Annual Quality Program Evaluation

Ambetter from Sunflower Health Plan 2019

Contents

Health Plan Quality Program Evaluation - 2019

Introduction

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

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

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

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

Program Overview

Quality Program

The Plan continues to be committed to the provision of a well-designed and well-implemented QAPI Program. Ambetter'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.

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 the Plan'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 2019 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.

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 the Plan's Board of Directors and QIC. The Work Plan is updated quarterly. The Plan QI Department collaborates with all organizational departments to develop and maintain a comprehensive Quality program.

The 2019 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 2020 QI Work plan is currently being updated and will be provided to the QIC for review and approval.

Organizational Report / Changes in Organization in evaluation year

Throughout 2019, 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.

Ambetter 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 2019 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 the Plan 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. The findings from the analysis completed for 2019 did not indicate the need for major revisions to Ambetter's QAPI, operations, or service delivery systems. Ambetter will take the necessary steps to demonstrate continuous quality improvement on the areas identified as priorities for improvement in 2020. The aim is to improve the health and well-being of our membership and increase partnership approach with providers. Ambetter continues with the purpose to transform the health of the communities we serve, one person at a time.

Scope of the Quality Program

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

Ambetter'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 members, as appropriate
- 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

The Plan's primary quality improvement goal is to assess, monitor, and measure improvement of the health care services provided to members served by the Plan. The Plan will ensure quality medical care for members, regardless of payer source, eligibility category or location of services whether provided in an acute setting, home and community-based setting.

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

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

Compliance Program Description

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 2019, Sunflower underwent the BBA/state audit, and KDADS member quarterly files. Additionally, in 2019 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 2019 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.

Cultural Competency

Ambetter from Sunflower Health Plan promotes and participates in the efforts to ensure that covered services are delivered in a culturally competent manner to all members and is responsive to members' health literacy needs, including those with limited English proficiency (LEP) and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. The Plan is committed to developing, strengthening, and sustaining healthy provider/member relationships. Members are entitled to receive dignified, appropriate, and quality care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process. The Cultural Competency Plan (CCP) strives to reduce health care disparities in clinical area, improve cultural competency in materials and communications, improve network adequacy to meet the needs of underserved groups, and to improve other areas of needs the organization deems appropriate.

Member Cultural Needs and Preferences (Medical Management, Customer Service, Quality) maintains and updates Member Demographic Information; at least annually, Medical Management performs a care management population assessment of the services utilized by the entire member population and any relevant subpopulations; Customer Service representatives and Care Managers receive Cultural Competency training as part of the new hire training plan and annually thereafter; the CCP plan is available to all members and providers via the Member Handbook and Ambetter website; the CCP plan addresses member language needs beginning with the Welcome section of the Member Handbook. Member materials are produced in English and Spanish and other language or format requests are accomplished through translation, interpreters, or appropriate accessible formats. The health plan contracts with Centene's language line vendor enabling Plan staff to communicate in the member's primary language via phone and in person, and is available 24 hours a day, 7 days a week, at no charge to the member. The Quality Improvement Committee (QIC) develops and annually updates a CCP that addresses the cultural, linguistic, and disability access needs identified in the population assessment and the Chief Medical Director is responsible for oversight of the CCP, including annual approval of the CCP.

The CCP addresses, at a minimum, the Plan's strategy for recruiting staff with backgrounds representative of Enrollees served; the availability of interpretive services; the availability of transportation services; Plan's ongoing strategy to meet the unique needs of Enrollees who have developmental disabilities and cognitive disabilities and its operation; Plan's ongoing strategy to provide services for home-bound Enrollees and the strategy's operation; Plan's ongoing strategy to engage local organizations to collaborate on initiatives to increase and measure the effectiveness of

culturally competent service delivery and its operation; and standards and performance requirements for the delivery of culturally and linguistically appropriate health care services.

In 2019 the health plan hired a Member Advocate in Customer Service who works closely with the LTSS Member Advocate and BH Member Advocate to assist members with needs related to housing, food, community resources, navigating the healthcare system and with any cultural or linguistic needs. Additionally, a Cultural Competency and Disability Awareness webinar training was offered to Network Providers on a quarterly basis instead of annually.

Delegation

Sunflower from Ambetter utilizes National Imaging Association (NIA), providing High Tech Imaging & Therapy, and Envolve Pharmacy Solutions (EPS), for delegated activities. Both NIA and EPS are NCQA accredited.

Committee Structure

Quality is integrated throughout the Plan, and represents the strong commitment to the quality of care and services for members and providers. To this end, the Plan has established various committees, subcommittees, and ad-hoc committees to monitor and support the QAPI Program. The Board of Directors 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 Board of Directors oversee development, implementation and evaluation of the QAPI Program. The BOD has ultimate authority and accountability for oversight of the quality of clinical and non-clinical care and services provided to Members. The Board of Directors report to the Centene Board of Directors, as the Plan is a wholly owned subsidiary of Centene Corporation. The Board supports the QAPI Program by:

- Adopting the initial and annual QAPI Program and establishing mechanisms for monitoring and evaluating quality, utilization, and risk;
- Supporting recommendations from the Quality Improvement Committee for proposed quality studies and other QI initiatives;
- Providing the resources, support and systems necessary for optimum performance of QI functions;
- Designating the Chief Medical Director (CMD) as 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 committee meets on a quarterly basis, at a minimum. For 2019, QIC met a total of six (6) times which included the quarterly meetings and two 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 2019. Typically, the Credentialing Committee meets monthly and on an ad-hoc basis.

Pharmacy and Therapeutic Committee
The Pharmacy and Therapeutics (P&T) Committee is a standing subcommittee of the QIC and is responsible for administering the routine oversight and operating authority of the Pharmacy Program. The QIC is the vehicle through which communication of pharmacy monitoring and reporting activities occurs with the Board of Directors. The P&T Committee ensures the plan provides a high quality, cost effective preferred drug list (PDL), an effective pharmacy program, and addresses quality and utilization issues related to pharmaceutical prescribing patterns, practices, and trends for Ambetter. The P&T Committee is a multidisciplinary team composed of the Associate Medical Director, Pharmacy Director, network physicians, network pharmacist, and other executive staff. For 2019, 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 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 the Plan's Chief Medical Director, Medical Director(s), the Vice President of Medical Management, and other operational staff, as needed. Network physicians also participate in this committee to provide input on process, policies and data. For 2019, the UM Committee met four (4) times. Typically, the UM Committee meets quarterly.

Quality Measures Committee (previously HEDIS Steering Committee)
The Quality Measures 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 Quality Measures 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 Quality Measures Committee meets quarterly and met four (4) times in 2019.

Grievance and Appeals Committee
The Grievance and Appeals Committee (GAC) is a subcommittee of the QIC and is responsible for tracking and analysis of member grievances and appeals including type, timeliness of resolution, performing barrier and root cause analysis, and making recommendations regarding corrective actions as indicated. The GAC is composed of the Plan'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 2019.

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 Medical Director. This committee includes participation by both network physicians and health plan medical directors. The PRC members utilize their clinical judgment in assessing the appropriateness of clinical care and recommending a corrective action plan that will best suit the particular provider's situation. For 2019, PRC for Physical Health met on one (1) occasion to review cases and make recommendations as appropriate. For the Behavioral Health PRC, that group met zero (0) times in 2019.

Performance Improvement Team
The Performance Improvement Team (PIT) is an internal, cross-functional quality improvement team that facilitates the integration of a culture of quality improvement throughout the organization. The PIT is responsible for gathering and analyzing performance measures, performing barrier and root cause analysis for indicators falling below desired performance, and making recommendations regarding corrective actions/interventions for improvement. The PIT is also responsible for overseeing the

implementation of recommended corrective actions/interventions from the QIC and/or its supporting subcommittees, monitoring the outcomes of those improvement efforts and 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 2019, with several subcommittee meetings of the PIT to address items such as the member experience survey, QRS and Stars initiatives. Multiple subcommittees report to the PIT. The PIT typically meets monthly.

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 2019, the work group met on twelve (12) occasions.

Ambetter Quality Workgroup
The Ambetter Quality Workgroup is unique to the Marketplace line of business and operationalizes the identification of improvement opportunities, specific objectives, the selection and implementation of improvement activities focused on HEDIS and CAHPS. Ambetter Quality Workgroup (AQW) is unique to the Ambetter line of business working to identify improvement opportunities, specific objectives, barriers, and steps to mitigate barriers. The workgroup is also responsible for selection and implementation of improvement activities. The workgroup includes cross-functional leaders (e.g., Compliance, Member Services, Utilization Management, Contracting, Provider Services, Medical Management, Quality Improvement), as well as employees who conduct or directly supervise the day-to-day activities related to clinical and operational improvement initiatives. A primary responsibility of the AQW is to ensure compliance with, and achieves optimal performance on all required and identified performance measures. To monitor success in the implementation of each intervention, monitoring rates monthly, and determining if initiatives were successful or not, then pursuing other opportunities for impact. Root cause analysis is another avenue utilized to determine opportunities. The QI Senior Leader or designee chairs this workgroup. The workgroup meeting frequency is quarterly or more often as necessary and reports to PIT. This workgroup met three (3) times in 2019.

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 2019
National Imaging Association	12
Envolve Pharmacy	4
Logisticare	12
EPC DM / NAL	12
Envolve Dental	4
Envolve Vision	4

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 2019, there were 24 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 2019, this committee convened one (1) 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 the Plan'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 Behavioral Health Medical Director or director level plan staff. The meetings occur on a quarterly basis. This committee reports off to the PIT committee. In 2019, this committee met four (4) times: March, June, Sept, and December.

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 2019. 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, nt formal reporting structure) (3)
- Senior Director, QI (Nurse) (1)
- Managers, QI (3)
    - Accreditation (Social Worker)
    - Performance Improvement (Nurse)
    - HEDIS (Social Worker)
- EPSDT Coordinator (Nurse) (1)
- Accreditation Specialist (Social Worker) (1)
- QI, Project Manager (2)
- QI, Care Manager (1)
- QI, Specialist (3)
- QI, Coordinator (3) (one is a Nurse)
- Senior QI Specialist (1)
- RA, Coding Analyst (1)
- RA, Member Coordinator (2)
- QI Administrative Assistant (1)
- Centene Corporate support

Quality Leadership in 2019

The plan Chief Medical Director served as the SEQI and provided continued leadership and oversight of QI. There was turnover of six (6) staff persons in 2019 in the QI Department. The turnover was attributed to one staff member seizing an opportunity to join a Centene sister health plan, one joined the Centene Corporate team, two retired, and one leaving due to a sudden and impactful family loss. Two of these positions were filled with new team members in 2019, with four positions remaining open at the close of the calendar year. 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 2019, the employment positions at the Plan 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.

Quality and Utilization Program Effectiveness

Objectives

Ambetter'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.

2019 Quality Improvement Strengths and Accomplishments

- Quality Improvement leadership includes two 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 MY2019.

- 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
- Monitored implemented Contract Amendment 33 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.
- Monitoring Medicaid Member grievance resolution TAT for 2019
- Monitoring Medicaid Member standard appeal resolution TAT for 2019
- Monitored Care Management activities
- Participated in member outreach health fairs/community events.
- Participated in provider conferences and seminars, presenting and providing information or as a conference participant.
- Envolve People Care’s Disease Management demonstrated active health coaching

- The Sunflower Customer Services/Provider Services call center provides education and referral services to members and providers. The call center received and responded to calls 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 value added services to our membership including in-lieu of services.
- 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.
- Added Provider Profile Reminders as an 'end of year push' initiative
- 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"
- Lab2U partnership to help close care gaps with in home testing option for Hemoglobin A1c testing.
- Implemented and automated GAC based reporting including UM denial and AIRS (Adverse Incident Reporting).
- Continued 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.
- Implemented text messaging technology to engage members and assist in care gap closure on 3 measures for Medicaid.

2019 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.
- Sunflower continues to work on P4P interventions for 2020.
- 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.

Population Characteristics

Member Demographics and Service Area

Ambetter from Sunflower started providing services to members in Kansas on January 1, 2018 in Johnson and Wyandotte counties. In 2019, Ambetter expanded to Leavenworth and Miami Counties. The Ambetter plan offered four levels of service members could select participation in, through Ambetter. There were 22,740 members in total, who selected Ambetter from Sunflower for their benefits. The following tables depicts the selected levels, as well as an age and gender breakdown for the Ambetter membership.

Ambetter Product	2018	2019
Gold Secure Care	966	4,372
Silver Zero Cost Share	84	1,350
Bronze Essential Care	5,478	16,919
Silver Balanced Care	11,089	99
Total	**17,617**	**22,740**

Age Group	2018	2019*
0-10	5%	6%
11-20	8%	8%
21-30	15%	17%
31-40	15%	16%
41-50	16%	16%
51-60	23%	21%
61-70	15%	16%
71-80	1%	1%
81-90	1%	0%
91+	1%	0%

*Rounding results may not equal 100%

Gender	2018	2019
Male	46%	44%
Female	54%	56%

Membership Characteristics

Ambetter membership increased by 5,123 from 2018 to 2019, with 74% of Ambetter members selecting the Bronze Essential Care product. The age group of 51-60 continue to represent the highest number of Ambetter members, with 21% of membership being in this category. Female membership continues to be higher than male membership within Ambetter. The female membership increased to 56%, while the male membership dropped to 44%.

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 Upper Respiratory Infection*, *Acute Pharyngitis*, and *Pediatric Body Mass Index, 5th percentile to less than 85th percentile for age*. For adults, *Adult Exam with Abnormal Findings* was the top diagnosis, followed by *Immunization Encounter and Essential Primary Hypertension. Encounter for Gynecological Examination* was the fourth most used diagnosis, followed by *Mammogram Screening* as the fifth top diagnosis for the Ambetter product line.

From a behavioral health standpoint, *Anxiety Disorder Unspecified* and *Generalized Anxiety Disorder* were the top two diagnosis for both the adult and child population. *ADHD Unspecified Type, ADHD Inattentive Type,* and *ADHD Combined Type* were the third, fourth, and fifth top diagnosis for children, respectively. For adults, *Major Depressive Disorder* was the third most common diagnosis, followed by *Nicotine Dependence Cigarettes* and *Nicotine Dependence Unspecified Uncomplicated* as the fourth and fifth top diagnosis for behavioral health. The following tables show the top diagnosis for adult and child members, regarding physical health and behavioral health

2019 Top Diagnosis

Top 5 Medical Diagnosis Child (Ages 0 - 18) Range: January 1, 2019 - December 31, 2019		
Diagnosis Code	**Diagnosis**	**# Unique Member**
Z00129	ENC RTN CHLD HLTH EX W/O ABNRM FIND	1,010
Z23	ENCOUNTER FOR IMMUNIZATION	936
J069	ACUTE UP RESPIRATORY INFECTION UNS	223
J029	ACUTE PHARYNGITIS UNSPECIFIED	223
Z6852	BODY MASS INDX PED 5TH% < 85TH% AGE	181

Top 5 Medical Diagnosis Adult (Ages 19+) Range: January 1, 2019 - December 31, 2019		
Diagnosis Code	**Diagnosis**	**# Unique Member**

Top 5 Medical Diagnosis Adult (Ages 19+) Range: January 1, 2019 - December 31, 2019		
Z0000	ENC GEN ADULT EXAM W/O ABNORM FIND	5,547
Z23	ENCOUNTER FOR IMMUNIZATION	4,098
I10	ESSENTIAL PRIMARY HYPERTENSION	4,003
Z01419	ENC GYN EX GEN RTN W/O ABNORM FIND	2,594
Z1231	ENC SCR MAMMO MALIG NEOPLASM BREAST	2,534

Top 5 Behavioral Health Diagnosis Child (Ages 0 - 18) Range: January 1, 2019 - December 31, 2019		
Diagnosis Code	**Diagnosis**	**# Unique Member**
F419	ANXIETY DISORDER UNSPECIFIED	58
F411	GENERALIZED ANXIETY DISORDER	55
F909	ADHD UNSPECIFIED TYPE	44
F900	ADHD INATTENTIVE TYPE	42
F902	ADHD COMBINED TYPE	39

Top 5 Behavioral Health Diagnosis Adult (Ages 19+) Range: January 1, 2019 - December 31, 2019		
Diagnosis Code	**Diagnosis**	**# Unique Member**
F419	ANXIETY DISORDER UNSPECIFIED	1,625
F411	GENERALIZED ANXIETY DISORDER	1,319
F329	MAJ DEPRESS D/O SINGLE EPIS UNS	1,088
F17210	NICOTINE DEPEND CIGARETTES UNCOMP	651
F17200	NICOTINE DEPEND UNS UNCOMPLICATED	571

Languages Spoken by Members

The Plan assesses members' linguistic needs based on the member reporting, requesting members of their primary language spoken. The Plan noted that English is reported as the primary language in 97% of our Ambetter population. Spanish is reported as the 2nd highest reported language spoken by our Ambetter members. A detailed breakdown of other less common languages is also noted in the following table.

Languages Spoken by Members

Language	Member Count	% of population
English	23,594	97.29%
Spanish	382	1.58%

Languages Spoken by Members

Language	Member Count	% of population
Chinese	120	0.49%
Vietnamese	80	0.33%
Korean	31	0.13%
Russian	13	0.05%
Hindi	11	0.05%
Gujarati	8	0.03%
Arabic	5	0.02%
French	3	0.01%
Portuguese	2	0.01%
Urdu	1	0.00%

Ambetter offers language assistance services to members who require translation services. Services are available for both telephonic and on-site interactions. The Plan Care Management, Customer Service, or Provider/Practitioner staff arranges these services. The Plan also has Spanish-speaking Care Management, Customer Services Representatives and Quality Improvement staff available. The Ambetter Customer Service Supervisor and Call Quality Analyst are also Spanish speaking, to ensure Spanish-speaking members receive appropriate services by the health plan, as Spanish is the highest utilizer of language line requests for the Ambetter membership. The following table represents the top languages for which Ambetter members have requested translation services by unique telephonic interactions from January 1, 2019 through December 31, 2019.

Language Service Line Requests

Language	Number of calls	Percentage of Total
Spanish	461	65.67%
Mandarin	54	7.69%
Vietnamese	46	6.55%
Arabic	18	2.56%
Korean	18	2.56%
Farsi	13	1.85%
Telugu	11	1.57%
Hindi	10	1.42%
Russian	10	1.42%
Burmese	9	1.28%
Haitian Creole	8	1.14%
Persian	6	0.85%
Amharic	5	0.71%
Ethiopian	5	0.71%
Punjabi	5	0.71%
Bengali	3	0.43%

Language Service Line Requests

Brazilian Portuguese	3	0.43%
Cantonese	3	0.43%
Lingala	2	0.28%
Nepali	2	0.28%
Urdu	2	0.28%
French	1	0.14%
Gujarati	1	0.14%
Indonesian	1	0.14%
Mandinka	1	0.14%
Pashto (Afghanistan)	1	0.14%
Polish	1	0.14%
Tigrigna (Eritrea)	1	0.14%
Azerbaijani	1	0.14%

Race/Ethnicity

The 2019 Qualified Health Plan Enrollee Experience (QHP EES) survey was the first survey administered to the Ambetter population. The QHP EES data, regarding race and ethnicity, is a combination of adult and child responses. Of the 304 QHP respondents, 75% reported being White, 8.6% as Black or African-American, and 7.5% of respondents reported as Hispanic or Latino descent. The QHP EES did not capture racial/ethnicity data for Asian, Native Hawaiian or other Pacific Islander, and American Indian or Alaska Native. The table below reflects member responses on race and ethnicity to the 2019 QHP EES.

QHP Enrollee Experience Race/Ethnicity

White	75.0%
Black /African American	8.6%
Hispanic / Latino*	7.5%
Asian	-
Hawaiian / Pacific Islander	-
American Indian / Alaskan	-
No race indicated	10.9%
Other	10%

*Percentages may not total 100% as “Hispanic/Latino” is evaluated separately in QHP as an Ethnicity rather than Race

Quality Performance Measures and Outcomes

NCQA Accreditation

The Plan received the NCQA Accreditation status for the Ambetter from Sunflower line of business from the National Committee for Quality Assurance (NCQA), effective in December of 2018. The Plan submitted an NCQA Accreditation First Survey for the Ambetter from Sunflower Marketplace line of business on February 18, 2020. The results from the survey were not

available at the time of this report. The Plan will include the survey results in the 2020 QAPI Program Evaluation.

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

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

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

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

The Plan continues to work with corporate resources to improve performance in these domains. Ambetter strives for continuous NCQA readiness, which involves ongoing review of all plan and quality improvement processes to be consistent with NCQA standards. Continued focus on opportunities for refinements made to hardwire accreditation compliance into processes including development of a process for policy review, and training of new staff on documentation requirements. In 2019, readiness reviews/audits, and ongoing health plan NCQA education and reminders, continued. Plan has a Manager of Quality Improvement and an Accreditation Specialist for NCQA accreditation efforts to ensure the plan has a focus on continued readiness for the Ambetter from Sunflower Marketplace line of business. Plan also works very closely with corporate resources to maintain NCQA compliance and readiness.

Healthcare Effectiveness Data Information Set (HEDIS®)

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

HEDIS Indicators

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

The Plan has been collecting data for Ambetter since January 2018, and loading the information into its certified-HEDIS software. The Plan focuses efforts to improve on HEDIS measures by factoring in those that are required for NCQA accreditation, and those that have Star ratings. Due to timing of this

report, the final results will not be available until the final HEDIS 2020 results are available. Results will likely be in July of 2020.

Childhood Immunizations
For Ambetter, the Plan utilizes immunization data from the Kansas State Immunization Registry or WebIZ as supplemental data. This data utilization started in 2018 by the Plan. The Plan uses the auditor approved CDC mapping table for the CVX immunization codes, in order to map them over from WebIZ to allow translation to the CPT codes for acceptance in our HEDIS software. Several interventions target these members during 2019. The interventions are below.

Childhood Immunizations Interventions for 2019 were:

- Alerts for Customer Service Representatives and Medical Management to indicate members who have care gaps and can remind them of the need for an appointment and/or assist with making one along with treatment, if needed
- Birthday card mailings
- Start Smart for Your Baby Program – outreach to parents of newborns to educate on Periodicity schedule
- Proactive Outreach Management (POM) calls made to parents/guardians of children to remind them of schedule for well-child visits, including immunizations
- HEDIS Quick Reference Guide distribution to new providers and annual updates to existing providers with ICD-10 updates
- Provider EPSDT Reference Kit developed and distributed to high volume providers
- Obtaining WebIZ Immunization Registry data, Web-IZ data pulls for CIS were completed in January, February, March, April, May, June, July, August, September, October, November and December.

The following table demonstrates the Plan's current Ambetter administrative results related to the HEDIS measures on Childhood Immunizations. Combo 3, evaluates compliance with completion of four diphtheria, tetanus, and pertussis (DTaP); three inactivated poliovirus (IPV); one measles, mumps, and rubella (MMR); three Haemophilus influenza type B (HiB); three hepatitis B; one varicella-zoster virus (VZV); and four pneumococcal conjugate vaccinations on or before the child's second birthday . Ambetter's total denominator for this population was nine (9) members in 2018, and the denominator in 2019 went up to thirty six (36) total members. It is important to note that the final HEDIS 2020 rate is not available at the time of this report; therefore, an administrative rate is in the following table.

HEDIS MEASURE	HEDIS 2019 (MY2018) Hybrid	HEDIS 2020 (MY2019) Admin*
DTaP Immunizations	62.50	58.33
H Influenza Type B Immunizations	87.50	69.44
Hepatitis B Immunizations	75.00	55.56
Influenza Immunizations		58.33
Measles, Mumps and Rubella Immunizations	100.00	86.11
IPV Immunizations	87.50	69.44
Pneumococcal Conjugate	87.50	55.56
Chicken Pox (VZV)	100.00	86.11

HEDIS MEASURE	HEDIS 2019 (MY2018) Hybrid	HEDIS 2020 (MY2019) Admin*
Combo 3	50.00	47.22

**Awaiting HEDIS 2020 Final Hybrid Rates*

The Plan is continuing to analyze data for opportunities to improve on compliance with vaccination completion. However, the Plan recognized from HEDIS data for HEDIS 2019, that it is common for the child to complete the vaccines, but often after their second birthday. This does not demonstrate compliance with the technical specifications. Therefore, the Plan will continue to educate on the importance of completing prior to the child's second birthday. In addition to continuing many of the 2019 interventions in 2020, the Plan will also continue to explore opportunities to expand partnerships with more health departments and providers, to close care gaps on childhood immunizations.

Adolescent Immunizations

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

Adolescent Immunizations Interventions for 2019 were:

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

The following table provided, demonstrates Plan current administrative results related to the HEDIS measures on Ambetter Adolescent Immunizations. Combo 2 evaluates compliance with completion of all suggested adolescent immunizations. Ambetter's total denominator for this population was fifteen (15) members in 2018; the membership went up in 2019 totaling seventy (70) members. It is important to note that the final HEDIS 2020 rate is not available at the time of this report; therefore, an administrative rate is in the table.

HEDIS MEASURE	HEDIS 2019 (MY2018) Hybrid	HEDIS 2020 (MY2019) Admin*
Meningococcal	46.67	54.29
Tdap	53.33	62.86

HPV	26.67	21.43
Combo 2	26.67	21.43

**Awaiting HEDIS 2020 Final Hybrid Rates*

The Plan reviewed the data from Adolescent Immunizations interventions in 2019 and determined a knowledge gap was common related to the HPV vaccination. Additionally, missed opportunities proved to be a barrier with care gap closure for adolescent immunizations. Therefore, the Plan will continue many of the interventions utilized in 2019 for 2020 while also continuing to explore methods to increase knowledge and understanding of the benefits the Tdap, Meningococcal, and HPV vaccinations offered to adolescents. The Plan will also explore additional partnerships with health departments as well as other providers on closing those care gaps and determining where there are opportunities to expand provider payment incentives.

Comprehensive Diabetes Care

The Plan worked on this HEDIS measure and its sub measures in 2019, for Ambetter members, to help members have a better understanding of diabetes. This includes the importance of routine monitoring, proper diet, and exercise all aimed at helping to improve their management of diabetes. All of the items can help potentially lessen or avoid complications that result from diabetes. These efforts included continued partnership with Envolve Benefit Option for the Eye Exam sub measure. Sunflower partnered with USMM, to perform in home visits for Sunflower diabetic members. 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 an Envolve Benefit Option staff member. 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.

Comprehensive Diabetes Care Interventions for 2019:

- Envolve Benefit Option HEDIS Outreach - Diabetic Retinopathy Exam sub-measure; monthly progress reports starting in July of 2016 and continued through 2019
- My Health Pays Program Incentives
- Medical Management performs outreach to non-compliant members and diabetic members in Care Management
- Customer Service and Medical Management training on measure to discuss care gaps with members on calls; reminders sent prior to care gap reports going out to members
- Use of KRAMES educational materials to educate members about diabetes care
- Envolve Benefit Option provides outreach to non-compliant members and offering member lab draws in the member's home, as well as BMI and blood pressure measurements
- Provider profiling report based first on attribution then assignment were distributed to providers of non-compliant members
- Provider scorecards for Sunflower P4P providers 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.
- Partnerships with FQHC's to close member care gaps

The following table provided demonstrates results related to the **Ambetter** Comprehensive Diabetes Care HEDIS measure. It is important to note that the final HEDIS 2020 rate is not available at the time of this report. Those results will be available in July 2020.

Ambetter HEDIS MEASURE	HEDIS 2019 (MY2018) Hybrid	HEDIS 2020 (MY2019) Admin*
CDC- Eye Care	31.39	31.18
CDC- HbA1c Adequate Control (<8%)	41.85	34.84
CDC- Monitoring for Nephropathy	94.65	89.78

**Awaiting HEDIS 2020 Final Hybrid Rates*

The Plan analyzed HEDIS data in 2019 to determine where opportunities exist to improve compliance with CDC measures. Member knowledge, understanding, and education continues to be a focus that the Plan continues to work on to address this barrier. In order to improve member engagement on these measures, the members have to have the knowledge and understanding of the significance for the testing. The knowledge and understanding will allow the appropriate treatment of their disease, which also promotes delaying progression of their diabetes and the complications that may result. The Plan will continue to analyze the interventions implemented in 2019, as well as continue to explore options for expanding partnerships with providers.

Timeliness of Prenatal Care

The Plan worked on this HEDIS measure and its sub measures in 2019, for Ambetter members, to help them have a better understanding of the importance of prenatal and postpartum care. This includes the importance of regular prenatal visits, quitting smoking or drinking alcohol, and taking supplements. Regular prenatal visits can help the member doctor monitor the pregnancy, along with assist in identifying any problems or complications before they become serious. All of these talking points can help ensure the health and safety for the member and their baby.

Timeliness of Prenatal Care Ambetter Interventions for 2019:

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

The following table provided demonstrates results related to the Ambetter Timeliness of Prenatal Care HEDIS measure. It is important to note that the final HEDIS 2020 rate is not available at the time of this report. The results will be available in July 2020.

HEDIS MEASURE	HEDIS 2019 (MY2018) Hybrid	HEDIS 2020 (MY2019) Admin*
Timeliness of Prenatal Care	67.50	53.47

**Awaiting final HEDIS 2020 rates*

The Plan continues to explore opportunities for improvement on Ambetter's Timeliness of Prenatal Care, which includes addressing barriers like member knowledge deficits, provider opportunities and transportation issues. The Plan will continue to monitor the impact of the Prenatal Care Provider

Payment Incentive arrangement for impact on completion of the Notice of Pregnancy and timely completion of the first prenatal visit. This intervention began in 2018 with planned continuation through 2020. In addition, the Plan will continue to utilize a variety of interventions in 2020 with the goal of furthering timeliness completion of the first prenatal visits.

Additional HEDIS Measures
Additional HEDIS measures that the Plan focused on in 2019 were Breast Cancer Screenings, Cervical Cancer Screenings, Adult Access to Preventive/Ambulatory Health Services, and Well Child 34. Those measures and their interventions are below.

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

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

Cervical Cancer Screening (CCS) Interventions for Ambetter:

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

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

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

The following table provided demonstrates results related to the Ambetter Cervical Cancer Screening, Breast Cancer Screening, and Well Child 3-6 HEDIS measures. It is important to note that the final HEDIS 2020 rate is not available at the time of this report. The results will be available in July 2020. The table states the administrative data for HEDIS 2019, as this is the baseline year for Cervical Cancer Screening and Well Child 3-6. However, HEDIS 2020 is the baseline year for Breast Cancer Screening due to the continuous enrollment factor, stated in the HEDIS Technical Measure Specifications. It is also important to note that while we are showing our rate at 100%, for Breast Cancer Screening, this high rate is due to the denominator totaling three (3) eligible members. This number should increase in Measurement Year 2020.

HEDIS MEASURE	HEDIS 2019 (MY2018) Final Admin Rate	HEDIS 2020 (MY2019) Admin Rate*
Cervical Cancer Screening	24.89	40.08

Well Child 3-6	64.36	68.18
Breast Cancer Screening	No Eligible Members	100.00

**Awaiting final HEDIS 2020 rates*

Patient Safety

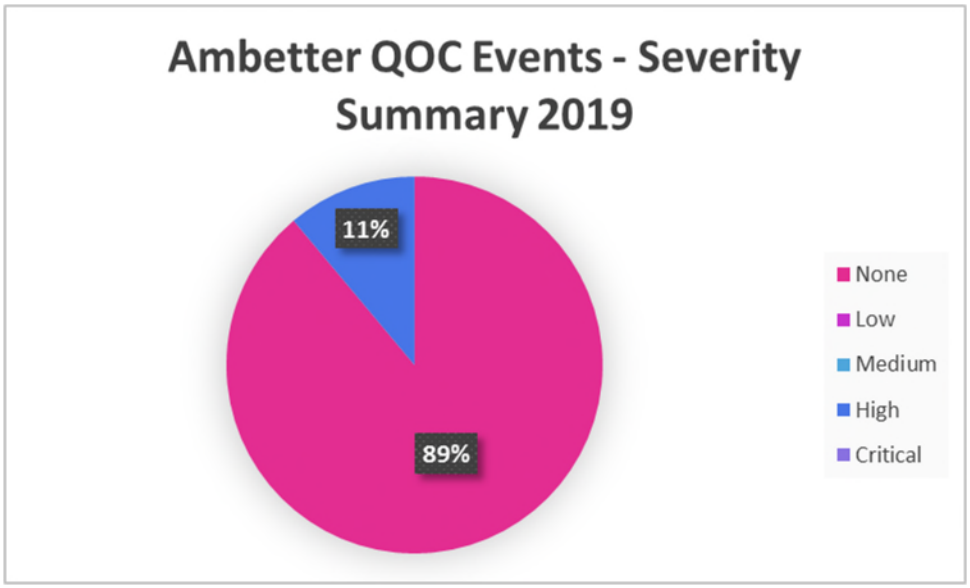
Quality of Care

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

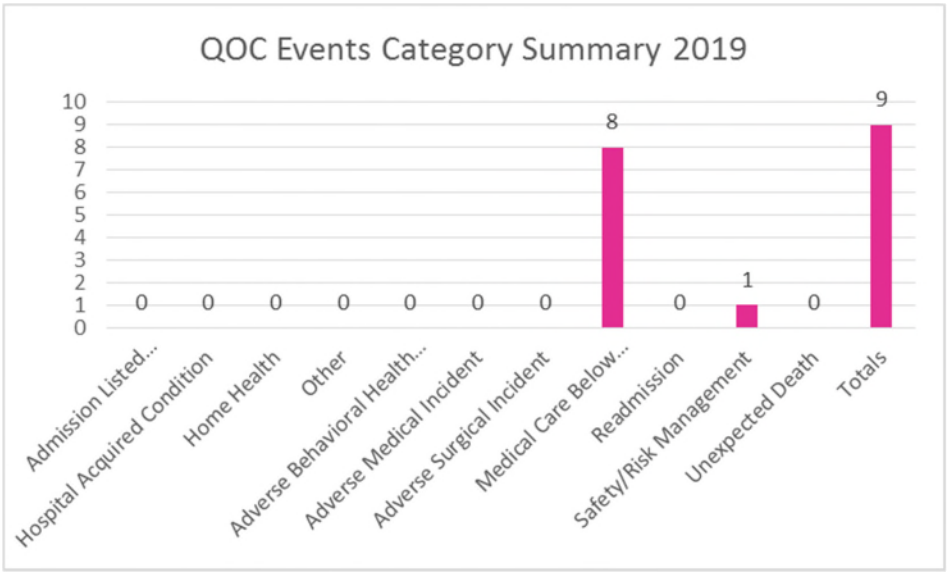
Quality of care events include but are not limited to the following:

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

The Plan reviews events both at an aggregate and provider/facilty level. The following graphics show the type and severity of QOCs reviewed by the Plan in 2019. As noted in the first graphic, the Plan's data on QOCs demonstrates 89% of the cases (8) referred for review as potential QOC were determined to not meet the criteria for a QOC. There were 11%, or 1 QOC reviewed, that had a final severity level of high. The second graphic provided depicts the severity level results from the cases refered as potential QOC events. The final severity levesl are based on the review of records provided to the Plan. This allowed for the reviewer to determine if there was a QOC concern and subsequently assign a severity level.



There were nine (9) **Ambetter** QOC events completed in 2019. The volume of QOCs was low given the total membership for the year being 22,644. Eight (8) out of the nine (9) fell into the *Medical Care Below Standard* category, as noted on the following graphic. There were no providers identified with three (3) or more potential QOC events for the year.



Member Satisfaction

Member Grievances

The Plan's Grievance & Appeal Committee and Quality Improvement Committee review grievance and appeal data on a quarterly basis. Analysis occurs at the Quality Improvement Committee, which is composed of departmental leaders and network physicians and enables the Plan to initiate quality improvement efforts to improve member satisfaction as needed. The following is a summary of the results and analysis for January 1, 2019 through December 31, 2019.

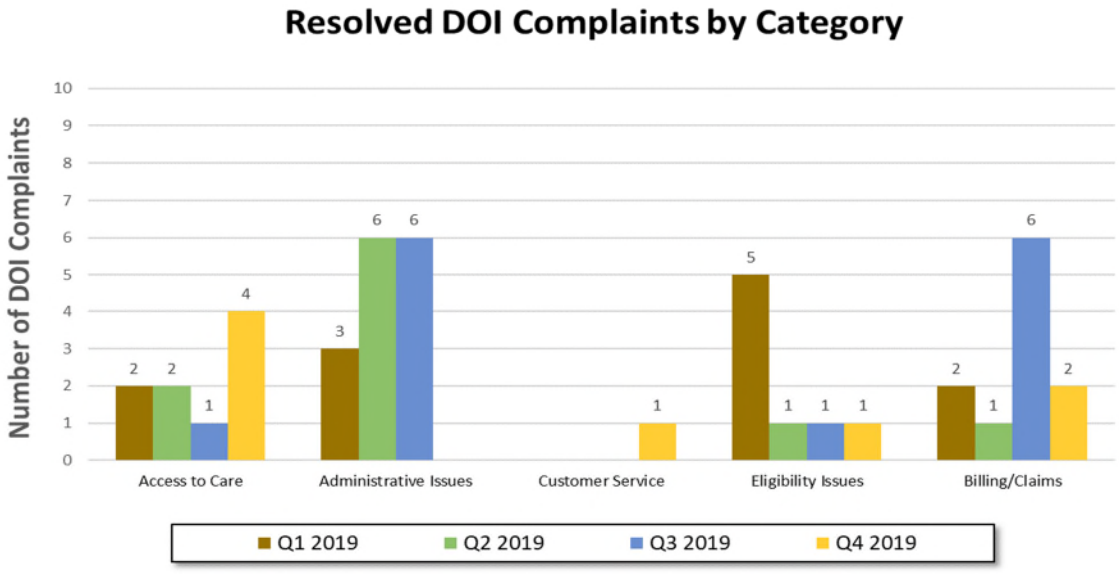
The following table below represents the member grievances totals by category in accordance with corporate and NCQA guidelines and then per 1000 members for 2019. The grievance category with

the highest volume was Billing/Financial at 71.7%. In review of these grievances, results show the most common financial issue was in regards to non-PAR provider balance-billing members. Attitude/Service – Health Plan was the second leading category at 14.3% which is a decrease from 2018.

Member Grievance Category	2019	2019 per 1000
Access to Care	30	1.32
Attitude/Service - Health Plan	49	2.16
Attitude/Service - Provider	8	0.35
Billing/Financial	246	10.86
Practitioner Office Site Quality	0	0
Delegated Vendor/Service	5	0.22
Quality of Care Issue	5	0.22
Total	**343**	**15.14**

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

The graph below demonstrates the Department of Insurance (DOI) Complaints by category for the entire year of 2019. There were 41 complaints, which shows a decrease from 2018. The category with the highest volume for 2019 was Administrative Issues with 15 complaints. The category encompasses a broad spectrum of complaint reasons. Some examples of the type of complaint that would fall into this category are members who had their policy cancelled after not making their premium payments, issues with the member services phone system and complaints regarding provider set up issues.



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

The following table demonstrates the Member Appeals resolved by category for the entire year of 2019, as well as the per 1000 calculation. The categories noted below are in accordance with corporate and NCQA guidelines.

Member Appeal Reasons	2019	2019 per 1000
Claim Dispute	9	0.4
ER - Out of Plan/OON	1	0.04
Inpatient - Admission	13	0.57
RX - Does Not Meet PA/Exceptions	115	5.1
RX - Off Label	6	0.26
RX - Not Covered per Benefit Plan	1	0.04
Surgical - Gastric Bypass	0	
Hospital - Other	0	
Administrative	0	
Surgery	5	0.22
Therapy	0	
Home Health	0	
Durable Medical Equipment (DME)	37	1.63
Outpatient Procedure	18	0.8
Facility (SNF)	0	
Consultation	3	0.13
Behavioral Health Service	3	0.13
Diagnostic	3	0.13

For 2019, *RX – Does Not Meet PA/Exception* made up the majority of the member appeals at 115 or 53.7% of the total member appeals. Of those 115 appeals, 64 or 55.65% were overturned on appeal which is consistent with what was seen in 2018. The second highest category for appeals is Durable Medical Equipment (DME) with 37 or 17.3%. Review of appeals data occurs on a monthly basis and education occurs with the identification of trends.

In 2019, 56% of member appeal decisions were reversed and 43% upheld on appeal. The Plan will continue to provide education to providers and encourage them to submit required documentation with the initial request for services/authorizations.

Member Satisfaction Survey
Ambetter conducted a Qualified Health Plan Enrollee Experience (QHP EES) survey for the Marketplace population to evaluate and compare health plan ratings by members. Ambetter strives to understand the problems members face in order to implement actions to achieve better performance on specific opportunities for improvement identified by the QHP EES.

Ambetter contracted with SPH Analytics, an NCQA-certified survey vendor, to conduct the QHP EES Adult and Child survey for Sunflower Marketplace members.

The overall objective of the QHP EES survey is to capture accurate and complete information about member-reported experiences with health care. Specifically, the survey aims to measure how well Sunflower is meeting members' expectations and goals; to determine which areas of service have the greatest effect on members' overall satisfaction; and to identify areas of opportunity for improvement, which assists Ambetter in improving the quality of care and service provided to its members.

The 2019 Summary of Key Measures and Key Drivers, as well as the current summary rate percentages, are listed in the table below.

Composite & Question Ratings	2019 Rate
Access to Care	**53%**
• Getting care as soon as needed	59%
• Getting appointment as soon as needed	56%
• Easy to get care believed necessary	55%
• Easy to get appointment with specialist	41%
Cultural Competence	**54%**
• Got interpreter when needed	NR
• Forms available in preferred language	79%
• Forms available in preferred format	65%
Care Coordination	**66%**
• Doctors have records/ information about care	81%
• Doctor office provides test/ x-ray results	71%
• Receive test/ x-ray results when needed	69%
• PCP informed of specialist care	52%
• PCP discuss Rx taken with you	74%
• PCP office helps manage care	55%
Access to information	**32%**
• Provide information on how plan works	32%
• Find out payment before service/equipment	31%
• Find out payment for Rx	32%
Plan Administration	**49%**
• Got information or help needed	45%
• Treated you with courtesy and respect	72%
• Wait time for customer service longer than expected	45%
• Forms easy to fill out	42%
• Health plan explains purpose of forms before filled out	42%
Overall Ratings	
Rating of Health Plan	**72%**
Rating of Health Care	**80%**
Rating of Personal Doctor	**88%**
Rating of Specialist	**82%**

This is the baseline year for the Marketplace QHP EES survey. Areas of focus for improvement are Access to Information, with all subcategories rating either 31 or 32 percent.

Behavioral Health Survey

Ambetter 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. Ambetter 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, Ambetter utilizes the survey results as a data source for other performance improvement initiatives throughout the year.

The sample size for the 2019 Marketplace Adult survey consisted of 465 members. The 465 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). From the 456 members, 80 valid surveys were completed. The surveys were completed by either mail or telephone. After adjusting for ineligible/non-responding members, the survey response rate was 17.2%.

The sample size for the 2019 Marketplace Child survey consisted of 24 members. The 24 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). From the 24 members, 10 valid surveys were completed. The surveys were completed by either mail or telephone. After adjusting for ineligible/non-responding members, the survey response rate was 41.7%.

BH Survey Response Rate

Survey Population	2019 Response Rate
Marketplace Adult	17.2%
Marketplace Child	41.7%

The 2019 Composite and Question scores for Ambetter's adult and child surveys are presented in the following tables.

Marketplace Adult Behavioral Health

Topics & Question Ratings	2019 Rate
Treatment (% Strongly Agree/Agree)	**NA**
• Location of services was convenient	86
• Able to get needed services	79
• Able to see a psychiatrist when wanted	77
• Felt comfortable asking questions about treatment and medication	92
• Felt free to complain	83
• Given information about rights	92
• I, not staff, decided my treatment goals	77
• I was encouraged to use consumer-run programs	65
Staff (% Strongly Agree/Agree)	**NA**
• Willing to see me as often as necessary	87
• Returned calls within 24 hours	84
• Were available at convenient times	87
• Believe I can grow, change and recover	87
• Encouraged me to take responsibility for how I live my life	84

Marketplace Adult Behavioral Health

Topics & Question Ratings	2019 Rate
• Told me what side effects to watch out for	81
• Respected wishes about who can receive information about my treatment	96
• Sensitive to my cultural background	87
• Provided information to allow me to take charge of my illness	88
Perceived Improvement (% Strongly Agree/Agree)	**NA**
• Deal more effectively with daily problems	76
• Better able to control my life	79
• Better able to deal with crisis	74
• Get along better with family	76
• Do better in social situations	70
• Do better in school/work	72
• Housing situation has improved	55
• Symptoms not bothering me as much	65
• Happy with friendships	78
• Have people with whom to do enjoyable things	78
• Belong in a community	70
• Have needed support in case of crisis	83
• Do things that are more meaningful	77
• Better able to take care of needs	82
• Better able to handle when things go wrong	81
• Better able to do things I want to do	75
Overall Measures (% Strongly Agree/Agree unless otherwise noted)	**NA**
• Like the services received	87
• If had other choices, would still choose this agency	82
• Would recommend to friends or family	88
• Satisfaction with counseling or treatment (% 8, 9, 10)	65

Marketplace Child Behavioral Health

Topics & Question Ratings	2019 Rate
Treatment (% Strongly Agree/Agree)	**NA**
• Helped to choose services	100
• Helped to choose treatment goals	89
• Participated in child's treatment	90
• Location of service was convenient	80
• Services were available at convenient times	80
• Got all help wanted for child	80
• Got as much help as needed	70
Staff (% Strongly Agree/Agree)	**NA**
• People helping us stuck with us no matter what	88
• Child had someone to talk to when troubled	80
• Treated me with respect	100
• Respected family's religious/ spiritual beliefs	89
• Spoke in a way I could understand	100
• Sensitive to cultural/ethnic background	89
Perceived Improvement (% Strongly Agree/Agree)	**NA**
• Symptoms not bothering as much	80

Marketplace Child Behavioral Health

Topics & Question Ratings	2019 Rate
• Better handling daily life	80
• Gets along better with family	90
• Gets along better with friends/others	80
• Doing better in school/work	60
• Better able to cope when things go wrong	70
• Better able to do things he/she wants to do	80
• Have people who will listen	89
• Comfortable talking about child's problems	89
• Have needed support in case of crisis	100
• Have people with whom I can do enjoyable things	100
Child Information	**NA**
• Child currently living with you (% yes)	100
• Child on medication for emotional/behavioral reasons (% yes)	50
• Still getting services from this agency (%Yes)	80
• How long did child receive service (%More than 1 year)	50
Overall Measures (% Strongly Agree/Agree unless otherwise noted)	**NA**
• Like the services received	100
• If had other choices, would still choose this agency	70
• Would recommend to friends or family	80
• Overall satisfied with services	90
• Satisfaction with counseling or treatment (% 8, 9, 10)	60

For the Marketplace Adult behavioral survey, three measures scored over 90%, which were *"Felt comfortable asking questions about treatment and medication," "Given information about rights,"* and *"Respected wishes about who can received information about my treatment."* Conversely, four measures rated below 70%, which were *"I was encouraged to use consumer-run programs," "Housing situation has improved," "Symptoms not bothering as much,"* and *"Satisfaction with counseling or treatment."* The scores for the overall measures, such as satisfaction with counseling or treatment, likelihood to recommend, or to choose their services again if given a choice are all on par with the Centene Adult average. The Marketplace Adult members tend to rate measures related to behavioral health *"Staff"* and *"Perceived Improvement"* higher than do Medicaid Adult members.

The results of the survey for the Marketplace Child behavioral health survey are on par with the results of other participating Centene plans. From the Marketplace Child survey, ten measures scored at 90% or higher, with seven of the ten scoring at 100%. In contrast, seven measures scored at 70% or below, with four measures scoring 60% or below. Conclusions based on the results of the Marketplace Child survey should be viewed with caution due to the small sample size, as only ten valid surveys were completed.

The data from the member satisfaction surveys will be shared with other departments within Sunflower Health Plan, to identify areas for improving member experience, when accessing behavioral healthcare and services.

Provider Satisfaction

Provider Appeals

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

In 2019, there were 17 provider appeals requiring medical necessity review by the Plan. The top category by volume was Timely Filing. These are appeal requests regarding the administrative denial of prior authorizations following untimely submission of the prior authorization request.

Provider Appeal Categories	2019
Timely Filing	8
Diagnostic - Genetic Testing	0
Inpatient - Admission	7
Inpatient - SNF/Continued Stay	0
Hospital - Other	0
Other - Mental Health Services	0
Outpatient - Procedure	1
Home Health	1
Total	**17**

Provider Satisfaction Survey

SPH Analytics (SPH), a National Committee for Quality Assurance (NCQA) Certified Survey Vendor, was selected by Sunflower Health Plan to conduct its 2019 Provider Satisfaction Survey. Information obtained from these surveys allows plans to measure how well they are meeting their providers' expectations and needs. Based on the data collected, this report summarizes the results and assists in identifying plan strengths and opportunities.

SPH Analytics followed a two-wave mail and internet with phone follow-up survey methodology to administer the provider satisfaction survey from August to October 2019. Sunflower's sample size was 2,000. SPH Analytics collected 348 surveys (91 mail, 26 internet, and 231 phone) from the eligible provider population. After adjusting for ineligible providers, the mail/internet survey response rate was 6.3%, and the phone response rate was 28.4%. 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

91 (mail) + 26 (Internet) / 2,000 (sample) – 143 (ineligible) = 6.3%

Phone Component

231 (phone) / 1,035 (sample) – 222 (ineligible) = 28.4%

For the 2019 survey, Sunflower continued to include those who could participate in providing feedback to include HCBS providers and nursing facilities. The 2019 survey results demonstrated the following demographics for response to the survey: 51.4% primary care providers, 27.1% specialty practices, Home Community Based Services (HCBS) 16.1%, followed by 21.5% for nursing facilities, and, 3.8% for Behavioral Health Clinicians. Of those who responded to the survey, 50.3% were responses from the office manager, 37.7% nurse/other staff responding, with 12.0% for physicians and 0.0% for Behavioral Health Clinicians who responded on the survey.

Overall Satisfaction with Plan

2019 Provider Satisfaction Composite Scores	2019 Summary Rate
Overall Satisfaction	48.9%
Comparative Rating of Sunflower compared with all other contracted health plans	35.20%
Finance Issues	33.60%
Utilization & Quality Management	28.70%
Network/Coordination of Care	20.70%
Pharmacy	13.10%
Health Plan Call Center Service Staff	27.90%
Provider Relations	40.90%
Recommended to Other Physicians Practices	38.20%

The above table demonstrates the 2019 baseline results for the Overall Satisfaction with Ambetter Plan. Of the total, 12.2% were completely satisfied, 36.6% were somewhat satisfied, 37.4% were neither dissatisfied nor satisfied, 7.6% were somewhat dissatisfied, and 6.1% were completely dissatisfied.

Access and Availability

Call Statistics (Member and Provider Calls)

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

The Customer Service and Medical Management Departments have corporate measures to meet telephone access standards for our Affordable Care Act product, Ambetter. The Plan is responsible for Provider Services, Utilization Management and Case Management call statistics for our providers and members. In 2019, the Customer Service Department was slightly under the Plan's parent company, Centene Corporation, performance goals for Provider Services inbound call statistics. The Plan expanded its service area on January 1, 2019. The Plan's Customer Service department had a total call volume of 20,646 for 2019. The Plan answered 81.5% of all calls within 38 seconds, missing the goal of 80% answered within 30 seconds. The 2019 abandonment rate was 1.81%, which demonstrates meeting the goal of less than 4%. The Plan has identified the need to hire and continue cross training staff to improve overall satisfaction and to exceed the standard. The Plan will continue monitoring and reporting telephone access on a monthly basis to allow for tracking, trending, and identifying any opportunities while striving to continue to meet or exceed the requirements.

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

Network Adequacy
Ambetter'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 Ambetter's 24/7 Nurse Advice Line, members have access to the health plan at all times.

Accessibility of Primary Care Services
Ambetter monitors primary care provider appointment accessibility against its standards, identifies opportunities for improvement and initiates actions as needed to improve results. The Plan incorporates 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 section 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
Ambetter defines urgent care appointments as within 48 hours from the time of the request for all practitioner types. Routine appointment accessibility for PCPs are not to exceed three weeks from the date of member requests. Access to a specialty care appointment within 30 days of request is the standard. For Behavioral Health, the access to care standard is 48 hours for urgent care, 10 days for routine care, and 6 hours for non-life threatening emergent care. Ambetter 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.

Ambetter surveyed a sample of participating (in network) credentialed practitioners, both PCPs and specialists (includes OB/GYN), and behavioral health, in 2019. No practitioners were excluded from the sample. Practitioner data was pulled from the Plan's provider management system, Portico. Data is collected by standardized survey. Ambetter'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 Ambetter is 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

Appointment Type	Standard and Performance Goal	Measurement Method	Measurement Frequency
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
Behavioral Health Non-Life Threatening Emergent Care within 6 hours	90% of surveyed Behavioral Health Prescribers within defined timeframe	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

Appointment Accessibility Results

The tables below demonstrates the results from 2019 assessment of Plan providers by types to include primary care, oncologists, OB/GYN providers and behavioral health providers. For the primary care providers (PCP), 324 were included in the Ambetter sample initially and 136 completed the survey fully, a 42% completion rate. The Plan failed to meet the goals for primary care urgent appointments within 48 hours, and primary care routine appointments not to exceed 3 weeks for new patients, but met performance goals for meeting standards for established patients. The survey for the Ambetter high impact specialists' targeted 133 oncology practitioners with 73 completing the survey, a 55% completion rate. The goal was not met for high-impact specialists except for first available appointment for established patients. For high-volume specialists, there were 277 OB/GYN in the survey and 97 completed the survey, a 35% completion rate. The results demonstrated failure to meet the goal for high-volume and high-impact providers sampled on: urgent appointments within 48 hours. The results show that the goal was met for first routine appointment within 30 days for OB/GYN for established patients. For Behavioral health, there were prescribers (106) and non-prescribers (145) in the survey with 18 and 64, respectively, completing the survey, 17% and 44% completion rate. For Urgent Care neither Prescriber nor Non-Prescriber Behavioral Health providers met the goal for Urgent Care standards. The Plan directs members with non-life-threatening emergencies to the ER. In all categories, regardless of patient status.

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

Appointment Type	Access Standard	Performance Goal	Appointment Results	Goal Met
Urgent Care	Primary care urgent appointments within 48 hours	90% of PCPs report availability of urgent appointment within timeframe	New Patients - 56%	No
			Established Patients – 76%	No
Routine Care - New Patients	Primary care routine appointments not to exceed 3 weeks	90% of PCPs report availability of routine appointment within timeframe	1st Available - 86%	No
			2nd Available - 84%	No
			3rd Available - 81%	No
Routine Care - Established Patients	Primary care routine appointments not to exceed 3 weeks	90% of PCPs report availability of routine appointment within timeframe	1st Available - 96%	Yes
			2nd Available - 93%	Yes
			3rd Available - 92%	Yes
Wait Time	Primary care wait time not to exceed 45 minutes	90% of PCPs report availability of wait time within timeframe	87%	No
Urgent Care (Oncology)	Oncology care for urgent appointments within 48 hours	90% of high-impact specialists report availability of urgent appointment within defined timeframe	New Patients – 77%	No
			Established Patients – 77%	No
Routine Care - New Patients (Oncology)	Oncology care for routine appointments within 30 Days	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 87%	No
			2nd Available - 87%	No
			3rd Available - 87%	No
Routine Care - Established Patients (Oncology)	Oncology care for routine appointments within 30 Days	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 95%	Yes
			2nd Available - 88%	No
			3rd Available - 88%	No
Wait Time (Oncology)	Oncology care wait time not to exceed 45 minutes	90% of high-impact specialists report availability of wait time within timeframe	81%	No
Urgent Prenatal Care (OB/GYN)	OB/GYN care for urgent appointments within 48 hours	90% of high-impact specialists report availability of urgent appointment within defined timeframe	New Patients – 61%	No
			Established Patients – 74%	No
Prenatal Care - New Patients (OB/GYN) – 1st Trimester	OB/GYN routine care within 30 days of the First Trimester	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 93%	Yes
			2nd Available - 88%	No
			3rd Available - 88%	No
			1st Available - 87%	No

Appointment Type	Access Standard	Performance Goal	Appointment Results	Goal Met
Prenatal Care - New Patients (OB/GYN) – 2nd Trimester	OB/GYN routine care within 30 days of the Second Trimester	90% of high-impact specialists report availability of routine appointment within defined timeframe	2nd Available - 84%	**No**
			3rd Available - 84%	**No**
Prenatal Care - New Patients (OB/GYN) – 3rd Trimester	OB/GYN routine care within 30 days of the Third Trimester	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 90%	**Yes**
			2nd Available - 89%	**No**
			3rd Available - 89%	**No**
Prenatal Care - Established Patients (OB/GYN) – 1st Trimester	OB/GYN routine care within 30 days of the First Trimester	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 95%	**Yes**
			2nd Available - 94%	**Yes**
			3rd Available - 91%	**Yes**
Prenatal Care - Established Patients (OB/GYN) – 2nd Trimester	OB/GYN routine care within 30 days of the Second Trimester	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 91%	**Yes**
			2nd Available - 90%	**Yes**
			3rd Available - 90%	**Yes**
Prenatal Care - Established Patients (OB/GYN) – 3rd Trimester	OB/GYN routine care within 30 days of the Third Trimester	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 91%	**Yes**
			2nd Available - 88%	**No**
			3rd Available - 88%	**No**
Wait Time (OB/GYN)	OB/GYN care wait time not to exceed 45 minutes	90% of high-impact specialists report availability of wait time within timeframe	90%	**Yes**
Urgent Care (Behavioral Health Prescribers)	Behavioral Health care for urgent appointments within 48 hours	90% of high-impact specialists report availability of urgent appointment within defined timeframe	New Patients – 29%	**No**
			Established Patients – 59%	**No**
Routine Care - New Patients (Behavioral Health Prescribers)	Behavioral health care for routine appointments within 10 Days	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 41%	**No**
			2nd Available - 24%	**No**
			3rd Available - 24%	**No**
Routine Care - Established Patients (Behavioral Health Prescribers)	Behavioral health care for routine appointments within 10 Days	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 67%	**No**
			2nd Available - 56%	**No**
			3rd Available - 50%	**No**

Appointment Type	Access Standard	Performance Goal	Appointment Results	Goal Met
Non-Life Threatening Emergent Care (Behavioral Health Prescribers)	Behavioral Health Non-Life Threatening Emergent Care within 6 hours	90% of surveyed Behavioral Health Prescribers within defined timeframe	100%	**Yes**
Urgent Care (Behavioral Health Non- Prescribers)	Behavioral health care for urgent appointments within 48 hours	90% of high-impact specialists report availability of urgent appointment within defined timeframe	New Patients – 61%	**No**
			Established Patients – 67%	**No**
Routine Care - New Patients (Behavioral Health Non-Prescribers)	Behavioral health care for routine appointments within 10 Days	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 81%	**No**
			2nd Available -72%	**No**
			3rd Available - 64%	**No**
Routine Care - Established Patients (Behavioral Health Non-Prescribers)	Behavioral health care for routine appointments within 10 Days	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st Available - 83%	**No**
			2nd Available - 77%	**No**
			3rd Available - 66%	**No**
Non-Life Threatening Emergent Care (Behavioral Health Non-Prescribers)	Behavioral Health Non-Life Threatening Emergent Care within 6 hours	90% of surveyed Behavioral Health Non-Prescribers within defined timeframe	98%	**Yes**

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

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

Practitioner Availability

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

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

For the 2019 Practitioner Availability Analysis, the Plan identified high-volume specialists as Obstetrics/Gynecology and high-impact specialists as Hematology/Oncology. For this report, the Plan used the State definition for "Hematology/Oncology", which includes both oncology practitioners and oncologists with a specialty in hematology. Hematology/Oncology is defined to be practitioners with a specialty of "329-Oncologist" which includes these taxonomies - 207RH0003X (Hematology and Oncology), 2080P0207X (Pediatric Hematology-Oncology), and 261QX0203X (Oncology, Radiation).

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

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

Practitioner Type	Standard	Results	Goal Met
Primary Care	90% of metro members have at least 1 Primary care provider within 10 miles or 15 minutes.	100%	Yes
	90% of micro members have at least 1 Primary care provider within 20 miles or 30 minutes	100%	Yes
Hematology / Oncology	90% of metro members have at least 1 hematology/oncology provider within 30 miles and 45 minutes	100%	Yes
	90% of micro members have at least 1 hematology/oncology provider within 45 miles or 60 minutes	100%	Yes

Practitioner Type	Standard	Results	Goal Met
Obstetrics and Gynecology	90% of metro female members have at least 1 OB/GYN within 40 miles or 60 minutes.	100%	Yes
	90% of metro female members have at least 1 OB/GYN within 75 miles or 100 minutes	100%	Yes
Psychiatry	90% of metro members have at least 30 miles or 45 minutes	100%	Yes
	90% of micro members have at least 1 psychiatrist within 45 miles or 60 minutes	100%	Yes

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

24 Hour Access/Availability

In 2019, the Plan utilized SPH Analytics to perform a survey for After Hours Care and the Plan reviewed member grievances. The survey sampled 270 Plan Providers, 69% of the providers were fully compliant, 185/270. There were 31% found noncompliant, 85/270. The Plan follows-up with the noncompliant providers to alert to the status and resurveys the provider for compliance.

After-Hours Care Survey			
Number of Ambetter Providers in Sample	**Number Fully Compliant**	**Number of Noncompliant**	**% of Providers Fully Compliant**
270	185	85	69%

Member grievances (i.e. complaints) regarding accessibility of services from January 1, 2019 through December 31, 2019 were reviewed. Grievances regarding after-hours access are in the Access-Other subcategory. There was one grievances in the Access-Other subcategory in calendar year 2019 for Ambetter. Review of this grievance determined there were zero complaints regarding primary care after-hours access in 2019 for Ambetter. The Plan established a goal of <0.50 member complaints and the goal was met in 2019, with a rate of 0.04/1000 member complaints regarding primary care after-hours access.

Disease Management Programs

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

Clinical Practice Guidelines

Sunflower utilized the following clinical and preventive health practice guidelines in 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 2018 related to practice guidelines were to continue and expand provider profiles in 2019 to a larger provider group to help increase knowledge, awareness and compliance.

Efforts Undertaken in 2019:
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 2018 and Sunflower will continue efforts in 2019:

- Continue to notify practitioners about the guidelines via newsletter and website announcements. Goal met in 2018 and continued in 2019.
- Continue member and provider outreach and education-based initiatives regarding all guidelines. Goal is related to provider profiles.
- Continue to meet applicable NCQA Standards throughout 2018 and continued in 2019 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.

Continuity and Coordination of Care

Continuity and Coordination of Medical Care

The Plan annually monitors the continuity and coordination of medical care through the following areas and initiates actions for improvement in the delivery of continuity and coordination of medical care:

- **Monitor 1:** The total number of newborns that have a follow-up visit with an outpatient provider within 30 days of discharge after delivery.
- **Monitor 2:** The total number of inpatient discharges resulting in a follow-up visit with an outpatient provider within 30 days.
- **Monitor 3:** The total number of members discharged from an inpatient setting following a live birth who had a postpartum visit with a primary care provider (PCP) or OB-GYN within 21- 56 days following discharge.
- **Monitor 4:** Practitioner satisfaction with the communication between primary care providers and specialists.

Monitor 1

The Plan follows the American Academy of Pediatrics (AAP) recommendation that criteria for newborn discharge include physiologic stability, family preparedness and competence to provide newborn care, social support system availability, and access to the health care system and resources. Ambetter's Start Smart for Your Baby (SSFB) maternal-child health program, is a comprehensive program to improve obstetrical and pediatric care services and reduce pregnancy-related complications, premature deliveries, low birth weight deliveries, and infant disease. The SSFB program integrates the models of care management, care coordination, disease management, and health education, striving to improve the health of mothers and their newborns. Wellness educational materials, member outreach, intensive care management, provider collaboration, and support of the appropriate use of medical resources, are all utilized to encourage and educate mother and provider. The program's multi-faceted approach to improving prenatal and postpartum care consist of Ambetter care managers providing telephonic outreach to mothers during the post-partum period to ensure that the mother and her infant are receiving the recommended follow-up care.

Administrative claims and encounters are used to evaluate the measurement period for this measure. Claims for office visit follow-up include paid, pending, and denied claims. The Plan identifies the

total number of newborns that have a follow-up visit with an outpatient provider within 30 days of discharge after delivery, based on a generated administrative claim and encounter report. The population from which the measure is drawn remains the total number newborns who become Ambetter members from member mothers who have a new patient appointment with a primary care physician within 30 days of discharge after delivery. The denominator is the total number of newborns discharged after delivery, by a member mother, during the 12-month measurement period. The numerator is the total number of newborn discharges in the measure that successfully completed a follow-up new patient appointment with a practitioner within 30 days; primary care providers and specialists are included. Ambetter's performance goal is to increase the 30-day follow-up rate by 5 percent each measurement period.

Measurement Period	Numerator	Denominator	Rate	Goal	Goal Met?
1/1/2018 - 12/31/2018	69	109	63.30%	Baseline	N/A

The baseline rate for Ambetter is set from the 2018 data, which reflects a current rate of 63.30%. The Plan identifies the following barriers related to the number of newborns having a follow-up visit with an outpatient provider within 30 days of discharge after delivery:

- Staff knowledge deficit related to recommended preventive care.
- Caregivers do not establish PCP care for newborn within the first 30 days.
- Caregiver's knowledge deficit regarding newborn follow-up post-delivery.
- Caregiver knowledge deficit related to recommended Preventative Pediatric Health Care.

Ambetter continues to work on the following opportunities related to the number of newborns having a follow-up visit with an outpatient provider within 30 days of discharge after delivery:

- Educate SSFB staff on AAP recommendations.
- Assist caregiver in establishing a relationship with provider for newborn.
- Educate caregiver on importance of newborn visits.
- Educate caregiver on AAP recommendations and on the benefits of routine care for the newborn and importance of established relationship with primary care for the newborn.

Monitor 2

In an effort to ensure a comprehensive discharge plan is developed and in place prior to discharge, Sunflower conducts multidisciplinary inpatient rounds to discuss newly admitted inpatient members to address discharge planning; the team includes Medical Directors, Concurrent Review Nurses, Physical Health Care Managers, LTSS Care Managers, Behavioral Health Care Managers, and leadership from each team. The discharge planning discussion includes any possible barriers to discharge, scheduled follow-up visits with a primary care or specialty provider, and other needed services. The Concurrent Review Nurse engages the hospital staff and the member's Care Manager, as applicable, to ensure appropriate discharge planning, assist with coordinating the discharge plan, and assesses for additional member needs. The discharge plan discussion includes the need for scheduled follow-up appointments, to occur within seven (7) days of discharge, organized post-discharge services, such as home care services, after-treatment services and/or therapy services, and information on what to do if a problem arises following discharge including primary care physician and the Care Manager contact information.

Ambetter's post-discharge outreach process includes outreach to members discharged to home, identified through review and stratification of the Inpatient Daily Census report and the Discharge Detail report. Designated staff make attempts to contact all identified members within 72 hours post-

discharge. The goal of this outreach is coordination and continuity of care as members move from the acute care setting to ensure members have appropriate access to needed follow up care, home care services and medication with the goal of preventing secondary health conditions or complications, re-institutionalization, re-hospitalization or unnecessary emergency room use. If after initial discussion, the member is determined by Ambetter to be at high risk for readmission and not already enrolled in care management, they are referred for Ambetter care management services. Under special circumstances, the Care Manager may determine a home visit or home health services are needed within seven (7) days following discharge for members with highly complex cases and/or discharge plans.

Administrative claims and encounters were evaluated for the measurement time period for the total number of inpatient discharges for all Ambetter members during the 12-month period. Claims for outpatient follow up visits included paid, pended, and denied claims. The denominator is the total number of inpatient discharges and included paid claims; pended and denied claims were excluded. Excluded were inpatient discharges with subsequent inpatient discharges within 30 days of the original discharge date; mental health or chemical dependency services were also excluded. The denominator was pulled per the NCQA HEDIS Technical Specifications for Inpatient Utilization. The numerator is the total number of inpatient discharges that resulted in an outpatient follow up visit with a practitioner within 30 days; primary care providers and specialists were included. Ambetter's performance goal is to increase follow-up visits with outpatient practitioners by 5 percentage points over the previous year results.

Measurement Period	Numerator	Denominator	Rate	Goal	Goal Met?
1/1/2018 – 12/31/2018	691	1,012	68.28%	Baseline	N/A

The 2018 reporting cycle is a baseline year for the Ambetter product line. The baseline rate of 68.28 percent is set from the 2018 data analyzed. The data reflects a total of 1,012 inpatient discharges during the measurement period, representing discharges of 691 unique members.

The following barriers were identified, regarding the total number of inpatient discharges that resulted in a follow-up visit with an outpatient practitioner within 30 days:

- Staff knowledge deficit related to transitions of care.
- Staff knowledge deficit regarding transportation statement of work as well as policy and procedure.
- Members do not recognize the importance of follow-up care and medication adherence after discharge.
- Members have unreliable transportation to follow-up visits.
- Transportation provider not always sending appropriate type of transportation vehicle for member with special needs.
- Unsuccessful outreach to members and no consistent process for outreach to members discharged.

The Plan will continue to work on the following opportunities, related to the total number of inpatient discharges that resulted in a follow-up visit with an outpatient practitioner within 30 days:

- Staff training regarding safe transitions and prevention of readmission.
- Provide training and education to staff on transportation benefit, forms, member portal, and alternative resources annually.
- Educate members regarding the importance of follow- up care following discharge.
- Member education regarding the transportation benefit.

- Work with transportation vendor to ensure appropriate vehicle provided to meet member needs and improve access to transportation service.
- Staff training on the process and importance of successful post hospitalization follow-up.

Monitor 3

The Plan is focused on improving health outcomes for new mothers and their infants. An ongoing challenge that was first identified in 2017 and continues today, is the frequent post-delivery focus on the infant, rather than the follow-up care for new mothers. The Ambetter Care Management team works with new mothers to ensure that a follow-up appointment occurs. These members receive a mailer that provides a checklist of conversations and examinations that need to occur during their first doctor visit post-delivery. The Plan continues efforts to focus on engagement and education of members, with emphasis on the importance of prenatal and post-partum visits, to ensure the best outcomes for the mother and newborn.

The Plan identified the total number of members discharged from an inpatient setting following a live birth who had a postpartum visit with a primary care provider (PCP) or OB-GYN within 21- 56 days following discharge. Ambetter utilized the 2018 and 2019 HEDIS PPC data set for trending and reporting. The population from which the measure was drawn is the total number of live births during the calendar year. The numerator is the number of members discharged from the inpatient setting with a follow-up visit with the PCP or OB-GYN within 21 and 56 days. The denominator is the number of members discharged from an inpatient setting following a live birth during the measurement period. The goal is to meet or exceed the NCQA Quality Compass 50th percentile.

Measurement Period	Numerator	Denominator	Rate	Met/Exceeded NCQA Quality Compass 50th Percentile	Goal Met?
HEDIS 2019 (MY 2018)	73	120	60.83%	82.10%	No

The HEDIS 2019 rate is a baseline year for Ambetter. The HEDIS 2019 rate of 60.83% did not meet or exceed the NCQA Quality Compass 50th percentile.

The Plan identified the following barriers associated with the total number of members discharged from an inpatient setting following a live birth who had a postpartum visit with a primary care provider (PCP) or OB-GYN within 21- 56 days following discharge:

- Case Management nurse knowledge deficit regarding pregnancy and delivery.
- Sunflower timely notification of a member's pregnancy, i.e. timely notification allows early outreach to provide sufficient support to the member, including assistance in scheduling a postpartum follow-up appointment for the mother.
- Lack of member awareness of the importance of timely follow-up visit for the mother, i.e. mothers who have delivered and feel "healthy" or see child as "healthy", do not see value in f/u visits for themselves post-delivery.

Ambetter will continue to work on the following opportunities related to the total number of members discharged from an inpatient setting following a live birth who had a postpartum visit with a primary care provider (PCP) or OB-GYN within 21- 56 days following discharge:

- Educate CM nurse on pregnancy and deliver and importance of post-partum care.
- Educate providers regarding the importance of submitting a timely notification of pregnancy

(NOP) to SHP.
- Member education regarding the importance of a timely follow-up visit.

Monitor 4

Ambetter monitors practitioner satisfaction with the communication between primary care providers and specialists through a provider satisfaction survey. The Plan's Provider Satisfaction Survey includes the evaluation of satisfaction with communication between primary care practitioners and specialty practitioners. Survey results allow Ambetter to assess the level of satisfaction regarding communication among treating providers to assure appropriate coordination of medical care is occurring. The Plan utilizes Symphony Performance Health (SPH) Analytics, an NCQA-certified survey vendor, to conduct the annual provider satisfaction survey.

In the standardized survey tool administered by SPH Analytics, two questions measure the timeliness and the frequency of communication between primary care practitioners and specialty practitioners in the survey's composite area of Network/Coordination of Care. The goal for the Provider Satisfaction Survey is an annual increase of 5 percentage points for the summary rate; summary rates represent the most favorable response percentage(s). Responses for the specific questions in the 2017- 2019 surveys are noted in the table below:

Provider Satisfaction Questions	2017 Summary Rate	2018 Summary Rate	2019 Summary Rate	Goal Met?
4C - The timeliness of feedback/reports from specialists in this health plan's provider network.	22.4% (n=147)	21.6% (n=153)	29.2% (n=195)	Yes
4D - The frequency of feedback/reports from specialists for patients in your care	22.3% (n=139)	22.4% (n=152)	28.9% (n=194)	Yes

Question 4C and 4D met the goal of a 5 percentage point improvement for 2019. The 2019 rate for question 4C had an increase of 7.6 percentage points from the 2018 rate, while question 4D had a 6.5 percentage point increase from the 2018 rate. The following provides details on the responses to question 4C and 4D.

Composite/ Attribute	2017 Responses	2018 Responses	2019 Responses
4C - The timeliness of feedback/ reports from specialists in this health plan's provider network.	Well below average/ Somewhat below average – 8.0%	Well below average/ Somewhat below average – 7.9%	Well below average/ Somewhat below average – 9.3%
	Average – 69.0%	Average – 70.6%	Average – 61.5%
	Somewhat above average – 14.0%	Somewhat above average – 14.4%	Somewhat above average – 15.9%
	Well above average – 8.0%	Well above average – 7.2%	Well above average – 13.3%
	(n =147)	(n =153)	(n = 195)
4D - The frequency of feedback/ reports from specialists for	Well below average/ Somewhat below average – 6.0%	Well below average/ Somewhat below average – 8.6%	Well below average/ Somewhat below average – 6.7%
	Average – 71.0%	Average – 69.1%	Average – 64.4%

Composite/ Attribute	2017 Responses	2018 Responses	2019 Responses
patients in your care.	Somewhat above average – 15.0%	Somewhat above average – 13.2%	Somewhat above average – 17.0%
	Well above average – 7.0%	Well above average – 9.2%	Well above average – 11.9%
	(n =139)	(n =152)	(n = 194)

The Plan identified the following barriers related to practitioner satisfaction with the communication between primary care providers and specialists:

- Members not communicating between providers.
- PCPs are not aware of which specialists their assigned members are seeing.
- Specialists unaware of the need to communicate with the member's PCP.

The Plan will continue to work on the following opportunities associated with practitioner satisfaction with the communication between primary care providers and specialists:

- Provide member education about the importance of informing their PCP of specialists they are seeing.
- Educate PCPs on how to determine if a member is seeing a specialist.
- Educate specialty groups regarding the importance of communicating with the member's assigned PCP on a frequent and timely basis.

Continuity and Coordination of Care between Medical and Behavioral Healthcare

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

The following table demonstrates how the Plan specifically monitors the areas:

Specific Area Monitored	Description of Monitor
Exchange of Information between behavioral health care and primary care practitioners and other relevant medical delivery system practitioners or providers	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)
Management of treatment access and follow-up for patients with coexisting medical and behavioral disorders	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD) HEDIS measure.
Implementation of a primary or secondary preventive behavioral health program	Number of members identified and screened for perinatal depression.

Specific Area Monitored	Description of Monitor
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
The Plan collects data and identifies opportunities to improve the exchange of information through the annual provider satisfaction survey, which includes evaluation of satisfaction with communication between behavioral health practitioners and primary care practitioners and levels of primary care practitioner satisfaction with behavioral health practitioner communication.

In the standardized survey tool administered by SPH Analytics for the Plan's 2019 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 2019. The response for question 4E demonstrated a decrease from 16.1% in 2018 to 15.7% for 2019. For question 4F, there was an increase from 24.1% in 2018 to 31.3% in 2019. These data points are noted in the table below.

Provider Satisfaction Questions	2019 Percent Satisfied	2018 Percent Satisfied	2019 Responses Composite/Attribute
4E: Please rate the timeliness of exchange of information/communication/reports from the behavioral health providers?	15.7%	16.1%	Excellent – 3.9% Very Good – 11.8% Good – 52.3% Fair – 23.5% Poor – 8.5% (n=153)
4F: How often do you receive verbal and/or written communication from behavioral health providers regarding your patients?	31.3%	24.1%	Always – 6.1% Usually – 25.1% Sometimes – 31.8% Often – 25.1% Rarely – 11.7% (n=179)

The Plan was unable to compare performance on the 2019 survey against a benchmark, as SPH Analytics does not provide Book of Business benchmarks for the two custom questions. Similarly, the composite for the Network / Coordination of Care section of the survey does not include the custom questions and was not reviewed for this report. The Plan identified opportunities for improvement demonstrated by the decline in performance from 2018 to 2019 related to timeliness of exchange of information from behavioral health providers. However, there was an improvement in 2019 in how often the behavioral health provider communicates. The Plan's goal for the 2019 provider satisfaction survey was an increase of 5% on each survey question. The Plan met this goal for the question of how often the behavioral health provider communicates (4F) but failed to achieve the goal for the timeliness question (4E). The Plan will continue to work on improvement.

The Plan has an integrated behavioral health provider network and 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.

The Plan's Behavioral Health staff have identified the following barriers related to the exchange of information between medical and behavioral healthcare providers, Plan efforts continue to work to address these:

- 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 the member's assigned PCP.
- Physical health inpatient facilities not sharing discharge clinical information.
- Members that move frequently or are homeless often times experience disruptions with their service providers.
- Members leaving acute inpatient for psychiatric care, self-perceive 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 do not have an established relationship with a PCP.

The Plan 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 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
- Member education regarding importance of sharing information between providers.
- Education of medical providers regarding a member's behavioral health providers.
- Education of behavioral health providers regarding a member's PCP.
- Encourage providers to share the discharge clinical information.
- Member education regarding the importance of sharing contact information with providers.
- Member education regarding the impact of mental health on all areas of their health and quality of life.
- Member education regarding establishing services with a PCP

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

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

behavioral health case management team collaborates to coordinate services to meet the member specific needs.

The AMM HEDIS measure has two indicators:

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

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

Antidepressant Medication Management (AMM)		
AMM Indicator	**HEDIS 2019**	**Met/Exceeded NCQA Quality Compass 50th Percentile**
Effective Acute Phase Treatment	70.75% (75/106)	No
Effective Continuation Phase Treatment	59.43% (63/106)	Yes

The HEDIS 2019 rates are baseline rates for the Plan, as the Ambetter product line was new in 2018 and the measurement year for HEDIS 2019 is calendar year 2018. The HEDIS 2019 rates met or exceeded the NCQA Quality Compass 50th percentile for *Effective Continuation Phase Treatment*, but did not meet or exceed for *Effective Acute Phase Treatment*.

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

Analysis of the data lead to the identification of the following barriers that were the focus of continued efforts:

- Treating provider is not aware the member is not taking prescribed medication consistently.
- Member's knowledge deficit regarding the importance of adherence with antidepressant medication and ways to manage side effects.
- Treating providers not familiar with the depression clinical practice guideline.
- Maintaining staff knowledge on depression management treatment and best practices.

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

- Utilize pharmacy data to identify members who are non-adherent in filling prescriptions and provide written notice to prescribers to inform of member non-adherence.
- Targeted outreach to members with a depression diagnosis and recently prescribed/fill of a new antidepressant medication.
- Educate providers about Sunflower's adopted clinical practice guidelines, including the depression guideline.
- All Behavioral Health Medical Management staff will participate in a Continuing Education course on diagnosis of depression and evidence-based practices for depression.

Appropriate Use of Psychotropic Medications
The Plan monitors the use of psychotropic medications by all members. This is measured through the HEDIS measure *Use of Multiple Concurrent Antipsychotics in Children and Adolescents* (APC). The APC measure looks at members 1-17 years of age who are on two or more concurrent antipsychotic medications for at least 90 consecutive days. The table below shows the Plan's results for HEDIS 2019.

Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)		
APC Indicator	**HEDIS 2019**	**Met/Exceeded NCQA Quality Compass 50th Percentile**
Rate	(0/7) 0.00%	N/A

APC is an inverted rate, meaning a lower rate is considered to be a better rate. For the Ambetter APC measure, an index period of January 1, 2018 – April 30, 2018 was used. The table above represents the Plan's baseline data for HEDIS 2019. The data shows there were 7 children identified in the denominator and 0 children identified in the numerator. The APC measure was not included in the NCQA Quality Compass. Therefore, the Plan's goal of meeting or exceeding the NCQA Quality Compass 50th percentile is not applicable.

The following barriers were identified regarding the appropriate use of psychotropic medications:
- Early identification of members placed on one antipsychotic medication.
- Early identification of members placed on two or more antipsychotics.
- Member utilization of appropriate levels of outpatient or community-based services along with or prior to engaging in the use of multiple antipsychotics
- Members who utilize inpatient or residential services have multiple prescribers of medications.

Opportunities identified to address barriers associated with the appropriate use of psychotropic medications are listed below:
- Identify members placed on one new antipsychotic within the age range of 1-17.
- Referral of members to the LifeShare team for further review. Early referral to maximize review.
- Review member referrals for members who are recently prescribed a second antipsychotic.
- Identify prescriber trends for practitioner/provider education.

Management of Treatment Access and Follow-up for Members with Coexisting Medical and Behavioral Disorders
The Plan 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.

A primary case manager is assigned to a member, who can be a behavioral health or physical health case manager. The member's needs are assessed to determine who the primary case owner will be. A secondary case manager/owner may be assigned if the member has both physical and behavioral health needs. The secondary case owner consults with the primary case owner and provides outreach services to the member as needed. Integrated rounds also increases communication regarding shared members.

The development of a shared care plan results in increased communication and a more collaborative approach. This approach allows both medical and behavioral health team members to employ and update a shared plan of member-driven goals. Additionally, this model allows the care management teams to provide cohesive education and resources to members for their medical and behavioral health needs.

Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications (SSD)		
Year	**Rate**	**Met/Exceeded NCQA Quality Compass 50th Percentile**
HEDIS 2019	77.4% (82/106)	N/A

The Plan launched the Ambetter product in January 2018. The table above represents the baseline data for the Ambetter SSD measure HEDIS 2019. The data shows there were 106 members identified in the denominator and 82 members identified in the numerator. The SSD measure was not included in the NCQA Quality Compass. Therefore, the Plan's goal of meeting or exceeding the NCQA Quality Compass 50th percentile is not applicable.

A barrier analysis was performed and the Plan recognized the following barriers to coordination of care for members with coexisting medical and behavioral disorders:

- Members not understanding the importance of having regular diabetic screenings while on antipsychotic medications.
- Members not communicating to PCP that they are seeing a BH provider.
- Prescribers not ordering diabetic screenings for members they prescribe antipsychotic medications.
- Members reluctant to engage with providers or with Health Plan representatives regarding healthcare.
- Staff knowledge regarding correlation between diabetes and the use of antipsychotic medications.

The Plan identified opportunities to overcome barriers associated with coordination of care for members with coexisting medical and behavioral disorders, listed below:

- Member education about importance of regular screenings.
- Educate members regarding importance of notifying providers of services they receive from other providers.
- Provider education to increase knowledge of importance of ordering diabetic screenings.
- Development of partnership with the community mental health centers to engage members.
- Staff education/training regarding diabetes and the use of antipsychotic medications.

Primary or Secondary Preventive Behavioral Healthcare Program

The Plan provides a preventive behavioral health program targeting early identification of pregnant members at risk for depression as a means to assure treatment access and follow-up for the members with coexisting conditions. The program, through collaboration with Behavioral health, provides early co-management of cases where a member may be experiencing depression along with their pregnancy

The preventative behavioral health program attempts to encourage the recently postpartum woman to identify the signs and symptoms of depression and seek help for depression to minimize complications. The goals of the program are to educate members in the perinatal period about the risks of depression, educate members regarding the signs and symptoms of depression, educate members about accessing services for treatment of depression, educate the member's provider if the member demonstrates depression using the Edinburgh Scale, and identify members at moderate or high risk for depression and engage them in preventative care to avoid adverse outcomes.

The program also identifies those who have delivered, which allows screening for the presence of, or risk for, post-partum depression. A referral is made for additional support to the behavioral health case management or disease management teams if a member self-reports struggling with depression or has a high score on the Start Smart OB assessment.

Both the prenatal and the postpartum activities provide members with information regarding depression in pregnancy, an Edinburgh Depression Scale, and a self-addressed stamped envelope for mailing the completed survey to the Plan. Practitioners are advised of the Perinatal Depression Screening Program through the Provider Manual.

The same Perinatal Depression Screening Program has been delivered for the Marketplace membership since December 2018. From that time through August 2019, 238 NOP's were mailed. During that same timeframe, 75 perinatal packets had been mailed to Ambetter members in Kansas. Due to a small member population, no completed surveys have been returned to the health plan as of the writing of this report, there is no data for tracking this metric. During the measurement year 2018, 9 Ambetter members were enrolled in Start Smart for Baby, as of the date of this report, there were 2 active Ambetter members enrolled. The Plan will continue to outreach to pregnant members to engage in care coordination and provide proper screening.

The following barriers were identified regarding management of members with coexisting medical and behavioral health disorders and Perinatal Depression Screening program:

- Underreporting of pregnancy leads to lack of timely outreach to pregnant members.
- Undiagnosed Perinatal depression.
- Member knowledge deficit about the Start Smart program and benefits of the program (i.e. depression screening).
- Provider knowledge deficit regarding services Sunflower can provide to members with perinatal depression.

The Plan is working on the opportunities listed below, regarding coexisting medical and behavioral health disorders and Perinatal Depression Screening program:

- Improving Notice of Pregnancy reporting.
- Identifying members at risk for perinatal depression.
- Member education regarding Start Smart program benefits.
- Provider education about plan services regarding perinatal depression.

Coordinating Special Needs of Members with Serious & Persistent Mental Illness
The Plan collects and analyzes data related to the coordination of special needs for members with serious and persistent mental illnesses through the use of the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* (APM) HEDIS measure. This measure looks at members 1-17 years of age who have received two or more antipsychotic prescriptions during the calendar year. APM measures how many of these members have had metabolic testing. To meet measure requirements a member must have had a glucose test or HbA1c and a test for LDL-C or cholesterol. The table below shows HEDIS 2019 results.

Rate	75.0% (3/4)	N/A

The population size for this measure is low, four members in total fell into the denominator. Of those four, three completed the tests required to meet the measure. Ambetter HEDIS 2019 is a baseline year. The SMD measure was not included in the NCQA Quality Compass. Therefore, the Plan's goal of meeting or exceeding the NCQA Quality Compass 50th percentile is not applicable.

The Plan's care management staff review all cases referred to them for care alerts within the Plan's medical records system. Impact Pro and Interpreta systems provide the care management staff with a care alert for members who fall within the SMD measure and need monitoring. Care management staff use this information to guide discussions with members/guardians about care needs the member may have. This discussion includes the member's ability to access available services. If there are any barriers, the care management staff will provide support to the member in researching options to overcoming those barriers. The care management team can provide ongoing coordination and communication to members/guardians and providers.
Below are the list of barriers identified for coordinating special needs of members with serious and persistent mental illness:

- Low member understanding about the importance of having regular screenings while on antipsychotic medications.
- Prescribers not aware of status of diabetic screenings for youth on antipsychotics.

The following opportunities were identified for coordinating special needs of members with serious and persistent mental illness:

- Review of member predictive modeling report to educate identified members.
- Provider education on using the portal to determine care gaps.

Ambetter from Sunflower Health Plan UM Program Evaluation - 2019

UM Program Overview

Purpose
The purpose of the Utilization Management (UM) Program Description is to define the structures and processes utilized within the Medical Management Department for both physical and

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

Scope

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

Goals

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

Implementation

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

Authority

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

The Chief Medical Director has operational responsibility for and provides support to the Plan's UM Program. The Plan Chief Medical Director, Vice President of Medical Management (VPMM) and/or any designee as assigned by the Plan President and CEO are the senior executives responsible for implementing the UM program including cost containment, medical quality improvement, medical review activities pertaining to utilization review, quality improvement,

complex, controversial or experimental services, and successful operation of the UMC. A board certified psychiatrist and licensed behavioral health practitioners are involved in the implementation, monitoring and directing of behavioral health aspects of the UM Program, and a dentist is involved in the implementation, monitoring and directing of dental health aspects of the UM program. A pharmacist oversees the implementation, monitoring and directing of pharmacy services. In addition to the Chief Medical Director, the Plan may have one or more Medical and/or associate Medical Directors.

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

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

Program Integration

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

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

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

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

- Early childhood intervention.
- State protective and regulatory services.

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

Complex Case/Care Management

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

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

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

- Identifying barriers to adherence to the care plan and recommended solutions for each barrier. Barriers may include but are not limited to issues such as:
  - Language or literacy issues, include general literacy limitations and health literacy
  - Visual or hearing impairment
  - Psychological/mental impairment
  - Financial and/or health insurance coverage limitations
  - Transportation
  - Cultural and/or spiritual preferences or values

    - Limited knowledge of condition(s)
    - Low motivation or ambivalence toward implementing change
    - Lack of, or limited, social or care giver support
    - Environmental factors
- Prioritized goals, which consider member and caregiver strengths, needs and preferences. Prioritization of goals occurs and includes prioritization by either numerical order or based on high, medium, or low priority. Design of goals includes being achievable and helping the member make changes towards the most optimal recovery possible.
- Interventions based on the member's risk factors, problems and/or needs, agreed upon goals, and personal preferences.
- Determination of a period for measuring progress on meeting care plan goals and reevaluation of the plan.
- Self-management plans to assist members in managing their own condition. The member must acknowledge understanding and agreement to the specific activities identified in the self-management plan and this agreement must be included in the Centene Documentation System (CDS). Care management activities involved in developing and communicating a member's self-management plan include:
    - Education provided to members, their family/guardian, or other caregivers to help manage the member's condition(s). This may include written educational materials or verbal instructions provided by the care manager.
    - The specific information/materials and the method of providing information to the member (i.e. verbally, letter, pamphlet, etc.) are available in the CDS.
    - When possible, self-management activities that can affect biometric data and are available, such as weight and blood pressure in the CDS.
    - Follow up by the care manager to assess completion of self-management activities.
- Documentation of the plan of care in the CDS.

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

Acuity	Needs	Recommended Frequency of Contact
Critical/High	Multiple co-morbidities, more than one chronic condition, presence of co-morbid, behavioral and/or mental health issues, and/or episode of serious illness or injury; discharge planning, and outpatient coordination of service needs; complex or chronic condition, symptomatic and at risk for admission or readmission.	Minimum of weekly contact until stable. Once stable, allow 2 weeks until complications are stabilized, barriers removed, and/or needed services are in place. Monthly contact unless condition deteriorates.
Moderate	Complex condition with many health care needs; condition is mostly stable with adequate caregiver support. If member assigned as high acuity previously, member is compliant with the care plan and making progress toward meeting care plan goals.	Weekly, biweekly or monthly contact

Acuity	Needs	Recommended Frequency of Contact
Low	Primarily psychosocial needs; no current unmet need for health care services but may have a history of condition that places the member at risk for potential problems or complications. If member assigned to a higher acuity level previously, member is compliant with the care plan, has met some goals, and making significant progress toward meeting remaining care plan goals.	One or two contacts and evaluation for care coordination discharge as appropriate

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

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

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

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

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

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

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

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

- Established dedicated care management staff for these products in attempt to increase penetration into care management programs.
- Establishing a dedicated outreach team to assist with identifying and engaging members for case management.
- Continuation of dedicated Transplant Care Manager Nurses to assist transplant members.
- Continuation of a Sickle Cell Care Management Program to assess and educate all sickle cell members, assists with resources, coordinates care between providers, and any other functions necessary.
- Efforts focus on assisting new mothers to obtain four well-child visits within the first 6 months of life to ensure babies are receiving timely immunizations and meeting appropriate developmental milestones.
- Ongoing efforts to increase the percentage of Notice of Pregnancy forms completed on pregnant women to identify the high-risk pregnancies and offer Start Smart Case

Management, which includes identifying any mother at risk for pre-term deliver and working with the physician and the member to consider 17P injections to reduce the risk of a pre-term birth.

- A continued close partnership with Utilization Management staff to arrange safe discharges for NICU babies.
- Integrated Case Management training program for staff as well as a Plan based internal study group to further encourage/assist CM team members in preparing for and obtaining their CCM certification through CMSA.
- Continued strengthening of coordination of care between departments. The Plan continues weekly rounds on inpatient members. The plan also utilizes integration with Complex Case Management Rounds, behavioral health and physical health integrated rounds to discuss, coordinate care/services with contracting providers and vendors.
- Training and implementation of Care Management Transformation, which is a coordinated care model that goes beyond the Integrated Care model. It consists of a member journey and care router process to guide members to the right level of care, with integrated, coordinated care teams that holistically address physical, BH, and social needs with appropriate staffing/expertise, utilizing evidence based, population specific care pathways.
- The Plan has a wide range of educational materials for members. This includes materials on various disease states and life events. The materials are brightly colored and easy to read and provide many talking points for care managers during contact with members.
- The Plan utilizes Krames Patient Education materials database, which contains patient education materials for thousands of diagnoses, medications, and medical procedures.
- Focused outreach and efforts surrounding Opioid utilization. With this epidemic being complex in nature an IDT, team works with members and providers impacted by this. The Plan feels the best approach is with an interdepartmental approach including pharmacy, provider relations, care management, both physical and behavioral, and medical affairs. In depth, training will be provided to the staff so that they may better support our members. In addition, there will be focused outreach to providers to address the matters regarding prescribing practices.

Disease Management

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

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

Credentialing and Recredentialing

Structure and Resources

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 Ambetter 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.

Statistics

Sunflower's number of practitioners in network for 2019 was 15,585, which included that which is delegated for dental and vision providers. In 2019, 748 Ambetter practitioners completed the re-credentialing process. Of those re-credentialed, 100% of those were re-credentialed successfully and timely. The number of those re-credentialed in 36-month timeframe was 2,320. Provider credentialing turnaround time averaged 10 days from application completion to committee. The table below reflects the 2019 Credentialing report for Sunflower.

Total number of practitioners in network (includes delegated providers)	15,585*
Number initial practitioners credentialed	931
Average Credentialing TAT from Complete Application to Committee (Days)	10 days
-	
Number of practitioners re-credentialed	748
Number of practitioners re-credentialed within a 36 month timeline	2,320
% re-credentialed timely	100%
Number with cause	0
Number denied	0

* Includes Medicaid, Envolve Vision and Dental

Member Rights and Responsibilities

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

Delegation Oversight

The Plan selected delegated vendors to oversee certain activities to ensure quality of care for its members. The Plan retains accountability for delegated services and monitors their performance

through annual audits and by requiring monthly performance measures reporting. These measures include, but are not limited to, the following:

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

The following is a listing of the delegated vendors for 2019. The first five vendors are wholly owned subsidiaries of Centene:

1. Envolve Vision - Plan's vision care provider. Envolve Vision provides utilization management, network development and maintenance, credentialing of their network, and claims payment data.
2. Envolve Pharmacy Solutions - Plan's pharmacy benefits manager. US Script provide information for prior authorizations, utilization management, verification of active licenses for all participating pharmacies, and claims payment data.
3. Envolve People Care (EPC, formerly Nurtur and NurseWise) - Plan's disease management provider, after-hours call center and nurse advice line. EPC provides disease management as noted in the table above under Disease Management section. The after-hours call center and nurse advice line provides bilingual care with registered nurses, which complete health screenings, and after hours nurse advice.
4. Envolve Dental – Plan's dental benefit manager. They provide prior authorizations, utilization management, network development and maintenance and claim payment information.
5. National Imaging Associates (NIA) - Plan's high-tech radiological imaging provider. NIA provides prior authorizations, credentialing of their network and first level appeals. Provides post-service audits related to therapy services for speech, physical and occupations therapies for appropriate utilization. NIA also is the vendor for post-service utilization review of speech, physical and occupational therapies.
6. Eliza – Vendor who provides health maintenance reminders via Interactive Voice Response system and is a nationally contracted vendor.
7. Logisticare – Plan's transportation vendor.

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

The Plan evaluates each delegated entity's capacity to perform the proposed delegated activities prior to the executing of a delegation agreement. The Plan retains accountability for any functions and services delegated. Therefore the Plan monitors the performance of the delegated entity through annual approval of the delegated programs (Credentialing, UM, QI, etc.), routine reporting of key performance metrics and annual or more frequent evaluation to determine whether the delegated activities are being carried out according to the contract, accreditation standards and program

requirements. The Plan retains the right to reclaim the responsibility for performance of delegated functions, at any time, if the delegate is not performing adequately.

Review and Approval

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

Approval

The Quality and Utilization Program Evaluation for 2019 has been reviewed and approved as follows:

Submitted By: Trisa Hosford, Manager QI Date: 4/16/20

QIC Chair Approval: Susan Beaman, VP QI Date of QIC: 4/16/20

UM Committee Chair Approval: Vanessa Johnson, VP UM Date: 4/20/20

Board Chair Approval: Michael Stephens, CEO Date: 5/21/20