals per 100,000 claims for 2018 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 state contract and supports accreditation with the National Committee for Quality Assurance (NCQA).

The 2018 Summary Rate Composite and Key Question scores for Plan are presented in CAHPS Adult and Child survey results provided below. These tables also demonstrate comparison of the survey results for 2018 against results for 2017, then with comparison to the Quality Compass® All Plans means and percentiles. The 2018 Quality Compass® National Benchmarks is the mean summary rate from the Medicaid adult health plans that submitted data to NCQA in 2018. The Medicaid Child CAHPS is compared to the 2018 Quality Compass® National Benchmarks; this benchmark compares against other Medicaid child plans that submitted to NCQA.

Sunflower's summary rate results for 2018 Composites and Key Questions for the CAHPS Medicaid Adult Survey compared to the 2018 Quality Compass National Benchmarks means and percentiles. Results for 2018 demonstrated slight decrease in Getting Care Quickly, Health Promotion and Education, Coordination of Care, Providing Needed Information, Getting Needed Care, Customer Service, Ease of Filling Out Forms, Rating of Health Care, Rating of Specialist and How Well Doctors Communicate. Additionally, improvement was noted in the Rating of Health Plan, Personal Doctor, and Shared Decision Making.

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Medicaid Adult CAHPS Survey Results

Composite & Question Ratings	2017 Rate	2018 Rate	2018 Quality Compass Percentile Met/ Exceeded 50th Percentile
Getting Needed Care	**86.2%**	**85.6%**	**Yes**
Ease of getting care, tests, or treatment needed	88.6%	87.5%	Yes
Obtaining appointment with specialist as soon as needed	83.8%	83.6%	Yes
Getting Care Quickly	**87.9%**	**86.9%**	**Yes**
Obtaining needed care right away	87.7%	91.1%	Yes
Obtaining appointment for care as soon as needed	88.1%	82.7%	Yes
How Well Doctors Communicate	**93.7%**	**92.6%**	**Yes**
Doctors explaining things in an understandable way	94.3%	91.9%	No
Doctors listening carefully to you	93.5%	93.2%	Yes
Doctors showing respect for what you had to say	93.8%	94.5%	Yes
Doctors spending enough time with you	93.1%	90.6%	Yes
Customer Service	**90.5%**	**87.5%**	**No**
Getting information/help from customer service	86.7%	82.4%	No
Treated with courtesy and respect by customer service	94.3%	92.5%	No
Shared Decision Making	**79.3%**	**82.9%**	**Yes**
Doctor/health provider talked about reasons you might want to take a medicine	94.1%	94.1%	Yes
Doctor/health provider talked about reasons you might not want to take a medicine	67.6%	69.9%	Yes
Doctor/health provider asked you what you thought was best when talking about starting or stopping a prescription medicine	76.3%	84.7%	Yes
Health Promotion and Education	**73.5%**	**72.1%**	**No**
Coordination of Care	**90.0%**	**86.1%**	**Yes**
Providing Needed Information	**86.7%**	**82.4%**	**No**
Ease of Filling Out Forms	**94.5%**	**91.6%**	**No**
Ratings Items			
Rating of Health Care	78.0%	**75.6%**	**Yes**
Rating of Personal Doctor	84.2%	**84.3%**	**Yes**
Rating of Specialist	85.4%	**83.8%**	**Yes**
Rating of Health Plan	75.4%	**80.6%**	**Yes**

Sunflower's 2018 summary rate results for Composites and Key Questions for the CAHPS Medicaid Child Survey by Title XIX and Title XXI compared to the 2018 Quality Compass All Plans. In 2018, Customer Service, Health Promotion and Education, Coordination of Care, Rating of Health Care, Ease of Filling Out Forms and Rating of Specialist demonstrated improvement for both the Title XIX and Title XXI survey respondents. Getting Needed Care and Shared Decision Making all demonstrated a reduction for the Child XXI population. 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	2017 Rate Title XIX	2018 Rate Title XIX	2018 Quality Compass Met/Exceeded 50th Percentile	2017 Rate Title XXI	2018 Rate Title XXI	2018 Quality Compass Met/Exceeded 50th Percentile
Getting Needed Care	**88.5%**	**89.0%**	**Yes**	**90.5%**	**88.9%**	**Yes**
Ease of getting care, tests, or treatment child needed	91.0%	92.7%	Yes	93.6%	92.6%	Yes
Obtaining child's appointment with specialist as soon as needed	87.2%	85.4%	Yes	87.7%	85.2%	Yes
Getting Care Quickly	**92.9%**	**92.5%**	**Yes**	**91.9%**	**91.9%**	**Yes**
Obtaining needed care right away	95.2%	95.8%	Yes	94.9%	92.2%	Yes
Obtaining appointment for care as soon as needed	91.4%	89.1%	Yes	89.4%	91.6%	Yes
How Well Doctors Communicate	**95.9%**	**95.8%**	**Yes**	**94.9%**	**95.6%**	**Yes**
Doctors explaining things in an understandable way	96.0%	97.0%	Yes	95.8%	96.5%	Yes
Doctors listening carefully to you	96.1%	96.5%	Yes	95.6%	96.7%	Yes
Doctors showing respect for what you had to say	97.5%	97.6%	Yes	96.7%	96.7%	Yes
Doctors spending enough time with your child	91.5%	92.0%	Yes	91.6%	92.7%	Yes
Customer Service	**89.0%**	**90.4%**	**Yes**	**89.7%**	**91.0%**	**Yes**
Getting information/help from customer service	83.8%	86.6%	Yes	82.7%	88.4%	Yes
Treated with courtesy and respect by customer service staff	93.6%	94.2%	Yes	94.3%	93.5%	No
Shared Decision Making	**79.1%**	**85.0%**	**Yes**	**80.4%**	**77.3%**	**No**
Doctor/health provider talked about reasons you might want your child to take a medicine	92.4%	97.1%	Yes	95.3%	90.6%	No
Doctor/health provider talked about reasons you might not want your child to take a medicine	66.8%	71.9%	Yes	70.0%	64.4%	No
Doctor/health provider asked you what you thought was best for your child when starting or stopping a prescription medicine	79.6%	86.0%	Yes	79.7%	76.9%	No
Health Promotion and Education	70.6%	**70.8%**	**No**	68.8%	**70.9%**	**No**
Coordination of Care	84.7%	**86.3%**	**Yes**	81.6%	**86.2%**	**Yes**
Ease of Filling Out Forms	94.3%	**94.7%**	**No**	93.0%	**95.4%**	**No**
Rating Items						

Child Composite & Question Ratings	2017 Rate Title XIX	2018 Rate Title XIX	2018 Quality Compass Met/Exceeded 50th Percentile	2017 Rate Title XXI	2018 Rate Title XXI	2018 Quality Compass Met/Exceeded 50th Percentile
Rating of Health Care	88.2%	**90.6%**	**Yes**	88.9%	**90.2%**	**Yes**
Rating of Personal Doctor	90.6%	**89.9%**	**Yes**	89.6%	**92.0%**	**Yes**
Rating of Specialist	89.4%	**95.7%**	**Yes**	89.3%	**89.7%**	**Yes**
Rating of Health Plan	88.9%	**88.8%**	**Yes**	88.9%	**90.3%**	**Yes**

Sunflower's goal for the 2018 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. Plan met the goal for most areas on the 2018 Adult and on the Child surveys. The Plan is focusing efforts on improving member satisfaction related to the following areas, including certain areas that impact multiple domains resulting in their inclusion below as focus areas. One example is Customer Service, which impacts Rating of Health Plan, Rating of Health Care, Rating of Personal Doctor and Specialist. Additionally, Customer Service focuses on members being treated with courtesy and respect along with getting the information or help they need.

Medicaid Adult Survey:

- Care Coordination
- Getting Care Quickly
- Customer Service

Medicaid Child Surveys:

- Customer Service
- Shared Decision Making
- Care Coordination

Sunflower utilized the vendor, Morpace for delivery, data collection and report completion of the CAHPS surveys in 2018. The areas noted as strengths for the Adult survey are as follows:

- Getting Care Quickly
- How Well Doctors Communicate
- Care Coordination
- Getting Needed Care
- Shared Decision Making
- Rating of Health Care
- Rating of Personal Doctor
- Rating of Specialist
- Rating of Health Plan

The one area noted as a relative weakness was Health Promotion and Education. As a result, Sunflower is focusing on Customer Service as an area to help drive the performance for the 2019 CAHPS Medicaid Adult survey.

For the 2018 Title XIX and Title XXI CAHPS child surveys, there only a relative weakness noted for Title XXI, which was Shared Decision Making. However, the strengths identified to be consistent for both are listed here:

- Customer Service
- Rating of Health Care
- Health Promotion and Education
- Ease of Filling Out Forms
- Rating of Specialist
- Coordination of Care

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. This also included the strengths/weakness analysis provided by Morpace, then 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, and Medical Management team which is integrated to include LTSS/Waiver, I/DD, and Behavioral Health. The Sunflower CAHPS/member experience workgroup met and discussed barriers, opportunities to address these barriers to increase member satisfaction, and potential interventions. Some of these barriers are noted to be an ongoing challenge with the membership served.

The 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 Plan 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.
- Lack of empathy from health plan staff
- Lack of health plan staff understanding of CAHPS questions members respond to

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

- Implementation of Customer Service training to improve member experience and perception
- Empathy training and video for health plan staff
- 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.

Sunflower chose to use the NCQA approved combined Title XIX and Title XXI survey results for the NCQA accreditation scoring in August of 2018. The final score assigned to Sunflower was 11.437 out of 13 possible points. Sunflower continues to strive for improvement on member satisfaction through a variety of interventions aimed at improving Customer Service and member experience.

Behavioral Health Survey

Sunflower conducted member satisfaction surveys specific to behavioral health services accessed utilizing the Mental Health Statistics Improvement Program Adult Consumer Satisfaction Survey (MHSIP) for adults and the Youth Survey for Families (YSS-F) for youth members. These surveys allow for evaluation and comparison of health plan ratings. Sunflower strives to understand the problems members face in order to implement actions that achieve better performance on specific opportunities for improvement identified within the survey results. In addition, Sunflower utilizes the survey results as a data source for other performance improvement initiatives throughout the year.

For the Medicaid Adult survey, the sample size for the 2018 behavioral health survey consisted of 1,746 members, with 471 completed valid surveys (mixed mail, and telephone). The 1,746 members represent the adjusted base after excluding members who were found to be ineligible or non-responders (refused to participate, returned blank survey, or could not be reached due to a bad address). After adjusting for ineligible or non-responding members, the Medicaid Adult survey response rate for 2018 was 27.0%.

BH Survey Response Rate

Survey Population	2018 Response Rate
Medicaid Adult	27.0%
Medicaid Child	23.3%

The sample size for the 2018 Medicaid Child survey consisted of 1,810 child members of Sunflower Health Plan using mixed (mail and phone) survey methodology. There were 422 valid surveys from the population. After adjusting for ineligible/non-responding members (190 Sunflower members identified as ineligible or non-responding), the survey response rate was 23.3%.

The 2018 Composite and Question scores for Sunflower's adult and child surveys are presented in the following tables.

2018 Medicaid Adult Behavioral Health

Medicaid *Adult* Behavioral Health Topics & Question Ratings	2018 Rate
Treatment (% Strongly Agree/Agree)	**NA**
Location of services was convenient	84.2
Able to get needed services	81.5
Able to see a psychiatrist when wanted	78.0
Felt comfortable asking questions about treatment and medication	89.0
Felt free to complain	79.1
Given information about rights	90.6
I, not staff, decided my treatment goals	75.0
I was encouraged to use consumer-run programs	70.8
Staff (% Strongly Agree/Agree)	**NA**
Willing to see me as often as necessary	84.2
Returned calls within 24 hours	81.5
Were available at convenient times	88.8
Believe I can grow, change and recover	81.5
Encouraged me to take responsibility for how I live my life	81.0
Told me what side effects to watch out for	78.4
Respected wishes about who can receive information about my treatment	90.7
Sensitive to my cultural background	85.4
Provided information to allow me to take charge of my illness	81.0
Perceived Improvement (% Strongly Agree/Agree)	**NA**
Deal more effectively with daily problems	73.3
Better able to control my life	71.2
Better able to deal with crisis	67.6
Get along better with family	68.4

Medicaid *Adult* Behavioral Health Topics & Question Ratings	2018 Rate
Do better in social situations	55.2
Do better in school/work	50.5
Housing situation has improved	66.2
Symptoms not bothering me as much	50.6
Happy with friendships	72.6
Have people with whom to do enjoyable things	72.5
Belong in a community	61.1
Have needed support in case of crisis	76.9
Do things that are more meaningful	69.3
Better able to take care of needs	69.6
Better able to handle when things go wrong	61.0
Better able to do things I want to do	61.2
Overall Measures (% Strongly Agree/Agree unless otherwise noted)	**NA**
Like the services received	90.4
If had other choices, would still choose this agency	84.7
Would recommend to friends or family	88.6
Satisfaction with counseling or treatment (% 8, 9, 10)	61.2

2018 Medicaid Child Behavioral Health

Medicaid *Child* Behavioral Health Topics & Question Ratings	2018 Rate
Treatment (% Strongly Agree/Agree)	**NA**
Helped to choose services	88.0
Helped to choose treatment goals	90.4
Participated in child's treatment	95.4
Location of service was convenient	85.9
Services were available at convenient times	84.5
Got all help wanted for child	84.6
Got as much help as needed	78.4
Staff (% Strongly Agree/Agree)	**NA**
People helping us stuck with us no matter what	82.4
Child had someone to talk to when troubled	83.5
Treated me with respect	92.5
Respected family's religious/ spiritual beliefs	89.4
Spoke in a way I could understand	96.1
Sensitive to cultural/ethnic background	85.8
Perceived Improvement (% Strongly Agree/Agree)	**NA**
Symptoms not bothering as much	61.8
Better handling daily life	65.8
Gets along better with family	67.4
Gets along better with friends/others	66.8

Medicaid *Child* Behavioral Health Topics & Question Ratings	2018 Rate
Doing better in school/work	65.9
Better able to cope when things go wrong	58.9
Better able to do things he/she wants to do	69.1
Have people who will listen	84.7
Comfortable talking about child's problems	87.0
Have needed support in case of crisis	85.3
Have people with whom I can do enjoyable things	85.9
Child Information	**NA**
Child currently living with you (% yes)	97.6
Child on medication for emotional/behavioral reasons (% yes)	83.9
Overall Measures (% Strongly Agree/Agree unless otherwise noted)	**NA**
Like the services received	92.8
If had other choices, would still choose this agency	84.9
Would recommend to friends or family	88.3
Overall satisfied with services	90.7
Satisfaction with counseling or treatment (% 8, 9, 10)	65.3

The 2018 behavioral health survey results will serve as the baseline rates. Sunflower's Medical Management, Quality Improvement and Network Development team members reviewed the survey results and identified strengths and opportunities. Data for benchmarking was unavailable to compare survey results. Therefore, Sunflower chose to assess strengths and opportunities based on percentage rates for each question.

2018 Medicaid Adult BH Survey

Strengths / Opportunities within Sunflower's BH Provider Network	Adult Strengths	Adult Opportunities
Treatment	Felt comfortable asking questions about treatment and medication (89.0%)	I was encouraged to use consumer-run programs (70.8%)
	Given information about rights (90.6%)	I, not staff, decided my treatment goals (75.0%)
Staff	Respected wishes about who can receive information about my treatment (90.7%)	Told me what side effects to watch out for (78.4%)
	Were available at convenient times (88.8%)	Encouraged me to take responsibility for how I live my life (81.0%)
	Sensitive to my cultural background (85.4%)	
Perceived Improvement	Deal more effectively with daily problems (73.3%)	Do better in school/work (50.5%)
		Symptoms not bothering me as much (50.6%)
		Do better in social situations (55.2%)

Strengths / Opportunities within Sunflower's BH Provider Network	Adult Strengths	Adult Opportunities
Overall Measures	Like the services received (90.4%)	Satisfaction with counseling or treatment (% 8, 9, 10) (61.2%)
	Would recommend to friends or family (88.6%)	

2018 Medicaid Child BH Survey

Strengths / Opportunities within Sunflower's BH Provider Network	Child Strengths	Child Opportunities
Treatment	Participated in child's treatment (95.4%)	Got as much help as needed (78.4%)
	Helped to choose treatment goals (90.4%)	
	Helped to choose services (88.0%)	
Staff	Spoke in a way I could understand (96.1%)	People helping us stuck with us no matter what (82.4%)
	Treated me with respect (92.5%)	
	Respected my family's religious/spiritual needs (89.4%)	
Perceived Improvement	Comfortable talking about child's problems (87.0%)	Better able to cope when things go wrong (58.9%)
	Have needed support in case of crisis (85.3%)	Symptoms not bothering me as much (61.8%)
	Have people with whom I can do enjoyable things (85.9%)	
Overall Measures	Like the services received (92.8%)	Satisfaction with counseling or treatment (% 8, 9, 10) (65.3%)
	Overall satisfied with services (90.7%)	

Of the survey scores, *Staff* strengths were high in both the adult and child survey results. Most all of the questions received a score of 80% or above with the exception of the adult survey question which asked if the members were told what side effects to watch out for (78.4%). Questions related to feeling respected by their provider received strong scores in both surveys. At a rate of 85.8% youth survey respondents reported their provider was sensitive to the member's cultural/ethnic background.

The questions with the lowest scores were in the *Perceived Improvement* area. Adult respondents indicated lower scores in the areas of doing better in school/work (50.5%), doing better in social situations (55.2%), and symptom reduction (50.6%). The youth survey respondents also scored low for symptom reduction (61.8%). At a rate of 58.9%, the youth survey respondents indicated they were better able to cope when things go wrong. This survey did not take into consideration how long a member had been in treatment. It is likely some of the respondents were in an early phase of treatment and may have yet to see an improvement in their functioning or symptom reduction at the time they completed the survey.

ACCESS & AVAILABILITY

Customer Service Call Statistics

The Customer Service Department has state contractual requirements to meet telephone access standards. In 2018 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 153,999 for 2018. The average speed to answer was 15 seconds for member calls and 23 seconds for provider calls. In 2018, Sunflower successfully met the goal of 80% answered within 30 seconds or less. The 2018 abandonment rate was 1.82% for member calls and 1.80% for provider calls, 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 upon enrollment with the Plan in the Member Handbook. Members receive an updated Sunflower Member Handbook annually. Member's Rights and Responsibilities are provided to the Sunflower participating provider network through its Provider Manual. Member Rights and Responsibilities are a part of the training curriculum for all new Customer Service Representatives.

Sunflower's Member Handbook includes appointment access standards educating members on wait time expectations to obtain routine, urgent and emergent medical and behavioral health services. With Sunflower's 24/7 Nurse Advice Line, members have access to the health plan at all times.

Accessibility of Primary Care Services

Sunflower monitors primary care provider appointment accessibility against its standards, identifies opportunities for improvement and initiates actions as needed to improve results. The Plan 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. The tables on the following pages denote the standards and performance.

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 21 days of request is the standard. For Behavioral Health the access to care standard is 10 days for Routine care. 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), and behavioral health, with Sunflower in 2018. No practitioners were excluded from the sample. Practitioner data was pulled from Sunflower's provider management system, Portico. Data is collected by standardized survey; 1,539

practitioners were included for the 2018 analysis. Sunflower'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 following table 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
Behavioral Health routine appointments not to exceed 10 days from the date of the members request	90% of surveyed Behavioral Health providers	Survey sample of Behavioral Health providers	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

The following table demonstrates the results from 2018 assessment of providers by types to include primary care, oncologists, OB providers and behavioral health providers. For the primary care providers (PCP's), 400 were included in the sample initially and 128 completed the survey fully. Sunflower failed to meet the goals for primary care urgent appointments within 48 hours, and primary care routine appointments not to exceed 3 weeks for new patients but met performance goals for meeting standards for established patients. For urgent care PCP appointments, PCPs failed to meet the goal. The survey for the high impact specialist's targeted 150 oncology practitioners with 18 completed the survey completely. For high-volume specialists, 150 OB/GYN providers were targeted and 42 completed the survey. The results demonstrated failure to meet the goal on high volume and high impact providers sampled on urgent appointments within 48 hours and did meet the goal for first routine appointment within 30 days for OB/GYN and Oncology. In addition, OB/GYN did meet the second routine appointment standard. For behavior health, prescribers and non-prescribers, 294 were targeted with 69 completing the survey. For Urgent care neither Prescriber nor Non-prescriber, behavioral health providers met the goal for Urgent Care standards.

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	New Patients - 63% Established Patients – 66%	No No
Primary care routine -New Patients appointments not to exceed 3 weeks	90% of surveyed PCPs report availability of routine appointment within timeframe	1st available: 83% 2nd available: 81% 3rd available: 80%	No No No
Primary care routine - Established Patients appointments not to exceed 3 weeks	90% of PCPs report availability of routine appointment within timeframe	1st available: 94% 2nd available: 92% 3rd available: 91%	Yes
Primary care – Wait Time not to exceed 45 Minutes	90% of PCPs report availability of Wait Time within timeframe	82%	No
Oncology **Urgent Care** appointments within 48 hours	90% of high-impact specialists report availability of urgent appointment within defined timeframe	39% for New Patients 56% for Established patients	No
Oncology **Routine Care - New Patients** appointments within 30 days	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st available: 89% 2nd available: 83% 3rd available: 83%	No No No
Oncology **Routine Care - Established Patients** appointments within 30 days	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st available: 94% 2nd available: 89% 3rd available: 89%	Yes No No
Oncology **–** Wait Time not to exceed 45 Minutes	90% of Oncology's report availability of Wait Time within timeframe	83%	No
OB-GYN care for urgent appointments within 48 hours	90% of high-volume specialists report availability of urgent appointment within defined timeframe	New Patients: 48% Established Patients: 52%	No No
OB-GYN Prenatal Care **- New Patients** routine appointments in the **1st** trimester within 30 days	90% of high-volume specialists report availability of routine appointment within defined timeframe	1st available: 92% 2nd available: 89% 3rd available: 84%	Yes No No
OB-GYN Prenatal Care **- New Patients** routine appointments in the **2nd** trimester within 30 days	90% of high-volume specialists report availability of routine appointment within defined timeframe	1st available: 84% 2nd available: 82% 3rd available: 76%	No No No
OB-GYN Prenatal Care **- New Patients** routine appointments in the **3rd** trimester within 30 days	90% of high-volume specialists report availability of routine appointment within defined timeframe	1st available: 82% 2nd available: 82% 3rd available: 76%	No No No
OB-GYN Prenatal Care **- Established Patients** for routine appointments in the 1st trimester within 30 days	90% of high-volume specialists report availability of routine appointment within defined timeframe	1st available: 97% 2nd available: 92% 3rd available: 87%	Yes Yes No

Measurement Results and Comparison to Performance Goal

Access Standard	Performance Goal	Results	Goal Met? (Yes/No)
OB-GYN Prenatal Care - **Established Patients** for routine appointments in the 2nd trimester within 30 days	90% of high-volume specialists report availability of routine appointment within defined timeframe	1st available: 97% 2nd available: 92% 3rd available: 87%	Yes Yes No
OB-GYN Prenatal Care - **Established Patients** for routine appointments in the 3rd trimester within 30 days	90% of high-volume specialists report availability of routine appointment within defined timeframe	1st available: 95% 2nd available: 90% 3rd available: 85%	**Yes** **Yes** **No**
OB-GYN Prenatal Care – Wait Time not to exceed 45 Minutes	90% of OB-GYN's report availability of Wait Time within timeframe	95%	**Yes**
Behavioral Health care for urgent appointments within 48 hours	90% of high-impact specialists report availability of urgent appointment within defined timeframe	33% for New Patients 38% for Established Patients	**No**
Behavioral health care for routine New Patient appointments within 10 Days	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st available: 77% 2nd available: 64% 3rd available: 59%	**No**
Behavioral health care for routine Established Patients appointments within 10 Days	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st available: 77% 2nd available: 69% 3rd available: 58%	**No**
Behavioral Health Non Prescriber care for urgent appointments within 48 hours	90% of high-impact specialists report availability of urgent appointment within defined timeframe	61% for New Patients 58% Established Patients	**No**
Behavioral Health Non Prescriber Care for routine appointments New Patients within 10 Days	90% of high-impact specialists report availability of urgent appointment within defined timeframe	1st available: 93% 2nd available: 82% 3rd available: 84%	**Yes** **No** **No**
Behavioral Health Non Prescriber Care for routine appointments Established Patients within 10 Days	90% of high-impact specialists report availability of urgent appointment within defined timeframe	1st available: 98% 2nd available: 91% 3rd available: 88%	**Yes** **Yes** **No**
Behavioral Health Non-Life Threatening Emergent Care within 6 hours	90% of surveyed Behavioral Health Prescribers and Non-Prescribers within defined timeframe	Prescribers: 96% Non-Prescribers: 95%	**Yes** **Yes**
Volume of member grievances regarding accessibility of services	Complaint volume of less than 5/1000 members	0.32%	**Yes**
Volume of member appeals regarding out of network service	Appeal volume of less than 5/1000 members	0	**Yes**
Adult Survey: *Getting Care Quickly* Composite	2018 Quality Compass 75th ≥ Percentile	86.9%	**Yes**

Measurement Results and Comparison to Performance Goal

Access Standard	Performance Goal	Results	Goal Met? (Yes/No)
Q4 Adult Survey: Percent of members who responded always or usually to "Obtained needed care right away"	2018 Quality Compass 90th ≥ Percentile	91.1%	**Yes**
Q6 Adult Survey: Percent of members who responded always or usually to "Obtained appointment for care as soon as needed"	2018 Quality Compass 50th ≥ Percentile	82.8%	**Yes**
Q56 (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	70.3%	**No**
Child Survey: *Getting Care Quickly* Composite	2018 Quality Compass 50th ≥ Percentile	TXIX 92.5% TXXI 91.9%	Yes Yes
Q4 Child Survey: Percent of members who responded always or usually to "Child obtained needed care right away"	2018 Quality Compass 50th ≥ Percentile	TXIX 95.8% TXXI 92.2%	Yes Yes
Q6 Child Survey: Percent of members who responded always or usually to "Child obtained appointment for care as soon as needed"	2018 Quality Compass 50th ≥ Percentile	TXIX 89.1% TXXI 91.6%	Yes 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	TXIX 86.6% TXXI 82.5%	Yes Yes
Member Grievances related to Appointment Access	< 5.0/1000 members	Grievance Database	Yes

Sunflower continues 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. In 2018, Sunflower started utilizing Morpace/SPH Analytics to perform the surveys for Appointment Access and After Hours. Sunflower established a goal to meet or exceed the 90% goal for compliance with appointment standards in 2018. The results demonstrated opportunities to focus improvement on for 2018.

Sunflower met their goals on the following measures:

- Volume of member grievances regarding accessibility of services
- Adult Survey: *Getting Care Quickly* Composite

- Volume of member appeals regarding out of network service
- Q4 Adult Survey: Percent of members who responded always/usually to “Obtained needed care right away”
- Q6 Adult Survey: Percent of members who responded always/usually to “Obtained appointment for care as soon as needed”
- Q56 (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?
- Child Survey: Getting Care Quickly Composite
- Q4 Child Survey: Percent of members who responded always/usually to “Child obtained needed care right away”
- Q6 Child Survey: Percent of members who responded always/usually to “Child obtained appointment for care as soon as needed”
- FQ85 Child Survey (custom question): In the last 6 months, when you phoned after regular office hours, how often did you get the help or advice you needed

After-Hours Care

In 2018, Sunflower started utilizing the vendor Morpace to perform the survey for After Hours Care. In addition to the survey results, other data sources were utilized which included the 2018 CAHPS surveys and member grievances. The Morpace survey sampled 300 Sunflower Providers, 45% of the providers demonstrated being fully compliant, 135/300. There were 55% found noncompliant, 165/300. Sunflower follows-up with the noncompliant providers to alert to the status and resurveys the provider for compliance. The 2018 CAHPS survey questions utilized for assessment of After-Hours Care are:

- Q# 55 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# 56 “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?”

2018 After-Hours Care Medicaid Survey			
Number of Providers in Sample	**Number Fully Compliant**	**Number of Noncompliant**	**% of Providers Fully Compliant**
300	135	165	45%

CAHPS Survey Questions for After Hours*	Title XIX 2017 Rate	Title XIX 2018 Rate	Title XXI 2017 Rate	Title XXI 2018 Rate	Adult 2017 Rate	Adult 2018 Rate
Child Q84/Adult Q55. In last 6 months, did you phone your child's or your personal doctor's office after regular office hours to get help/advice?	12%	12.50%	9%	8.50%	18.00%	15.20%
Child Q85/Adult Q56. 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?	78.80%	**86.60%**	83.50%	**82.50%**	84.80%	**70.30%**

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

The CAHPS data revealed 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 8.5% to 15.2% in 2018 for both child populations and the adult population. Title XXI and Adult 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 2017 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. Of the three populations, only the Child Title XIX result demonstrated an increase in getting the help or advice needed after hours for 2018 compared to 2017. Sunflower will continue to monitor this data on an annual basis to assess for opportunities for improvement from our membership. Grievances regarding after-hours access are captured in the Access-Other subcategory. There were thirty-nine grievances in the Access-Other subcategory in calendar year 2018 for Sunflower. Review of these grievances determined there were zero complaints regarding primary care after-hours access in 2018 for the Plan. Sunflower established a goal of <0.50 member complaints and the goal was met in 2018, with a rate of 0.00/1000 member complaints regarding primary care after-hours access.

Access to behavioral healthcare practitioners and after-hours access is monitored on a regular basis and actions are initiated when needed to improve performance by Sunflower as the behavioral health component was incorporated into Sunflower for all of 2018. Sunflower handles all aspects related to survey monitoring and any actions needed as appropriate.

CAHPS Survey – Access Measures

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. Sunflower continued in 2018 to utilize additional CAHPS questions to capture data to assess primary care access information.

The table below demonstrates the Sunflower rates for the CAHPS Adult survey results comparing 2018 to 2017. In addition, the tables demonstrates the plans ranking per Quality Compass.

Composite & Question Ratings	2017 Rate	2018 Rate	2018 Quality Compass Ranking Met/Exceeded 50th Percentile
Getting Care Quickly	**87.9%**	**86.9%**	**Yes**
Obtaining needed care right away	87.7%	91.1%	Yes
Obtaining appointment for care as soon as needed	88.1%	82.8%	Yes

Below, the table that demonstrates Sunflower's Child CAHPS survey results for comparison of 2018 results with 2017 survey demonstrated by Title XIX and Title XXI member satisfaction survey results specific to Getting Care Quickly.

Child Composite & Question Ratings	2017 Rate Title XIX	2018 Rate Title XIX	Title XIX 2018 Quality Compass Met/Exceeded 50th Percentile	2017 Rate Title XXI	2018 Rate Title XXI	Title XXI 2018 Quality Compass Met/Exceeded 50th Percentile
Getting Care Quickly	**92.9%**	**92.5%**	**Yes**	**91.9%**	**91.9%**	**Yes**
Obtaining needed care right away	95.2%	95.8%	Yes	94.9%	92.2%	Yes
Obtaining appointment for care as soon as needed	91.4%	89.1%	Yes	89.4%	91.6%	Yes

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 but are not limited to: grievance and appeal data, CAHPS survey results, and the strength/weakness analysis. These reviews incorporate representatives from key Sunflower departments, including Provider Relations, Medical Management that includes LTSS/Waiver, I/DD, and Behavioral Health, Quality Improvement (including the Grievance and Appeal Coordinator), Network & Contracting, Customer Services, Compliance, and Pharmacy. The Sunflower CAHPS/member experience workgroup met, reviewed data and identified barriers, opportunities for improvement and interventions 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, both telephonic and in person, which members and providers are routinely accessing. Sunflower monitors the availability of practitioners in the network that speak other languages, and based on the lack of grievances regarding cultural/linguistic issues feels we are meeting the population needs. Spanish is the highest language need, after English, for our current membership. 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 Plan residents. However, interpreter services and translation of written materials is available to any Plan member as needed.

Practitioner Availability
Practitioner availability monitoring is completed for primary care practitioners (PCPs), high volume and high impact specialty care practitioners, and behavior healthcare practitioners.

PCPs are defined as physicians with a primary specialty designation of family/general medicine, internal medicine, pediatric medicine, or a subspecialty related to those specialties. Advanced practice clinicians under the personal supervision of an eligible physician may also be eligible. The PCP may practice in a solo or group setting or at a Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Department of Health Clinic, or similar outpatient clinic. With prior written approval, Sunflower may allow a specialist provider to serve as a PCP for members with special healthcare needs, multiple disabilities, or with acute or chronic conditions as long as the specialist is willing to perform the responsibilities of a PCP.

Behavioral health practitioners (BHP) and substance use disorder (SUD) providers are managed by Plan. Sunflower is accountable for all services. The Plan establishes the practitioners and providers as the following: Psychiatrists, Clinical Psychologists, and Masters Level Clinicians. The geographic distribution of behavioral healthcare practitioners for Medicaid are distributed as MD (e.g. psychiatrists) and Non-MD behavioral health therapist.

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

Sunflower defines geographic distribution standards for PCPs and high-volume/high-impact specialists, and ratio/numeric standards for PCPs and high-volume specialists. The below table lists the practitioner type, standards, measurement method, and results for each practitioner type for whom availability is monitored. The standards are monitored annually.

Practitioner Type	Standard	Measurement Method	Results	Goal Met?
PCPs: All Types	95% of urban members have at least 1 PCP within 20 miles.	Quest Analytics	99.9%	Yes
	95% of rural members have at least 1 PCP within 30 miles.	Quest Analytics	99.9%	Yes
	At least 1 PCP per 2000 members	Ratio of PCPs to members	1:40	Yes
PCPs: Family Practitioners/ General Practitioners	95% of urban members have at least 1 FP or GP within 20 miles	Quest Analytics	99.9%	Yes
	95% of rural members have at least 1 FP or GP within 30 miles	Quest Analytics	99.8%	Yes

Practitioner Type	Standard	Measurement Method	Results	Goal Met?
	At least 1 FP or GP per 2000 members	Ratio of FPs/GPs to members	1:81	Yes
PCPs: Internal Medicine	95% of urban members ≥19 have at least 1 internist within 20 miles	Quest Analytics	99.7%	Yes
	95% of rural members ≥19 have at least 1 internist within 30 miles	Quest Analytics	92.20%	**No**
	At least 1 IM per 2000 adult members	Ratio of internists to members	1:28	Yes
PCPs: Pediatrics	95% of urban members ≤18 years of age have at least 1 pediatrician within 20 miles	Quest Analytics	99.5%	Yes
	95% of rural members ≤18 years of age have at least 1 pediatrician within 30 miles.	Quest Analytics	72%	**No**
	At least 1 Pediatrician per 2000 members under age 19	Ratio of pediatricians to members	1:338	Yes
PCP Extenders: Nurse Practitioners	95% of members have at least 1 NP within 20 miles	Quest Analytics	99.9%	Yes
	95% of rural members have at least 1 NP within 30 miles.	Quest Analytics	99.6%	Yes
	At least 1 NP per 2000 members	Ratio of NPs to members	1:140	Yes
PCP Extenders: Physician Assistants	95% of members have at least 1 PA within 20 miles	Quest Analytics	97.2%	Yes
	95% of rural members have at least 1 PA within 30 miles.	Quest Analytics	98.3%	Yes
	At least 1 PA per 2000 members	Ratio of PAs to members	1:334	Yes
Obstetrics and Gynecology	95% of urban female members have at least 1 OB/GYN within 15 miles	Quest Analytics	97.2%	Yes
	95% of rural female members have at least 1OB/GYN within 60 miles.	Quest Analytics	94.4%	Yes
	At least 1 OB/GYN per 2000 members	Ratio of OB/GYN practitioners to members	1:201	Yes
Hematology/ Oncology	95% of urban members have at least 1 Hematology/Oncology provider within 25 miles	Quest Analytics	96.4%	Yes
	95% of rural members have at least 1 Hematology/Oncology provider within 100 miles.	Quest Analytics	83.80%	**No**
	At least 1 Hematology/Oncology provider per 5000 members	Ratio of Hematology/Oncology providers to members	1:687	Yes
Psychiatrists (BH/SUD)	95% of urban members have at least 1 Psychiatrist within 30 miles.	Quest Analytics	97.80%	Yes
	95% of rural members have at least 1 Psychiatrist within 60 miles.	Quest Analytics	93.90%	**No**
	At least 2 Psychiatrist per 1000 members	Ratio of Psychiatrist providers to members	1:330	Yes
	95% of urban members have at least 1 Clinical Psychologist within 30 miles.	Quest Analytics	100%	Yes

Practitioner Type	Standard	Measurement Method	Results	Goal Met?
Clinical Psychologists (BH/SUD)	95% of rural members have at least 1 Clinical Psychologist within 60 miles.	Quest Analytics	100%	Yes
	At least 2 clinical psychologist per 1000 members	Ratio of Clinical Psychologist providers to members	1:324	Yes
Masters Level Clinicians (BH/SUD)	95% of urban members have at least 1 Masters Level Clinician within 30 miles.	Quest Analytics	100%	Yes
	95% of rural members have at least 1 Masters Level Clinician within 60 miles.	Quest Analytics	100%	Yes
	At least 5 master level clinician per 1000 members	Ratio of Master Level Clinician providers to members	1:103	Yes

Geographic analysis of practitioner 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 one 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 Medicaid members residing in rural areas: internal medicine and pediatricians. However, it is important to note that family and general practitioners met the standard in rural areas, meaning that members have access to primary care in rural areas, but may not have access to primary care practitioners that specialize in the care of adult or children and adolescent populations. Sunflower also measures availability for PCP-Extenders, i.e. nurse practitioners and physician assistants, which both met the standards for urban and rural members. All PCP types exceeded the numeric/ratio standards established by Sunflower: 1:2000 for each type of PCPs.

Sunflower's standards for high-volume, i.e. OB/GYN practitioners, are that 95% of female members have access to at least one OB/GYN within 15 miles for urban areas and within 60 miles for rural areas; both standards were met for OB/GYNs. High-impact specialists, identified as hematology and oncology specialists, did meet the urban (95% of members have at least one specialists within 25 miles) geographic standard. However, the rural (95% of members have at least one specialist within 100 miles) geographic standard was not met. The results of the 2017 practitioner availability analysis for hematology and oncology access for urban members was 95.7%; in 2018, this number increased to 96.4%. For hematology and oncology practitioner availability for rural members, the results of the 2017 practitioner availability analysis indicated 83.4%, increasing slightly in 2018 to 83.8%.

Sunflower analyzed behavioral health access for 2018, as behavioral health integration at the plan. The access standard was met for both urban and rural for non-MD Behavioral Health therapists, and psychiatry access is being met for urban areas. However, access is not met for psychiatry in rural areas (93.9% to goal of 95%). Sunflower is researching available psychiatrists in rural counties where we are not meeting access, which are Barber, Cheyenne, Decatur, Gove, Graham, Greeley, Jewell, Logan, Mitchell, Norton, Osborne, Phillips, Rawlins, Republic, Sheridan, Sherman, Smith, Thomas, Wallace, and Washington.

Sunflower will target the rural counties for further investigation and outreach to improve access for rural members based on the network adequacy report that indicated the lowest access percentages for hematologists/oncologists: Butler and Montgomery (semi-urban counties). Then for the rural counties of Cheyenne, Decatur, Finney, Grant, Gray, Greeley, Hamilton, Haskell, Kearny, Meade, Morton, Rawlins, Seward, Sherman, Stanton, Stevens, Thomas, Wallace, and Wichita. For OB/GYN, the counties with the lowest access percentages were Miami (semi-urban) and Cheyenne, Decatur, Gove, Jewell, Logan, Rawlins, Republic, Sheridan, Sherman, and Thomas. Of the counties listed above concentrated in Northwest and Southwest Kansas, all are 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 is contracted with all available hospitals in the rural and frontier areas.

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

- Utilizing newly developed report that compares KMAP listing to Sunflower network to identify providers who are non-par for recruitment/contracting
- Identifying potential providers through other sources such as competitor websites, medicare.gov, NPPES, licensing websites, listings from the local medical societies and provider associations, case managers, Member Connections representatives, established community relationships, other internet resources and personal recommendations from network providers in the area.
- Utilizing listings of newly licensed providers and state reports of providers issued new NPI numbers, which may include identifying providers through sources such as Kansas Board of Healing Arts and local Medical Societies.
- Reviewing non-par claim reports.
- Approaching PCPs and other providers with limited or closed panels, and request that they open their panels to new members or members
- 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.

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. Centene utilizes SPH Analytics, a National Committee for Quality Assurance (NCQA) Certified Survey Vendor, to conduct the provider satisfaction survey for all Centene health plans.

SPH Analytics followed a one-wave mail and internet with phone follow-up survey methodology to administer the provider satisfaction survey from August to October 2018. Sunflower's sample size was 1,647. SPH Analytics collected 221 surveys (85 mail, 26 internet, and 108 phone) from the eligible provider population. After adjusting for ineligible providers, the mail/internet survey response rate was 7.5%, and the phone response rate was 15.5%. 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

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

Phone Component

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

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

2018 Provider Satisfaction Composite Scores	2018 Summary Rate	2017 Summary Rate	2016 Summary Rate	2015 Summary Rate
Overall Satisfaction	66.30%	61.2%	58.9%	53.2%
Comparative Rating of Sunflower compared with all other contracted health plans	35.20%	34.6%	32.2%	24.0%
Finance Issues	33.60%	37.3%	33.8%	22.9%
Utilization & Quality Management	28.70%	29.6%	26.7%	18.1%
Network/Coordination of Care	20.70%	22.4%	21.6%	22.0%
Pharmacy	13.10%	16.6%	14.7%	12.7%
Health Plan Call Center Service Staff	27.90%	30.8%	29.7%	22.1%
Provider Relations	40.90%	36.5%	36.1%	25.0%
Recommended to Other Physicians Practices	38.20%	NA	NA	NA

Sunflower has demonstrated year over year improvement for the Overall Satisfaction with Plan compared with past years. Some composite scores have fluctuated minor amounts. 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 of continued focus from the CAHPS survey on Care Coordination for Sunflower in 2019.

Continuity and Coordination of Care between Medical and Behavioral Healthcare
Sunflower's Medical Management team demonstrates an integrated model with both Physical and Behavioral Health being focused upon. 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; and
- Special needs of members with severe and persistent mental illness.

The following table 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	Antidepressant Medication Management (AMM) HEDIS Measure: Acute Phase & Continuation Phase
Appropriate Use of Psychotropic Medications	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)
Screening and Management of Coexisting Disorders	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD) HEDIS measure.
Preventive Behavioral Program	Number of members identified and screened for perinatal depression.
Special Needs of Members with Serious and Persistent Mental Illness	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) HEDIS measure.

Exchange of Information between Behavioral Health and Primary Care

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.

In the standardized survey tool administered by SPH Analytics for Sunflower's 2018 Provider Satisfaction Survey, two questions measure the timeliness and the frequency of communication from behavioral health practitioners to primary care practitioners. Responses for the specific questions are noted in the table below for 2018. The response for question 4E demonstrated an increase from 13.3% in 2017 to 16.1% for 2018. For question 4F, there was a decrease from 25.4% in 2017 to 24.1% in 2018. These data points are noted in the table below.

Provider Satisfaction Questions	2018 Percent Satisfied	2017 Percent Satisfied	2016 Percent Satisfied	2018 Responses Composite/Attribute
4E: Please rate the timeliness of exchange of information/communication/reports from the behavioral health providers?	16.1%	13.3%	17.8%	Excellent – 3.2% Very Good – 12.9% Good – 57.3% Fair – 17.7% Poor – 8.9% (n=124)
4F: How often do you receive verbal and/or written communication from behavioral health providers regarding your patients?	24.1%	25.4%	37.7%	Always – 3.8% Usually – 20.3% Sometimes – 45.1% Often – 24.8% Rarely – 6.0% (n=133)

Sunflower was unable to compare performance on the 2018 survey 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 a decline in performance from 2017 to 2018 related to the question of how often the behavioral health provider communicates. However, there was an improvement in 2018 in the timeliness of exchange of information from behavioral health providers. Plan's goal for the 2018 provider satisfaction survey was an increase of 5% on each survey question. Sunflower met this goal for the timeliness question (4E) but failed to achieve the goal for the question of how often the behavioral health provider communicates (4F). Sunflower will continue to work on improvement here, as it is imperative to the members and their overall health.

Sunflower has integrated the behavioral health provider network and as a result will continue to promote the exchange of information through completion of an assessment for each member upon discharge for a behavioral health inpatient admission. The Plan identifies a member's PCP and faxes the discharge assessment, which includes information regarding discharge medications and behavioral health providers with whom the member has follow up care arranged. Discharge summaries containing protected health information related to HIV/AIDS or substance abuse treatment are not eligible for re-disclosure to the member's PCP unless the

member provides specific written consent to release the information obtained by the Plan. Efforts are made to obtain this consent to allow 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's Behavioral Health staff have identified the following barriers related to the exchange of information between medical and behavioral healthcare providers while efforts 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.
- 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 for as they are resistant to others outside of their perceived support group.
- Plan identified that members in Foster Care can be a challenge with moving placements and are working to bridge the gaps between providers including behavioral health.

Sunflower continues to work on the following opportunities, which 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.
- 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. Identify a primary case owner who 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. Practitioners from both primary care health and behavioral health treat members with depressive disorders and prescribe antidepressant medications. Sunflower's physical and behavioral health case management team members collaborate with each other to coordinate services the member needs.

The AMM HEDIS measure has two indicators:

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

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

Antidepressant Medical Management	HEDIS 2017 Final Rate	HEDIS 2018 Final Rate	HEDIS 2019 Admin Rate*	Met/Exceeded NCQA HEDIS 2018 Quality Compass 50th Percentile
Effective Acute Phase Treatment	51.02% (952/1866)	49.66% (876/1764)	51.95%	No
Effective Continuation Phase Treatment	33.76% (630/1866)	32.03% (565/1764)	33.24%	No

*Awaiting final HEDIS 2018 data

Sunflower's HEDIS 2018 (measurement year 2017) rate for the *Effective Acute Phase Treatment* measure did not meet the goal of reaching or exceeding the Quality Compass 50th percentile. The reported rate for HEDIS 2018 demonstrated a decrease of 1.36 percentage points. Therefore, Sunflower chose to continue to work to increase performance in HEDIS 2019. The preliminary HEDIS 2019 rates indicate an improvement over HEDIS 2018 has occurred.

Sunflower's HEDIS 2018 (measurement year 2017) rate for *Effective Continuation Phase Treatment* measure did not meet the goal of reaching or exceeding the Quality Compass 50th percentile. The reported rate for HEDIS 2018 demonstrated a decrease of 1.73 percentage points. Sunflower chose to continue to work to increase performance in HEDIS 2019. The preliminary HEDIS 2019 rates indicate an improvement over HEDIS 2018 has occurred.

Sunflower provides 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 Plan staff make referrals. Adherence to treatment plans, including antidepressant medications, is a primary focus of the program. The Plan 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.

Sunflower offered Depression Disease Management (DM) to members with depression through Q2 of 2018. Outreach was made to members identified with a diagnosis of depression to engage members in the DM program. Sunflower staff made referrals. Adherence to treatment plans, including antidepressant medications, was a primary focus of the program. Many members received a depression diagnosis from a primary care physician. The DM program

provided these members with education and support in locating needed services to treat and manage symptoms.

The Disease Management program for depression and perinatal depression was modeled after the Evidence Based Practice, Impact Model created at the University of Washington. The program screened for depression via case managers, predictive modeling, claims reviews, and self-report. The program monitored symptomology via PHQ9 for depression cases and Edinburgh assessments for perinatal depression. Members gained insight on their condition via education on the condition itself and recommended treatments regarding current symptomology. Members were offered care coordination to supplement existing services and to help maintain low symptomology as the symptoms decrease.

In Q3 of 2018, Sunflower decided to shift the DM program to incorporate elements of the program within Sunflower's existing medical management teams. Sunflower is adjusting the depression screening tool used for complex case management and for pregnant members. Members who have elevated depression scores will be offered case management supports with Sunflower's behavioral health case management team.

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 available to the member.

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

- Article in the provider newsletter, educated providers about Plan'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.
- Sunflower staff training on the diagnosis of depression and evidence-based practices for depression.

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 measure 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.

Sunflower's data trends for the past three years can be seen in the table below. The goal was to achieve a 5% improvement over the previous year. The HEDIS 2018 reported rate exceeded that goal with a rate of 80.66%, which is a 5.99% improvement over HEDIS 2017. The same analysis will be conducted when Sunflower receives the final HEDIS 2019 rates.

The table provided on the following page demonstrates the results on this HEDIS measure as noted above.

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Rate	Met/Exceeded NCQA Quality Compass 50th Percentile
HEDIS 2017 Final Rate	76.10% (1261/1657)	No
HEDIS 2018 Final Rate	80.66% (1305/1618)	No
HEDIS 2019 Admin Rate*	76.38%	N/A

*Awaiting final HEDIS 2019 data

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 diabetes screening guideline.
- Member knowledge deficit regarding diabetes screening

Sunflower implemented efforts to overcome barriers. Listed below are efforts that took place in 2018 with regard to overcoming and assisting members with improved health and quality of life.

- Integrated medical and behavioral health care management services to address medical and behavioral health needs concurrently.
- Referral of all members identified as non-compliant within the SSD measure to the case management team for education, coordination of care, and support in scheduling diabetic screening appointments. Developed partnership with Community Mental Health Centers (CMHCs) to provide the CMHCs with a list of attributed members. The CMHCs will then provide support to their members in scheduling and completing their diabetic screening. Member letter to educate members of the importance in completing annual diabetic screening.

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 for both physical and behavioral health, including assignment of responsibility to appropriate individuals, in order to promote fair, impartial and consistent utilization decisions and coordination of medical and behavioral care for the health plan members.

Scope

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

Goals

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

Implementation

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

Authority

The Plan Board of Directors (BOD) has ultimate authority and accountability for the oversight of the quality of care and services provided to members. The BOD oversees development, implementation and evaluation of the Quality Improvement Program. The Plan BOD delegates the daily oversight and operating authority of the utilization management (UM) activities to the Sunflower'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 Sunflower's QIC, which reports to the BOD. The UM Program is reviewed and approved by the Sunflower's BOD on an annual basis.

The Chief Medical Director has operational responsibility for and provides support to the Sunflower'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 Sunflower'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, Sunflower 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

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

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

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

- Identifying barriers to adherence to the care plan and recommended solutions for each barrier. Barriers may include but are not limited to issues such as:

  - Language or literacy issues, include general literacy limitations and health literacy
  - Visual or hearing impairment
  - Psychological/mental impairment
  - Financial and/or health insurance coverage limitations
  - Transportation
  - Cultural and/or spiritual preferences or values
  - Limited knowledge of condition(s)
  - Low motivation or ambivalence toward implementing change
  - Lack of, or limited, social or care giver support
  - Environmental factors
- Prioritized goals, which consider member and caregiver strengths, needs and preferences. Goals will be prioritized in numerical order or based on high, medium, or low priority. Goals will be designed to be achievable and help the member make changes towards the most optimal recovery possible.
- Interventions based on the member's risk factors, problems and/or needs, agreed upon goals, and personal preferences.
- Timeframe for measuring progress on meeting care plan goals and reevaluation of the plan.
- Self-management plans to assist members in managing their own condition. The member must acknowledge understanding and agreement to the specific activities identified in the self-management plan and this agreement must be included in the Centene Documentation System (CDS). Care management activities involved in developing and communicating a member's self-management plan include:
  - Education provided to members, their family/guardian, or other caregivers to help manage the member's condition(s). This may include written educational materials or verbal instructions provided by the care manager.
  - The specific information/materials and how the information was provided to the member (i.e. verbally, letter, pamphlet, etc.) are noted in the CDS.
  - When possible, self-management activities that can affect biometric data and be charted, such as weight and blood pressure, are documented in the CDS.
  - Follow up by the care manager to assess whether self-management activities have been completed.
- Documenting the plan of care in the CDS.

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

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The following table demonstrates the frequency of contact based on acuity level:

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

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

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

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

The following criteria are used to determine when discharge from care management should occur:

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

Once the member is identified as eligible for discharge from care management services, the care manager ensures appropriate notification is provided. The care manager discusses the impending discharge from care management with the member and/or family/guardian as appropriate. The care manager explains to a member who wishes to decline care management, how it can be of help to them and encourages them to use care management services. Community resources may also be presented as an option. The care manager contacts the member's PCP and other providers when appropriate, regarding the impending discharge. Lastly, a letter discharging the member from the care management program is generated through the CDS and sent to the member and the PCP, documenting the reason for discharge and a reminder to contact the care manager in the future, if medical concerns arise. A Member Satisfaction Survey may be sent with the member's closure letter, per Health Plan policy. See P&P CM.08 *Care Management Member Satisfaction Survey*.

Sunflower determined the care management identification criterion being utilized was adequately identifying the population at risk. The data reviewed in this population assessment does not indicate a need for any fundamental changes in the care management program at this time, Sunflower's protocol for complex care management will remain essentially the same in 2018 as no material changes in the membership relative to product line, age/gender, language, and race and ethnicity were identified. Sources of the data includes but are not limited to:

- Claim or encounter data
- Predictive modeling software
- Hospital discharge data
- Pharmacy data
- UM data - e.g. hospital admission data, NICU reports, inpatient census, precertification/prior authorization data, concurrent review data
- Emergency Department (ED) Utilization reports
- Laboratory data
- Readmission reports
- State/CMS Enrollment Process and other State/CMS supplied data

- State defined groups such as Children with Special Health Care Needs and Aged, Blind, and Disabled (ABD/SSI)
- Information provided by members or their care givers, such as data gathered from Health Risk Assessments
- Information provided by practitioners, such as Notification of Pregnancy (NOP) forms

Although it was determined that a fundamental change in the program is not warranted at this time, there continue to be changes made to the overall care management services provided by Plan as the health plan has matured and moves into the fifth year of operations. Some of the improvements include:

- Post-discharge nurse positions to contact all members not in case management after they have been discharged from the hospital.
- Integration of Behavioral Health and Physical Health
- Continuation of dedicated Transplant Care Manager Nurses to assist transplant members.
- Continuation of a Sickle Cell Care Management Program to assess and educate all sickle cell members, assists with resources, coordinates care between providers, and any other functions necessary.
- Continuation of focused 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.
- Ongoing efforts to increase the percentage of Notice of Pregnancy forms completed on pregnant women to identify the high-risk pregnancies and offer Start Smart Case Management, which includes identifying any mother at risk for pre-term deliver and working with the physician and the member to consider 17P injections to reduce the risk of a pre-term birth.
- A continued close partnership with Utilization Management staff to arrange safe discharges for NICU babies.
- Continuation of an Integrated Case Management training program for staff as well as a Sunflower based internal study group to further encourage/assist CM team members in preparing for and obtaining their CCM certification through CMSA.
- Continued strengthening of coordination of care between departments. Sunflower continues weekly rounds on inpatient members. Sunflower also continues 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.
- Training and implementation of Care Management Transformation, which is a coordinated care model that goes beyond the Integrated Care model and consists of a member journey and care router process to guide members to the right level of care. It consists of integrated, coordinated care teams that holistically address physical, BH, LTSS, and social needs with appropriate staffing/expertise, utilizing evidence based, population specific care pathways.
- Plan has a wide range of educational materials for members. This includes materials on various disease states and life events. The materials are brightly colored and easy to read and provide many talking points for care managers during contact with members.
- Plan continues to use the Krames Patient Education materials database, which contains patient education materials for thousands of diagnoses, medications, and medical procedures.

- Focused outreach and efforts surrounding Opioid utilization. With this epidemic being complex in nature an IDT team has been developed to work with members and providers impacted by this. Plan feels this is best accomplished with an interdepartmental approach including pharmacy, provider relations, care management, both physical and behavioral, and medical affairs. In depth, training will be provided to the staff so that they may better support our members. In addition, there will be focused outreach to providers to address the matters regarding prescribing practices.

Disease Management

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

- Asthma
- Diabetes
- Tobacco Cessation
- Raising Well
- Hypertension
- Targeted Case Management
- Weight Management
- Heart disease
- COPD
- Hyperlipidemia
- Puff Free Pregnancy

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 for 2018. The first five are wholly owned subsidiaries of Centene:

1. Envolve Vision - Sunflower's vision care provider. Envolve Vision provides utilization management, network development and maintenance, credentialing of their network, and claims payment data.
2. Envolve Pharmacy Solutions - 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.
3. Envolve People Care (EPC, formerly Nurtur and NurseWise) - Sunflower's disease management provider, after-hours call center and nurse advice line. EPC provides disease management for the following programs: Asthma, Coronary Artery disease, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, Hypertension, Hyperlipidemia and Tobacco Smoking Cessation. The after-hours call center and nurse

advice line provides bilingual care with registered nurses that complete health screenings and provide after-hours nurse advice.

4. Envolve Dental - Sunflower's dental benefit manager that provides prior authorizations, utilization management, network development and maintenance and claim payment information.
5. USMM – In-home healthcare services, mail-in lab test kits and risk adjustment in-home visits.
6. National Imaging Associates (NIA) - Sunflower's high-tech radiological imaging provider. NIA provides prior authorizations, credentialing of their network and first level appeals. NIA also is the vendor for post-service utilization review of speech, physical and occupational therapies. Provides post-service audits related to therapy services for speech, physical and occupations therapies for appropriate utilization.
7. Optum - Assists Sunflower in obtaining risk assessment information, data collection on pregnant members and facilitating utilization of 17P
8. Logisticare - Sunflower's transportation vendor.

Quarterly meetings occur 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. Regular meetings with USMM occur related to the specific projects that they work on for Sunflower. 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. The Plan 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.). This includes routine reporting of key performance metrics and annual or more frequent evaluation to determine whether the delegated activities are 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.

Integration of BH components from EPC to the health plan continued throughout 2018 for full integration. Additionally, in 2018, Sunflower continued the monthly operations meetings with Logisticare, which allows for focus on data analysis, follow up with actions taken based on trends identified from member grievances and other data available to both Logisticare and Sunflower. There were also three in-person meetings with Logisticare and Plan in 2018. Both are committed to improving the transportation grievances, member and provider experience with Logisticare.

Newly delegated entities are required to have a pre-delegation audit prior to contract implementation. All entities are subject to annual audits and submit regular reports of key functions to the Delegated Vendor Oversight Committee.
The table provided contains the results of vendor audits conducted in 2018 and scope of the review. It is important to note while vendors are often put on QIP from the corporate audits, there were not findings specific to the plan on all of those matters. However, Sunflower placed great focus on improvements with the transportation vendor Logisticare in 2018 specifically with regard to member grievances. Sunflower's ongoing efforts with Logisticare focus on policies, education and consistency with state contractual requirements. This included monthly and quarterly meetings with Logisticare to review the member grievances related to transportation, trends noted in those data, this allowed for discussions and feedback along with steps taken to correct opportunities for improvement.

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

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

Summary of QAPI Program Effectiveness

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

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 2018 were reviewed and continued as appropriate for measures where continued improvement was warranted.

Strengths:

- Continued demonstration of year over year improvements on Member satisfaction survey results
- Incorporates provider feedback into processes for continuous quality improvement
- Continued steady improvement in HEDIS scores year over year
- Access and Accessibility
- Integration of physical and behavioral health
- Continued results showing year over year improvement on Provider Satisfaction survey results
- Utilizing innovation to drive Quality through Provider P4P arrangements, and increased collaboration with providers, health departments, schools and other organizations to improve the quality of care members receive

Opportunities for Improvement:

- Continue efforts to promote provider and specialist communication to improve coordination of care
- Provider education to increase efficiencies and to increase their awareness of the efforts of Sunflower with regard to preventive and well care for members
- Explore additional opportunities to continue to innovate to drive quality improvement through more collaborative efforts

Because of this analysis, it has been identified that processes and operational systems are continuing to increase with regard to stabilization, which has allowed for innovation, producing positive results, and in some instances, our efforts reveal negative findings as the plan matures and enforces guidelines. Sunflower has now gained six (6) years of complete data, reinforcing Sunflower's position to continue to innovate and drive continuous quality improvements through the PDSA methodology that includes the analysis of data for trends to identify processes with opportunities for improvement while assessing for statistically significant changes. The findings from the analysis completed for 2018 did not indicate the need for major revisions to Sunflower's QAPI, operations, or service delivery systems. However, there were changes that were required with the procurement of the KanCare 2.0 contract to support Sunflower's continued dedication to continue upon the foundation built on previous quality improvement experience to maintain and drive further improvement from the gains achieved in 2018. Sunflower will take the necessary steps to demonstrate continuous quality improvement on the areas identified as priorities for improvement in 2019. The aim is to improve the health and well-being of our membership and increase partnership approach with providers. Sunflower continues with the purpose to transform the health of the communities we serve, one person at a time.