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

January 1 - December 31, 2017

*Data as available by 3/14/2018

Introduction

The purpose of this evaluation is to provide a systematic analysis of Sunflower Health Plan's (Sunflower) performance of the Quality Improvement (QI) activities and to evaluate the overall effectiveness of the Quality Assessment and Performance Improvement (QAPI) Program. The QI Department has established reporting QI activities as outlined in the QI Work Plan. This evaluation is focused on activities and interventions completed during the period of January 1 - December 31, 2017. The QAPI, QI Work Plan and QI Program Evaluation are reviewed and approved at least annually by the Quality Improvement Committee (QIC) and the Sunflower Health Plan's Board of Directors (BOD).

Mission

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

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

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

Purpose

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

Member Demographics and Service Area

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

Assessment of Sunflower's membership population has been completed annually from 2013 through 2017. A systematic review was undertaken to determine if there have been material changes in the population that would require the case management program to be substantially revised.

Membership Characteristics

Sunflower is in its fifth year of operations providing Medicaid services to members in Kansas. Annually, TANF and CHIP members consistently make up the majority of the Sunflower membership. The children ages 0-10 continue to comprise 43% of the membership for 2017 which is slightly lower than 2016. Those members of the ages 0-20 years make up 70% of the members served by Sunflower. Males and females remained consistent in distribution from 2016 to 2017. Sunflower's membership by month data demonstrates there has been a decrease in multiple products. From July, 2016 to June, 2017, there was a reduction of approximately 10% in membership.

The Sunflower membership characteristics for comparative purposes for 2015, 2016 and 2017 are shown in the tables below:

Percentage of Member Population by Product

Product	% of Population for 2015	% of Population for 2016	% of Population for 2017
CHIP	14%	10%	10%
Foster Care	4%	4%	4%
IDD	*	3%	3%
LTC Dual	6%	4%	4%
LTC Non-Dual	3%	2%	2%
SSI Dual	5%	4%	4%
SSI Non-Dual	7%	7%	8%
TANF	61%	66%	65%
Total**	100%	100%	100%

*IDD not previously broken out

**Rounding results in some totals >100%

Member Age Breakdown

Age Group	2015	2016	2017
0-10	47%	46%	43%
11-20	26%	27%	27%
21-30	7%	7%	8%
31-40	5%	6%	6%
41-50	4%	3%	4%
51-60	4%	4%	5%
61-70	3%	3%	3%
71-80	2%	2%	2%
81-90	2%	1%	2%
91+	0	1%	1%

Member Gender Breakdown

Gender	2015	2016	2017
Male	46%	46%	46%
Female	54%	54%	54%

The table below depicts the membership for each product throughout the timeframe demonstrating relative consistency. The data contained within this table represents Sunflower's membership based on financials for those said months and does not reflect any retro activities for those timeframes. Foster Care, IDD and LTC non-dual membership noted small membership increases over the twelve month period. Consistency was noted for Foster Care, IDD, LTC Dual and Non-Dual and both SSI products. There were decrease in membership noted for the CHIP, TANF, LTC Dual, SSI Dual and Non-Dual products..

Member Enrollment

Product	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
CHIP	14,782	13,777	13,801	13,662	13,316	13,205	12,997	12,991	13,061	12,966	12,851	12,731
Foster Care	5,486	5,522	5,529	5,581	5,610	5,613	5,625	5,593	5,603	5,575	5,616	5,585
IDD	4,100	4,118	4,126	4,123	4,122	4,112	4,154	4,140	4,145	4,156	4,153	4,142
LTC Dual	6,211	6,218	6,222	6,213	6,192	6,144	6,088	6,038	6,031	5,985	5,973	5,903
LTC Non-Dual	2,472	2,486	2,550	2,557	2,556	2,561	2,509	2,518	2,548	2,577	2,605	2,614
SSI Dual	5,616	5,622	5,622	5,634	5,689	5,706	5,661	5,660	5,668	5,564	5,486	5,473
SSI Non-Dual	10,249	10,313	10,313	10,295	10,299	10,298	10,230	10,211	10,198	10,149	10,112	10,106
TANF	98,384	98,772	98,772	98,591	97,177	95,410	92,484	89,869	89,217	87,410	87,314	86,212
Total	**147,300**	**146,935**	**146,935**	**146,656**	**144,951**	**143,049**	**139,748**	**137,020**	**136,471**	**134,382**	**134,110**	**132,766**

Sunflower membership experienced a decrease from June of 2016 to July of 2017. Kansas Medicaid remained unchanged with respect to expansion. Members continue to have an annual open enrollment period to allow them to change MCO's. As most members do not act upon making change, Sunflower does not expect to experience much member movement to be reflected in 2018.

Languages Spoken by Sunflower Members

Language	Member Count	% of population
Sudanese	1	0.00%
Arabic	151	0.12%
Chinese	37	0.03%
German	6	0.00%
English	107,193	88.67%
French	15	0.01%
Gujarathi	2	0.00%
Hindi	14	0.01%
Italian	2	0.00%
Korean	14	0.01%

Language	Member Count	% of population
LAO	28	0.02%
Other	150	0.12%
Persian	9	0.01%
Portuguese	1	0.00%
Russian	46	0.04%
Serbo-Croatian	8	0.01%
Somali	6	0.00%
Spanish	3,768	3.12%
Tagalog	3	0.00%
Thai	2	0.00%
Unknown	9,328	7.72%
Urdu	6	0.00%
Vietnamese	104	0.09%
Total	120,894	100.00%

Sunflower assesses members' linguistic needs based on the state eligibility files which query members on their primary language spoken, 88.67% of Sunflower members speak English, the number that did not report a primary language demonstrated a decrease to 7.72% for 2017 compared to 2016, and those who speak Spanish remained relatively consistent at 3.12%. A detailed breakdown of other less common languages is also noted in the table above. Those reporting their language as "Other" was 0.12%.

Sunflower offers language assistance services to members who require translation services. Services are available for both telephonic and on-site interactions. These services can be arranged by Sunflower Care Management, Customer Service, or Provider/Practitioner staff for member interactions with both Sunflower staff and network providers. The table below represents the top languages for which members have requested translation services by unique interactions during the assessment time period. Sunflower also has Spanish-speaking Care Management and Customer Services Representatives available on staff. The Sunflower Customer Service Supervisor and Call Quality Analyst are also Spanish-speaking to ensure Spanish-speaking members are well served by the health plan. The table below depicts the Language Service Line Requests that occurred from January 1, 2017 through December 31, 2017.

Member Languages from Language Line Use

Language	# of Calls	% of Population
Spanish	6299	83.95%
Swahili	167	2.23%
Somali	165	2.20%
Nepali	160	2.13%
Burmese	153	2.04%
Arabic	104	1.39%

Language	# of Calls	% of Population
Russian	72	0.96%
Vietnamese	67	0.89%
Mandarin	46	0.61%
Kenya/Rwanda	33	0.44%
Karen	29	0.39%
Tigrigna (Eritrea)	25	0.33%
American Sign Language	21	0.28%
French	19	0.25%
All Other Languages	143	2.16%
Total	**7503**	**100.00%**

Race/Ethnicity

The tables below reflect race and ethnicity and are based on member responses on race and ethnicity to the 2017 CAHPS adult and child member satisfaction surveys. The data provided allows for comparison to the designated race/ethnicity provided on the 2016 CAHPS member satisfaction surveys as well. The Child survey noted for both 2016 and 2017 represents an aggregated report of two separate child surveys completed for Title XIX and Title XXI. Both demonstrated results for the general child population as well as the child with chronic conditions.

Child Race / Ethnicity Category	2016 Child General Population CAHPS	2017 Child General Population CAHPS	2016 Child With Chronic Conditions CAHPS	2017 Child With Chronic Conditions CAHPS
White	81.5%	77%	83.8%	82%
Black /African American	10.1%	10%	15.6%	14%
Hispanic / Latino**	31.7%	35%	19.6%	21%
Asian	4.4%	4%	2.0%	2%
Hawaiian / Pacific Islander	1.2%	1%	1.5%	1%
American Indian / Alaskan	4.9%	5%	7.0%	5%
Other	13.3%	12%	8.7%	9%

Adult Race / Ethnicity Category	2016 Adult CAHPS	2017 Adult CAHPS
White	77.2%	75%
Black /African American	15.0%	13%
Hispanic / Latino**	12.8%	11%
Asian	2.4%	2%
Hawaiian / Pacific Islander	0.2%	1%
American Indian / Alaskan	8.3%	5%
Other	9.5%	7%

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

Sunflower noted an increase in those responding as Hispanic/Latino for the general child population from 31.7% in 2016 to 35% in 2017 and the child with chronic condition also noted a slight increase with those noted to be Hispanic/Latino from 19.6% in 2016 to 21% in 2017. Both of those groups of respondents noted a decline in those reporting as White. The remainder of the race/ethnicity categories stayed relatively the same for the general child and child with chronic conditions. The adult survey respondents demonstrated a small decline in all the ethnicity groups reported.

Overall, the results from the 2017 CAHPS surveys for both adult and child populations indicate that there was consistency with respect to the race/ethnicity of the Sunflower membership in comparison from 2016 to 2017. There was not any evidence of significant changes demonstrated in the ethnicity of the membership surveyed. The majority of Sunflower adult membership is white followed by Black/African Americans and then by the Hispanic/Latino membership. Again in 2017, the child survey results demonstrated consistency compared to 2016. This was evidenced as the majority of respondents indicated their race/ethnicity as white, followed by Hispanic/Latino and then Black/African American. This remains consistent with results demonstrated previously on both the adult and child 2016 CAHPS surveys as well as including the general child and children with chronic conditions.

Program Overview

Sunflower continues to be committed to the provision of a well-designed and well-implemented QAPI Program. Sunflower's culture, systems and processes are structured around its mission to improve the health of all enrolled members. The QAPI Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of health care provided to all members, including those with special needs. This systematic approach to quality improvement provides a continuous cycle for assessing the quality of care and services in such areas as preventive health, acute and chronic care, behavioral health, over and under-utilization, continuity and coordination of care, patient safety, administrative and network services.

Scope

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

Sunflower's QAPI Program monitors the following:

- Acute and chronic care management
- Behavioral health care
- Care Management
- Compliance with member confidentiality laws and regulation
- Compliance with preventive health guidelines and practice guidelines
- Continuity and coordination of care
- Data collection, analysis and reporting
- Delegated entity oversight
- Department performance and service
- Employee and provider cultural competency
- Fraud and abuse detection, prevention and reporting
- Home support service utilization for LTSS services
- Information Management

- Marketing practices
- Member enrollment and disenrollment
- Member Grievance System
- Member satisfaction
- Customer Services
- Network performance
- Organization Structure
- Patient safety
- Primary Care Provider changes
- Pharmacy
- Provider and Plan after-hours telephone accessibility
- Provider appointment availability
- Provider Complaint System
- Provider network adequacy and capacity
- Provider satisfaction
- Provider Services
- Selection and retention of providers (credentialing and re-credentialing)
- Utilization Management, including under and over utilization
- Policies to support the QAPI program

Goals

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

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

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

Objectives

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

- To establish and maintain a health system that promotes continuous quality improvement;
- To adopt evidence-based clinical indicators and practice guidelines as a means for identifying and addressing variations in medical practice;
- To select areas of study based on demonstration of need and relevance to the population served;

- To develop standardized performance measures that are clearly defined, objective, measurable, and allow tracking over time;
- To utilize Management Information Systems (MIS) in data collection, integration, tracking, analysis and reporting of data that reflects performance on standardized measures of health outcomes;
- To allocate personnel and resources necessary to:
    - support the quality improvement program, including data analysis and reporting;
    - meet the educational needs of members, providers and staff relevant to quality improvement efforts;
- To seek input and work with members, providers and community resources to improve quality of care provided to members;
- To develop partnerships with new stakeholders and providers to establish services and relationships to support home and community based services and LTC residential options;
- To oversee peer review procedures that will address deviations in medical management and health care practices and devise action plans to improve services;
- To establish a system to provide frequent, periodic quality improvement information to participating providers in order to support them in their efforts to provide high quality health care;
- To recommend and institute "focused" quality studies in clinical and non-clinical areas, where appropriate.

Committee Structure

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

Board of Directors

The Sunflower Board of Directors oversees development, implementation and evaluation of the QAPI Program. The BOD has ultimate authority and accountability for oversight of the quality of clinical and non-clinical care and services provided to Members. Sunflower's Board of Directors reports to the Centene Board of Directors as Sunflower is a wholly-owned subsidiary of Centene Corporation. The Board supports the QAPI Program by:

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

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

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

The QIC is composed of Sunflower's CEO/President, Chief Medical Director, Associate Medical Director, and QI senior leadership, along with other Sunflower executive staff representing Medical Management (including Utilization Management and Case Management), Network Development/Contracting, Customer Service, Compliance, and Pharmacy departments, with other ad hoc members as necessary. Additional QIC attendees include staff responsible for clinical appeals and Waste Abuse and Fraud. The first QIC meeting was held December 19, 2012, prior to implementation of KanCare, and continues to meet on a quarterly basis, at a minimum. For 2017, QIC met a total of five (5) times which included the quarterly meetings and also one ad hoc meeting.

Credentialing Committee
The Credentialing Committee is a standing subcommittee of the QIC and is responsible for administering the daily oversight and operating authority of the Credentialing Program. The QIC is the vehicle through which credentialing activities are communicated to the Board of Directors. The Credentialing Committee is responsible for the credentialing and re-credentialing of physicians, non-physician practitioners, facilities, long-term care providers, and other practitioners in Sunflower's network, and to oversee the credentialing process to ensure compliance with regulatory and accreditation requirements. The Credentialing Committee is facilitated through Centene's corporate office and is composed of Sunflower's Chief Medical Director and Associate Medical Director, Centene's Corporate Credentialing Director, network physicians, and other Sunflower QI staff. The Credentialing Committee met 13 times in 2017. Typically the Credentialing Committee meets monthly and on an ad-hoc basis.

The Credentialing Department is responsible for ensuring all practitioners are appropriately licensed and experienced in their field. This is accomplished through applying rigorous standards that verifies practitioner's license, education, training, experience, certification, malpractice history, work history, and quality of care attributes. To become a participating provider in the Sunflower network, each practitioner must meet the minimum qualifications as outlined by the State of Kansas and the National Committee for Quality Assurance (NCQA). The Credentialing Department is housed at Centene's corporate offices. The table below reflects the 2017 Credentialing report for Sunflower.

Sunflower's number of practitioners in network for 2017 was 15,549 which included that which is delegated for dental and vision providers. In 2017, 597 Sunflower 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 3,162. These details are depicted in the table that follows. Provider credentialing turnaround time averaged 11.3 days from application completion to committee which is down from 12 days for 2016. There was also the termination of one provider for cause and one that was rejected in 2017. This information is depicted in the table that follows below.

2017 Credentialing Statistics	
Total number of practitioners in network (includes delegated providers) as of 12/31/2017	15,549* Includes Medicaid, Envolve Vision and Dental
Initial Credentialing (excludes delegated)	
Number initial practitioners credentialed	1,054
Average Credentialing TAT from Complete Application to Committee (Days)	11.3 days
Re-credentialing	
Number of practitioners re-credentialed	597
Number of practitioners re-credentialed within a 36 month timeline	3,162
% re-credentialed timely	100%
Terminated/Rejected/Suspended/Denied	
Number with cause	1
Number denied	1

Pharmacy and Therapeutic Committee

The Pharmacy and Therapeutics (P&T) Committee is a standing subcommittee of the QIC and is responsible for administering the routine oversight and operating authority of the Pharmacy Program. The QIC is the vehicle through which pharmacy monitoring and reporting activities are communicated to the Board of Directors. The P&T Committee ensures Sunflower provides a high quality, cost effective preferred drug list (PDL), an effective pharmacy program, and addresses quality and utilization issues related to pharmaceutical prescribing patterns, practices, and trends. The P&T Committee is a multidisciplinary team composed of Sunflower's Associate Medical Director, Pharmacy Director, network physicians, and other executive staff. For 2017, P&T met two (2) times covering 4q2016 and 1q2017 in the first meeting and then the 2q2017 and 3q2017 in the second meeting.

Utilization Management Committee

Routine and consistent oversight and operating authority of utilization management activities is delegated to the Utilization Management Committee (UMC) which reports to the QIC and ultimately to the Sunflower Board of Directors. The UMC is responsible for the review and appropriate approval of medical necessity criteria, protocols, and utilization management policies and procedures. Additionally, the UMC monitors and analyzes relevant data to detect and correct patterns of potential or actual inappropriate under- or over-utilization which may impact health care services, coordination of care, appropriate use of services and resources as well as member and practitioner satisfaction with the UM process. The UMC is composed of Sunflower's Chief Medical Director, Medical Director(s), Sunflower's Vice Presidents of Medical

Management, and other operational staff as needed. Network physicians also participate in this committee to provide input on process, policies and data. For 2017, UM Committee met four (4) times. Typically, the UM Committee meets quarterly.

HEDIS Steering Committee
The HEDIS Steering Committee oversees Sunflower's HEDIS process and performance measures. The Committee reports directly to the QIC and reviews monthly HEDIS rate trending, identifies data concerns, and communicates both plan and corporate initiatives to Sunflower Senior Leadership. The Committee directs clinical, non-clinical, member and provider initiatives to improve selected HEDIS measure performance. The HEDIS Steering Committee oversees the implementation, progression and outcomes monitoring of initiatives specific to HEDIS, recommends resources necessary to support the on-going improvement of HEDIS scores, reviews/establishes benchmarks or performance goals for HEDIS and oversee delegated vendor roles in improving HEDIS scores. The Committee meets a minimum of quarterly and is facilitated by the HEDIS Coordinator. Membership includes the senior leadership of QI, the CEO/President, Chief Medical Director, Associate Medical Director, and Senior Leadership of Medical Management, with representation from Contracting/Network Management, Member/Provider Services, and Pharmacy. The HEDIS Steering Committee meets quarterly and met four (4) times in 2017.

Peer Review Committee
The Peer Review Committee (PRC) is an ad-hoc committee of the QIC and is responsible for reviewing inappropriate or aberrant service by a provider including alleged quality of care concerns, adverse events, and sentinel events where initial investigation indicates a significant potential or a significant, severe adverse outcome has occurred, or other cases as deemed appropriate by the Chief Medical Director. This committee includes participation by both network physicians and health plan medical directors. The PRC is expected to use their clinical judgment in assessing the appropriateness of clinical care and recommending a corrective action plan that will best suit the particular provider's situation. For 2017, PRC met on ten (10) occasions to review cases and make recommendations as appropriate.

Performance Improvement Team
The Sunflower Performance Improvement Team (PIT) is an internal, cross-functional quality improvement team that facilitates the integration of a culture of quality improvement throughout the organization. The PIT is responsible for gathering and analyzing performance measures, performing barrier and root cause analysis for indicators falling below desired performance, and making recommendations regarding corrective actions/interventions for improvement. The PIT is also responsible for overseeing the implementation of recommended corrective actions/interventions from the QIC and/or its supporting subcommittees, monitoring the outcomes of those improvement efforts and reporting back to the designated committee.

The PIT meets monthly and includes representation from each functional area within Sunflower. Membership includes staff that conducts or directly supervises the day-to-day activities of the departments, i.e. Case Management, Compliance, Member Connections, Contracting, Customer Services, Network Development, Prior Authorization, Provider Relations/Services, Quality Improvement or other members as determined by the topic under discussion. The PIT met eleven (11) times in 2017, with several subcommittee meetings of the PIT to address items such as the CAHPS survey results and Pay for Performance (P4P) activities. The PIT typically meets monthly.

Three subcommittees report to the PIT, as described below:

Member and Community Advisory Committee (MCAC)

The goal of the Member and Community Advisory Committee (MCAC) is to solicit member input into the Quality Improvement Program, operations, and services that are provided to members. The purpose of the MCAC is to act as a focus group to facilitate member and community perspective on the quality of care and services offered by Sunflower Health Plan and to offer recommendations for improvement to Customer Services and community engagement, assisting the plan to remain member centric and provide services and activities that improve member quality of care and satisfaction. The MCAC met four (4) times in 2017.

Vendor Joint Operations Committees

The Vendor Joint Operations Committees (JOCs) are active sub-committees of the PIT, whose primary function is to provide guidance to, and oversight of, the operations affecting the scope of functions of delegated vendors, including review of periodic activity reports from delegated vendors, ensuring compliance with all NCQA standards and regulations related to the delegation relationship, and recommending actions to address any identified opportunities for improvement in delegated services. The purpose of the 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 Sunflower functional area as well as representation from the delegated vendors.

Vendor	Number of Meetings in 2017
National Imaging Association	20
Envolve Pharmacy	13
Logisticare	31
EPC DM / NAL	10
Envolve Dental	17
USMM	11
Optum	4
LifeShare	4
Envolve Vision	15
EPC (CBH)	59
EPC (STRS)	4

Long Term Support and Services Advisory Committee

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

Physician Advisory Committee

In 2017, the Physician Advisory Committee was initiated with its first meeting occurring in July and the second one in November. The committee is comprised of practicing primary care physicians in Sunflower's network who provide clinical advice and quality oversight from the physician perspective. The PAC is chaired by the Chief Medical Director and is scheduled on a quarterly basis. This allows for a close working relationship with Sunflower's Chief Medical Officer and Network leadership to ensure maintenance of the highest standards in care quality, efficiency, transparency, and relentless pursuit of healthy 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.

Grievance and Appeals Committee

The Grievance and Appeals Committee (GAC) is a subcommittee of the QIC and is responsible for tracking and analysis of member grievances and appeals including type, timeliness of resolution, performing barrier and root cause analysis, and making recommendations regarding corrective actions as indicated. The GAC is composed of Sunflower's Chief Medical Director, Pharmacy Director, QI leadership, Grievance Coordinators, Clinical Appeals Coordinators, Lead Clinical Appeals Nurse and representatives from Customer Service and Medical Management. The GAC provides summary reports to the QIC at regular intervals, but no less than quarterly. Meetings typically are held quarterly or more frequently as needed. The GAC met four (4) times in 2017.

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 2017. The QI department is now composed of the following members:

- Chief Medical Director, serving as the Senior Executive for Quality Initiatives (SEQI) (member by position and role)
- Medical Director of Utilization Management (member by position and role, not formal reporting structure)
- Senior Director, QI (Nurse)
- Managers, QI (Nurses – 3 total)
- Quality Improvement Auditor (Nurses - 2)
- EPSDT Coordinator
- HEDIS Coordinator
- Grievance Coordinator (2 total)
- Accreditation Specialist
- Lead Clinical Appeals Coordinator (Nurse)
- Clinical Appeals Coordinator (Nurse – 3 total)
- QI Project Manager (2)
- QI, Care Manager (2)
- QI, Specialist (2)
- RA, Coding Analyst
- RA, Member Coordinator
- Centene Corporate support

Quality Leadership in 2017
The plan Chief Medical Director served as the SEQI and provided continued leadership and oversight of QI. There was turnover of three (3) staff persons in 2017 in the QI Department. The turnover was attributed to personal choices or taking positions outside of Sunflower; one of which went to Corporate. The Medical Record Review and Risk Adjustment teams were integrated into the Quality Improvement team in 2017. Routine assessments of work volume and progress with respect to plan priorities allow for reallocation of staff resources to address needs encountered in work volume spikes and also to address priority areas that are in need to ensure the member and provider needs are met as integral parts of the business.

In 2017, the employment positions at Sunflower have remained relatively consistent as the plan membership had minimal change and product lines remained unchanged. Staffing needs continue to be assessed on an ongoing basis to ensure the plan is able to accommodate member needs, improve quality, and to adequately address the volume of routine audits and reporting uniquely required by the state contract.

Compliance Program
Sunflower's Compliance Department, in conjunction with Centene Corporate, is responsible for ongoing monitoring and investigation of potential waste, abuse and fraud related to providers, members, and internal staff. Sunflower's Compliance Department is responsible for establishing and maintaining an effective compliance program that meets the seven elements as defined by Office of Inspector General (OIG).

In 2017, Sunflower underwent the BBA/state audit, KID Financial Exam (additional documentation requested), KDADS member quarterly files submissions and KDADS Provider Credentialing Audit. Additionally, in 2017 KFMC our EQRO performed validation of HEDIS measures and other measures included in 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. Sunflower anticipates the start of the 2017 Performance Measure Validation in June of 2018. Sunflower complied with record requests for quarterly Home and Community Based Services (HCBS) documentation audit requests for the first three quarters of 2017. At the time of this report compilation, Sunflower was currently uploading the requested documents for the fourth quarter 2017 review. Sunflower is also awaiting the final results of HCBS audits from the state. Sunflower participated in an Information Systems Capability Assessment (ICSA) audit in 2016 which occurs every other year and was determined to have an infrastructure that enables collection, analysis and reporting of data to support quality assessment and improvement activities. Additionally, the system provides capability of tracking enrollees should they change programs allowing for continual assessment of continuity of enrollees. The system also provides ability to restrict reports to KanCare data and stratification by product line for report submission to State up to CMS. Sunflower submitted the ISCA review in early 2016 and received the results of the findings in July of 2017 which resulted in there being no recommendations for Sunflower at that time related to the ISCA audit. Sunflower anticipates the next ISCA audit in 2018.

QAPI Program Effectiveness
Throughout 2017, the QI Department continued its collaboration with all organizational departments to facilitate continuous improvement in performance by empowering all stakeholders through education, communication, data analysis and evaluation. Sunflower has continued to improve the quality of care and services provided to the membership through continuous assessment of patterns, trends and identification of barriers to desired outcomes.

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

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

The 2017 QI Work Plan defines the activities, the person(s) responsible for the activity, the date of expected task completion and the monitoring techniques that will be used to ensure completion within the established timeframe. The QI Work Plan is presented to the QIC on an annual basis for approval, through the annual evaluation process and at regular intervals throughout the year. The 2018 QI Work plan is currently being updated and will be provided to the QIC for review and approval.

Quality Improvement Program Integration
The QI Program Evaluation, QI Program Description, and the QI Work Plan are integrated. The year-end QI Program Evaluation identifies barriers, opportunities for improvement, results and recommended interventions. The QI Evaluation is then used to make modifications to the coming year's QI Program Description and to create the key metrics of the QI Work Plan.

Strengths and Accomplishments:

- Quality Improvement leadership expanded to have four nurse leaders 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.
- 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. Development of comprehensive plans for future improvement opportunities using multidisciplinary team.
- Continued use of skill in HEDIS operations to allow for the plan to do over-reads during hybrid season, optimization of data captured through state immunization registry,

collection of supplemental data from in-home assessments and other opportunities for potential impact on HEDIS measures for MY2017.

- Continued evaluation and updates to systems to incorporate state reporting criteria to reduce reporting errors and automate some reporting functions.
- First LTSS CM satisfaction survey was completed
- Revised provider profiles to be based primarily on attribution and then provider assignment as appropriate.
- Continued evaluation, modification, and update of templates for trending of Grievances and Appeals and Quality of Care issues data for more in depth analysis and display for team members and Committee, allowing improvement opportunities to be more easily identified.
- Continued efforts to review all Sunflower and vendor grievance and appeals documentation, revising and creating more consistency to reduce member confusion.
- Partnered with vendors to look through opportunities to improve efficiencies and satisfaction through education of providers, health plan staff and members
- Continued use of developed reports for monitoring and to identify cases at risk of not meeting turn-around time (TAT) for grievances and appeals before they are out of TAT.
- Utilize developed process in documentation system to route 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.
- Efforts continue to evaluate and refine processes for State Fair Hearings, including documentation storage, and increasing reliability and quality of work product to Office of Administrative Hearings (OAH).
- Continued partnership with Sunflower Clinical Analytics Team to improve data integrity, revise provider profiles and accuracy related to member outcomes, strategic initiatives and to meet state reporting requirements.
- Implemented changes in Grievance Appeals Report (GAR) along with process changes to ensure that grievances are worked timely to meet State contractual requirements.
- Implemented Contract Amendment 25 on 5/1/17 related to appeals, grievances and State Fair Hearings which included health plan trainings to increase knowledge and understanding of requirements
- Member grievance resolution TAT for 2017 was 100%, while acknowledgment was at 98.69%
- Member standard appeal resolution TAT for 2017 was 99.7% and acknowledgment was at 98.5%
- Care Management worked with 11,958 members in 2017.
- NurseWise advice line handled 3,760 total calls in 2017.
- Participated in approximately 121 member outreach health fairs/community events.
- Participated in approximately 105 provider conferences and seminars, presenting and providing information or as a conference participant.
- Continued partnership with Nurtur to provide disease management services for Sunflower members.
- Nurtur’s 2017 monthly average for active health coaching is 850 members, and for Education is 2,050.

- Answered 161,476 calls in the call center in 2017 with an 86.25% service level. The average speed to answer was 19 seconds.
- The Sunflower Customer Services/Provider Services call center provides education and referral services to members and providers. The call center received and responded to an average of 3, 105 calls weekly regarding benefit inquiries, concerns, complaints, and request for arranging services.
- Continued to focus on expanded sources for supplemental data that allow better HEDIS data capture to reduce provider record request burden, which included use of records received via the secure Provider Portal, in-home vendor assessments and utilization of KHIN as sources.
- Utilized WebIZ, state immunization registry to improve capture of immunization data for HEDIS.
- Provided $1.9M in value added services to our membership and $911,785 for in-lieu of services.
- Achieved an overall claims payment average TAT of 9.93 days on over 315,000 claims a month (excluding pharmacy claims).
- Continued to partner 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.
- Scorecards implemented to allow monitoring of health plan rating scores that included both CAHPS and HEDIS data, allowing for current year trends to previous year and gap to meet thresholds and rating score.
- Implemented 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
- Continued partnership with Quest/ExamOne to help close care gaps on Hemoglobin A1c testing, Monitoring for Nephropathy, BMI measurements and Blood Pressure measurements.

Opportunities for Improvements:

- HEDIS rates are a focus for continued improvement; Sunflower continues to evaluate resources and opportunities for education and incentives to improve rates.
- Sunflower continues to work on P4P interventions for 2018.
- Sunflower will implement interventions to continuously improve Member and Provider satisfaction with Sunflower services and operations based on survey results and other avenues of feedback including appeals and grievances.
- Sunflower will continue to develop and expand trending reports for data analysis and focused intervention.
- Continued HPV PIP to strive for improvement in the HPV vaccination compliance for adolescents
- Continue efforts 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.
- Continue to work with the other Kansas Medicaid MCOs on issues to improve care to Medicaid beneficiaries as necessary.
- GAR changes identified system opportunities as well as report and/or process changes, to ensure State reporting requirements are being met.
- Continue to explore opportunities to expand P4P partnerships with network providers to improve the quality of care members receive

QUALITY PERFORMANCE MEASURES AND OUTCOMES

Performance Improvement Projects

Sunflower is required by state contract to have at least two Performance Improvement Projects (PIPs) annually. Additionally, it is a contractual requirement that one of those is related to behavioral health. Sunflower's PIPs for 2017 were related to HPV Vaccination Rates for Adolescent and the newly initiated PIP focusing on Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD). The Initiation and Engagement for Alcohol and Other Drugs PIP ended in 2016.

Human Papilloma Virus (HPV) Vaccination

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

Each of the MCOs had proposed a separate goal for 2015 performance that was based on their HEDIS 2015 final rate for the measure. Upon evaluation by the State and EQRO this was not utilized as the baseline year performance and HEDIS 2017(MY2016) was identified as the baseline year for re-measurement. Thus, Sunflower's baseline was based on the HEDIS 2017 rates for MY2016. Those final rates are depicted in the table below. Combined rate for males and females was 19.23%, while females only was 21.74% and males only was noted to be 16.75%. Based on this performance, the MY2017 goal for Sunflower's combined rate is 20.19%, which would demonstrate a 5% increase from the previous years' performance. The HEDIS Technical Specifications changed in 2016 to include males. During 2017, the HEDIS Technical Specifications were updated again requiring two doses versus three in specific circumstances to offer protection against HPV. However for measurement year 2016, performance will be measured on females only. HEDIS 2017(MY2016) provided the baseline for combined males/females and males rates.

The three MCOs started with provider profiles to raise provider awareness and enlist their assistance with member compliance. Letters were also sent to the parents/guardians of the members who were non-compliant to provide educational material to help increase awareness and understanding related to the importance of the vaccination with the intended outcome of increasing the vaccination rate. Additionally, efforts were initiated with multiple clinics to offer extended hours to provide well child visits and vaccinations that were not limited to just the HPV vaccination and included both the Tdap and Meningococcal vaccines for Adolescents and CIS as well. Outreach to members by phone was implemented to assist in scheduling appointments and arranging transportation to promote attendance with appointments. Educational materials were provided on the plan website as resources specifically aimed to assist providers with having conversations related to HPV vaccinations with parents of adolescents. Three different provider educational opportunities were offered in 2017. One of those was a CME event that

included partnering with the American Cancer Society that offered CME credits in August of 2017. Additionally, the MCO's continued to partner with health departments and FQHCs to engage members by promoting walk-in clinics and community events. In 2017, although the rates are not yet final the preliminary rates show improvement. MCO's continue to explore ways to increase collaboration with more provider types beyond Primary Care to explore and continue efforts to address missed opportunities.

The table provided on the following page demonstrates the year over year results on final HEDIS rates as well as the HEDIS administrative rates for HEDIS 2018 since the final results are not yet available.

HEDIS Measure	HEDIS 2016 (MY2015) Hybrid	HEDIS 2017 (MY2016) Hybrid	HEDIS 2018 (MY2017) Admin	Met/Exceeded NCQA 2016 Quality Compass 50th Percentile
Meningococcal	64.90	66.59	73.33	No
Tdap	81.74	82.69	83.84	No
HPV (boys and girls)	N/A	19.23	32.20	N/A
HPV (girls only)	17.01	21.74	21.48	No
HPV (boys only)	N/A	16.75	17.16	N/A

**Awaiting final HEDIS 2018 rates*

Initiation and Engagement for Alcohol and Other Drugs

In the fourth quarter of 2016, Sunflower evaluated and proposed to the state opportunities for a PIP that would replace this PIP that was concluding on Initiation and Engagement for Alcohol and Other Drugs. This PIP thus concluded and in 2017, a new PIP started that replaced it focusing on behavioral health HEDIS measure noted with an opportunity to impact members positively, Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications.

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

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

Interventions implemented:

1. Referred non-compliant members to the CM team for education and support in completing their screening.
2. Mailed letters to members to educate them on the importance of screening and to offer support as needed.

3. Behavioral Health leadership met with the Association of Community Mental Health Centers of Kansas to inform the provider network of the PIP and discuss ideas for improvement within the state.
4. A provider newsletter article was sent to all Sunflower providers to prescribers of antipsychotic medications to encourage members to complete annual screening.
5. Sunflower engaged Community Mental Health Centers (CMHC) providers in a pay for performance program related to appropriate diabetes screening of members at risk. In addition, Community Mental Health Centers (CMHC) were provided a monthly data set of attributed members who fell within the PIP. This data set informed CMHCs of each member's compliance status with the screening. CMHCs were asked to support members in completing the screening.
6. Internal trainings among behavioral health and physical health staff were provided by Sunflower's Medical Directors. The training discussed diabetes, antipsychotic medications, and the importance of annual screenings.

HEDIS MEASURE	HEDIS 2017 (MY2016) Hybrid	HEDIS 2018 (MY2017) Admin.*	Met/Exceeded NCQA 2016 Quality Compass 50th Percentile
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications	76.10	77.96	No

**Awaiting final HEDIS 2018 rates*

NCQA Accreditation

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

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

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

Additionally, the QI strengths specifically noted are noted below:

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

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

having well-organized and documented files for credentialing and re-credentialing of providers. They were also noted for strong delegate oversight and very knowledgeable credentialing staff with 8/8 on file reviews as well. Sunflower's member materials were noted to be compliant and easy for members to use.

There were opportunities identified for Sunflower as well from this. Those opportunities for improvement revolved around physician information transparency, hospital directory data on the organization's web page, and hospital information transparency. Sunflower continues to work with corporate resources to improve performance in these domains.

Sunflower strives for continuous readiness which involves ongoing review of all plan and quality improvement processes to be consistent with NCQA standards. Continued focus on opportunities for refinements were made to hardwire accreditation compliance into processes including revision of member letters with auto attachments that include appeal information, development of a process for policy review, and training of new staff on documentation requirements. In 2017 readiness reviews/audits, and ongoing health plan NCQA education and reminders continued. Sunflower also started preparing for LTSS and BH. Sunflower has a lead for NCQA accreditation efforts to ensure the plan has a focus on continued readiness. Sunflower also works very closely with corporate resources to maintain NCQA compliance.

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

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

Sunflower has been collecting HEDIS data since plan inception January 2013 and loading the information into its certified-HEDIS software. Sunflower focuses efforts to improve on HEDIS measures by factoring in those that are required for NCQA accreditation and those that are included in the yearly state Pay for Performance (P4P) measures. Sunflower continued to track progress on these measures on a monthly basis throughout 2017 while actively working interventions throughout 2017. Unfortunately due to the timing of the due date of this report, a determination as to whether the measure goals will be met will not be able to be provided until the final HEDIS 2018 results are available, which will likely be in July of 2018. As an area for improvement, in 2018 the HEDIS work-plan will focus on the NCQA and state recognized P4P measures. Sunflower's performance on HEDIS measures in MY2016 contributed to the achievement of 'Commendable' status by NCQA.

Childhood Immunizations

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

- Alerts for Customer Service Representatives and Medical Management to indicate members who have care gaps and can remind them of the need for an appointment and/or assist with making one along with treatment, if needed
- Birthday card mailings the month prior to the member's birthday, as a reminder of Well Child Checks and Immunizations
- Implemented warm phone calls to parents/guardians of the children and adolescents with care gap needs for immunizations and well exams
- Monthly post cards sent for newborns born previous month with Periodicity schedule
- Baby showers given for parents of newborns, providing educational information concerning child wellness issues
- Start Smart for Your Baby Program – outreach to parents of newborns to educate on Periodicity schedule
- Proactive Outreach Management (POM) calls made to parents/guardians of newborns to remind them of schedule for well-child visits, including immunizations
- Back to school initiatives in Sedgwick County to promote immunization compliance
- Corporate "Healthy Reminders" mailer sent out bi-monthly to remind members of immunizations completed and due
- HEDIS Quick Reference Guide distribution to new providers and annual updates to existing providers with ICD-10 updates
- Gap analysis for high volume providers currently available on the Provider Portal
- Provider newsletter article completed in Summer 2017 issue with an article pertaining to supporting HEDIS scores
- Well child provider profile based first of provider attribution then assignment to augment immunizations by children getting necessary well child visits
- Provider EPSDT Reference Kit developed and distributed to high volume providers
- Obtaining WebIZ Immunization Registry data, Web-IZ data pulls for CIS were completed in April, June, July, August, September, November and December.
- Engaged network physicians in Pay for Performance program rewarding providers for ensuring members complete required infant and adolescent immunization.

For 2017, the P4P measure tied to Childhood Immunization focused in on Comb 10 which is compliance for all 10 of the vaccinations. The final HEDIS rate for CIS, Combo 10 for HEDIS 2017 (MY2016) was 31.01% and the administrative rate for Sunflower is 30.42% pending the final HEDIS 2018 results anticipated in July of 2018.

The table provided on the following page demonstrates results related to HEDIS measures on Childhood Immunizations. Combo 10 is also provided as it evaluates compliance with completion of all 10 of the immunizations which is a Sunflower Pay for Performance measure. It is important to note that the final HEDIS 2018 rate is not available at the time of this report, therefore an administrative rate is provided.

HEDIS MEASURE	HEDIS 2016 (MY2015) Hybrid	HEDIS 2017 (MY2016) Hybrid	HEDIS 2018 (MY2017) Admin Rate*	Met/Exceeded NCQA 2016 Quality Compass 50th Percentile
DTaP Immunizations	88.33	77.40	72.98	No
H Influenza Type B Immunizations	89.76	87.98	83.33	No
Hepatitis A Immunizations	87.86	87.74	87.75	Yes
Hepatitis B Immunizations	93.81	91.35	86.35	Yes
Influenza Immunizations	47.86	40.38	42.15	No
Measles, Mumps and Rubella Immunizations	88.57	88.94	88.10	No
IPV Immunizations	93.33	89.90	86.08	No
Pneumococcal Conjugate	78.81	79.57	74.25	Yes
Rotavirus Immunizations	79.76	72.12	68.69	Yes
Chicken Pox (VZV)	88.57	87.98	87.75	No
Combo 10	39.29	31.01	30.42	No

***** *Awaiting HEDIS2018 Final Hybrid Rates*

In 2017, Sunflower continued interventions aimed to improve the immunization completion for children including but not limited to the following:

- Provider Care Gaps were shared on members who were non-compliant for immunizations.
- Implemented warm phone calls to parents/guardians of adolescents needing immunization by QI staff
- Alerts for Customer Service Representatives and Medical Management to indicate members who have care gaps and can remind them of the need for an appointment and/or assist with making one along with treatment, if needed.
- Corporate “Healthy Reminders” mailer sent out bi-monthly to remind members of immunizations completed and due.
- HEDIS Quick Reference Guide distribution to new providers and annual updates to existing providers with ICD-10 updates.
- Gap analysis for high volume providers currently available on the Provider Portal.
- Provider EPSDT Reference Kit was updated and available to providers via Sunflower Health Plan Website.
- Obtaining KDHE Immunization Registry data. Web-IZ data pulls completed for IMA in April, June, July, August, September, November, and December.
- In June, letters were sent to non-compliant members alerting them to nearby clinics that would administer immunizations via walk-in or providers in their area who provide these.
- Engaged network physicians in Pay for Performance program rewarding providers for ensuring members complete required infant and adolescent immunization.

Sunflower continues to analyze data for opportunities to improve on compliance with vaccination completion. However, Sunflower recognized from HEDIS data for HEDIS 2017 that it is not uncommon for the child to complete the vaccines but often after their second birthday which does not demonstrate compliance with the technical specifications. Therefore, Sunflower will continue to educate on the importance of completing prior to the child’s second birthday. In addition to continuing many of the 2017 interventions in 2018, Sunflower will also continue to

explore opportunities to expand partnerships with more health departments and providers to close care gaps on childhood immunizations. Provider payment incentives are also opportunities for potential expansion to assist for consideration.

Adolescent Immunizations

Immunizations for Adolescents continues to be a priority for Sunflower Health Plan. This measure continued as one of our Pay for Performance measures for the State of Kansas in 2017 and also for 2018 with the focus being on Combo 2 which is the demonstration of completion of the Tdap, Meningococcal and HPV vaccination series. None of the immunizations covered in the IMA HEDIS metric exceeded the 50th percentile. Sunflower continued with direct outreach to members and/or their parents.

Immunizations for Adolescents Interventions for 2017 were:

- A CentAccount reward of $15 is given to adolescent members who complete the HPV series prior to their 13th birthday.
- Provider Care Gaps were shared on members who were non-compliant for immunizations.
- Implemented warm phone calls to parents/guardians of adolescents needing immunization by QI staff
- Alerts for Customer Service Representatives and Medical Management to indicate members who have care gaps and can remind them of the need for an appointment and/or assist with making one along with treatment, if needed.
- Corporate “Healthy Reminders” mailer sent out bi-monthly to remind members of immunizations completed and due.
- HEDIS Quick Reference Guide distribution to new providers and annual updates to existing providers with ICD-10 updates.
- Gap analysis for high volume providers currently available on the Provider Portal.
- Provider EPSDT Reference Kit was updated and available to providers via Sunflower Health Plan Website.
- Obtaining KDHE Immunization Registry data. Web-IZ data pulls completed for IMA in April, June, July, August, September, November, and December.
- In June, letters were sent to non-compliant members alerting them to nearby clinics that would administer immunizations via walk-in or providers in their area who provide these.
- In February, POM calls were initiated to non-compliant members of one or more vaccinations to schedule an appointment with their provider prior to their next birthday.
- Telephonic outreach to non-compliant members was made by Sunflower Health Plan, Johnson and Sedgwick County Health Departments, and Grace Med in November and December encouraging members to obtain immunizations. Engaged network physicians in Pay for Performance program rewarding providers for ensuring members complete required infant and adolescent immunization.

The table on the following page depicts the previous final rates for HEDIS 2017 and the administrative rate for HEDIS 2018 for the Adolescent Immunizations individually and then also by the Combo 2 which assesses compliance with completion of all three of the Adolescent Vaccinations per HEDIS technical specifications. Final rates for HEDIS 2018 are not yet available. The notable increase in HPV vaccinations is anticipated to be secondary to the changes with the HEDIS technical specifications that require 2 doses instead of 3 in specific circumstances to consistent with dosing recommendations.

HEDIS MEASURE	HEDIS 2017 (MY2016) Hybrid	HEDIS 2018 (MY2017) Admin.*	Met/Exceeded NCQA 2016 Quality Compass 50th Percentile
Meningococcal	66.59	73.33	No
Tdap	82.69	83.84	No
HPV	19.23	32.20	No
Combo 2	17.79	30.61	No

**Awaiting HEDIS 2018 Final Hybrid Rates*

Sunflower reviewed the data from interventions in 2017 and determined a knowledge gap was common related to the HPV vaccination. Additionally, missed opportunities continue to be a barrier with immunization care gap closure in adolescents. Therefore, Sunflower will continue many of the interventions utilized in 2017 for 2018 while also continuing to explore methods to increase knowledge and understanding of the benefits the Tdap, Meningococcal and HPV vaccinations offer adolescents. Sunflower will also explore additional partnerships with health departments as well as other providers on closing those care gaps and determining where there are opportunities to expand provider payment incentives.

Comprehensive Diabetes Care

Sunflower continued to work on this HEDIS measure and its sub measures in 2017 to help members garner a better understanding of Diabetes, importance of routine monitoring, proper diet, and exercise all aimed at helping to improve their management of diabetes and potentially lessen or avoid complications that result from Diabetes. These efforts included continued partnership with Envolve Vision Care for the Eye Exam sub measure. Sunflower continued the venture, as was established in fourth quarter of 2015, with Quest/ExamOne in 2017. The project's goal was to impact those members who were still showing non-compliant with their diabetes monitoring and to allow them the option to have their lab draws, blood pressure, height and weight measurements taken in their own home by a Quest/ExamOne staff member. This resulted in 977 members who were referred to Quest/ExamOne for in-home visits. Out of those contacted, 84 in-home visits were completed and resulted in success rate of 9%. Sunflower also proceeded with follow up of the members who were not interested in the in-home visits by the Medical Management team to help members find a provider, make appointments, arrange transportation, educate the members on the importance to have these tests done annually, and even referred members as appropriate for the Disease Management services available to them via Nurtur.

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

Interventions: Comprehensive Diabetes Care

- Corporate "Healthy Reminders" mailed in 2017, highlighting the sub-measures completed and those that still needing compliance
- Envolve Vision's (OptiCare) HEDIS Outreach - Diabetic Retinopathy Exam sub-measure; monthly progress reports starting in July of 2016 and continued through 2017
- CentAccount Program Incentives
- Medical Management performs outreach to with non-compliant members and diabetic members in Care Management

- Member mailer postcards and letter with measure/test dates and reminders
- Customer Service and Medical Management training on measure to discuss care gaps with members on calls; reminders sent prior to care gap reports going out to members
- Use of KRAMES educational materials to educate members about diabetes care
- Member Newsletter containing detailed information on the importance of screenings, and proper diabetes care
- Quest Diagnostics providing outreach to non-compliant members and offering member lab draws in the member's home, as well as BMI and BP measurements
- Revised the provider profiling report based first on attribution then assignment were distributed to providers of non-compliant members
- Provider newsletter articles related to plan performance and goals
- Include P4P measure review/discussion in DVO meetings with vendors who have the ability to assist members on eye exams, diabetes education and disease management
- Continued partnerships with FQHCs to close member care gaps
- Engaged network physicians in Pay for Performance program rewarding providers for ensuring diabetic members complete recommended screening with Hemoglobin A1c.

For HEDIS 2017, all the sub measures demonstrated improvement. Hemoglobin A1c control <8% saw an increase of 33% from the previous year while the poor control sub measure noted a reduction of 14%. While the Eye Care sub measure noted a 15% increase. The table provided below demonstrates results related to Comprehensive Diabetes Care HEDIS measure. It is important to note that the final HEDIS 2018 rate is not available at the time of this report. Those results are expected in July of 2018.

HEDIS MEASURE	HEDIS 2016 (MY2015) Hybrid	HEDIS 2017 (MY2016) Hybrid	Met/Exceeded NCQA 2016 Quality Compass 50th Percentile
Comprehensive Diabetes Care - Blood Pressure Control	53.88	54.88	No
Comprehensive Diabetes Care - Eye Care	61.42	70.70	Yes
Comprehensive Diabetes Care - HbA1c Testing	84.48	87.44	Yes
Comprehensive Diabetes Care - HbA1c Adequate Control (<8%)	40.13	53.26	Yes
Comprehensive Diabetes Care - HbA1c Poor Control	46.68	40.23	Yes
Comprehensive Diabetes Care - Monitoring for Nephropathy	77.83	87.91	No

Sunflower analyzed HEDIS data in 2017 to determine where opportunities exist to improve compliance with CDC measures. Member knowledge, understanding and education continues to be a focus that Sunflower continues to work on addressing this barrier. In order to improve member engagement on these measures, the members have to have the knowledge and understanding of the significance for the testing to allow the appropriate treatment of their disease that also promotes delaying progression of their diabetes and the complications that may result. Sunflower will utilize interventions implemented in 2017 as well as explore options for expanding partnerships with providers.

Annual Dental Visit

The Annual Dental Visit (ADV) measure focuses on the members who are 2-20 years of age having had at least one dental visit during the measurement year. This measure continues as one of our Pay for Performance measures for the State of Kansas in 2017. Based on administrative data, Sunflower demonstrated a 61.89 from administrative data. Therefore, it is anticipated that Sunflower will achieve the 75th percentile on Quality Compass for measurement year 2017.

Annual Dental Visit Interventions for 2017 include the following:

- HEDIS Quick Reference Guide distribution to new providers and annual updates to existing providers with ICD-10 updates.
- Participate in Envolve Dental Delegated Vendor Organization meetings in order for Quality Manager to provide education on current ADV HEDIS rates and interventions.
- Grace Med and Health Partnership Clinic outreached to their members who were non-compliant for annual dental visits.
- Dental kits (including toothbrush, toothpaste, and floss) are sent to members ages 2 – 20 who have visited the Emergency Department for dental claims. The letter included in the dental kit encourages to the member to call Customer Service to find a dentist in their area for their dental needs.
- In April, POM calls went to 11,690 members who hadn't received a dental visit since 1/1/2016.
- In May, an IVR (Interactive Voice Response) script was played to all members calling Customer Service reminding parents to schedule an annual check-up for their children with their dentist.

The table below depicts the HEDIS measure final results for ADV for HEDIS 2017 and the administrative data on this measure for HEDIS 2018 since the final results are not yet available.

HEDIS MEASURE	HEDIS 2016 (MY2015) Hybrid	HEDIS 2017 (MY2016) Hybrid	HEDIS 2018 (MY2017) Admin.*	Met/Exceeded NCQA 2016 Quality Compass 50th Percentile
Annual Dental Visit	61.21	63.49	61.89	YES

**Awaiting final HEDIS 2018 rates*

With continued year over year improvement, Sunflower continues to analyze data for opportunities for improvement on ADV. Member knowledge and understanding continues to be barriers that Sunflower focuses efforts on to ensure members know the recommendations and the services available to promote the annual dental visits for overall health promotion. Therefore, Sunflower will continue to utilize interventions from 2017 while also exploring opportunities to expand to impact continued improvement.

Timeliness of Prenatal Care

Timeliness of Prenatal Care continued as a Pay for Performance measures for Sunflower in 2017. Based on hybrid data, Sunflower didn't achieve the 50th Percentile on Quality Compass for measurement year 2016 but has continued efforts to improve on this measure for the well-being of the expectant mothers and their babies. Sunflower identified several barriers, which included challenges for members to receive prenatal care within the first trimester or within 42 days of enrollment in the organization. This was likely complicated by those members made

retroeligible after their first trimester had elapsed. However, Sunflower continues efforts to improve the compliance with the Timeliness to Prenatal Care measure.

Timeliness of Prenatal Care Interventions for 2017 are noted below:

- Implemented a Provider Pay for Performance arrangement with select providers based on completion of the Notice of Pregnancy and timely first prenatal visit being completed
- Cent Account rewards are given to members who receive 3, 6, and 9 month prenatal visits. Members receive $15 per visit and also receive an additional $15 for completing a Notice of Pregnancy.
- HEDIS Quick Reference Guide distribution to new providers and annual updates to existing providers with ICD-10 updates.
- PLE Report is run daily and is given to Quality Improvement Representatives to conduct outreach to newly pregnant members to assist with completion of the Notice of Pregnancy, establishing care, providing resources, assisting with appointments, transportation and information.
- Member Connections Representatives placed health promotion easels in FQHC's, pharmacies, and dollar stores creating awareness for pregnant ladies to obtain prenatal care. The easels have a "takeaway" piece of paper which offers Sunflower Health Plan contact information and stresses the importance of moms and babies health.
- Logisticare Transportation provided a report to Sunflower Health Plan of any members that they were transporting to a prenatal care appointment. Member Connections outreaches to these members to ensure they are receiving quality prenatal care and have completed a Notice of Pregnancy form.

The table on the following page depicts data for Timeliness of Prenatal Care for final rates for HEDIS 2016 and 2017, since the final rates are not yet complete and available for HEDIS 2018.

HEDIS MEASURE	HEDIS 2016 (MY2015) Hybrid	HEDIS 2017 (MY2016) Hybrid	Met/Exceeded NCQA 2016 Quality Compass 50th Percentile
Timeliness of Prenatal Care	72.38	70.29	No

Sunflower continues to explore opportunities for improvement to impact the Timeliness of Prenatal Care which includes addressing barriers like member knowledge deficits, provider opportunities and transportation issues. Sunflower will also 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 which was new in 2017 to determine effectiveness and potential expansion of this program. Also, Sunflower will continue to utilize a variety of interventions in 2018 with the goal of furthering timeliness completion of the first prenatal visits.

Two additional HEDIS measures that Sunflower focused on in 2017 were Breast Cancer Screenings and Cervical Cancer Screening for the entire population served. Cervical Cancer Screening is also a state P4P measure. Those measures and their interventions are noted on the following page.

Breast Cancer Screening (BCS) Interventions:

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

Cervical Cancer Screening (CCS) Interventions:

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

The table below depicts final HEDIS rates for HEDIS 2016 and HEDIS 2017 along with the administrative rate for HEDIS 2018 for Breast Cancer Screening and Cervical Cancer Screening. The final HEDIS 2018 rates are anticipated to be complete and available in July of 2018. While Sunflower did not achieve the 50th percentile, year over year improvement has been noted from 2016 to 2017. Cervical Cancer Screening demonstrated a 3.91% improvement while Breast Cancer Screening had a 6.03% improvement. Sunflower continues efforts to improve on both of these measures for the members served.

The table provided below demonstrates the year over year final HEDIS results on these two measures as well as the administrative data for HEDIS 2018. Those final results are anticipated in June of 2018.

HEDIS MEASURE	HEDIS 2016 (MY2015) Final	HEDIS 2017 (MY2016) Final	HEDIS 2018 (MY2017) Admin Rate*	Met/Exceeded NCQA 2016 Quality Compass 50th Percentile
Cervical Cancer Screening	47.30	49.15	48.70	No
Breast Cancer Screening	45.12	47.84	46.45	No

**Awaiting final HEDIS 2018 rates*

Sunflower continues to assess data from these two measures to improve member compliance through identification of opportunities to address barriers. Historical information is impactful to demonstrate member exclusion or compliance with these measures. Therefore, Sunflower continues to explore how to gain those records for use in the HEDIS project. This is important to members who may be new to the plan or had instances of care multiple years prior to becoming a Sunflower members. Sunflower will continue to use interventions from 2017 while also continuing to explore additional provider partnerships aimed at care gap closures for breast and cervical cancer screenings.

Behavioral Health HEDIS Measures

The behavioral health measures that were the plan's focus for 2017 were Follow-Up after Hospitalization for Mental Health, Initiation and Engagement of AOD Treatment and Diabetic

Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications.

Interventions for Follow-Up after Hospitalization for Mental Health:

- CM involvement during Hospital Discharge Planning, including assistance with appointments; referral is received by CM as soon as the authorization request is received by the health plan
- CMHCs and hospitals work together to ensure discharge planning occurs and follow-up appointments have been scheduled
- Educate CMHCs, Inpatient Hospital Administrators and Chief of Medical Staff as to the importance of this indicator while elevating awareness of the need to collaborate with the health plan's CM to ensure follow-up appointments are scheduled
- Staff training on measure
- BH HEDIS Coordinator to manage clinical team interventions and track progress
- Engaged Community Mental Health Center (CMHC) provider in Pay for Performance program rewarding providers for ensuring members complete appropriate follow up after hospitalization for mental health.

The Initiation and Engagement of Alcohol and Other Drug Dependence Treatment measure had a Performance Improvement Project by SHP that ended in 2016. Sunflower followed the HEDIS technical specifications on this measure in 2017 after the PIP ended.

Interventions for Initiation and Engagement of AOD Treatment:

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

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

- Outreach and engagement of non-compliant members into Care Management to complete the recommended screening and treatment as needed
- Member mailer to educate and encourage glucose or HbA1c screening
- Provider newsletter article educating on performance improvement project and risk of member’s developing diabetes with the use of antipsychotic medications
- Provide CMHCs with monthly reports to include a list of their members and the compliance status of diabetic screening
- Internal staff trainings on diabetes and use of antipsychotic medications Engaged
- Community Mental Health Center (CMHC) provider in Pay for Performance program rewarding providers for ensuring members complete recommended diabetes screening test.

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

HEDIS MEASURE	HEDIS 2016 (CY2015) Final Admin.	HEDIS 2017 (CY2016) Final Admin.	HEDIS 2018 (CY2017) Admin. *	Met/Exceeded NCQA 2016 Quality Compass 50th Percentile
Follow-up after Hospitalization for Mental Illness - 7 day	67.20	68.62	62.20	Yes
Follow-up after Hospitalization for Mental Illness - 30 day	78.02	81.04	77.93	Yes
Initiation and Engagement of AOD Treatment: Initiation	39.44	39.13	35.43	No
Initiation and Engagement of AOD Treatment: Engagement	11.45	13.69	10.79	Yes
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications	75.27	76.10	77.96	No

** Awaiting final HEDIS 2018 rates*

Sunflower plans to continue interventions from 2017 in 2018, while also utilizing feedback to determine opportunities and barriers to be addressed. Member education is key and continues to be a barrier to focus on. Member compliance with these HEDIS measures relies on member understanding of the need and significance for follow up visits and screening for successful management of their mental illness and overall health. Therefore, Sunflower plans to explore how to further partner with providers, expand member education and demonstrate improvement on these measures in 2018.

HEDIS Pharmacy Measures

Sunflower focused on multiple Pharmacy measures in 2017 with the goal to demonstrate improvement on these. Those measures were: Use of Multiple Concurrent Antipsychotics in Children/Adolescents, Metabolic Monitoring for Children/Adolescents, Antidepressant Medication Management and Follow up ADHD. The aim was to continue to demonstrate improvement with compliance on the use of medications, compliance with appropriate monitoring secondary to antipsychotic use and then compliance with taking medications to help ensure optimal outcomes for the members as appropriate with an overall goal of helping them to achieve their own personal goals.

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

- Care Management team utilized care alerts on assigned members and addressed identified gaps with members to facilitate the appropriate care
- Referred members identified as being on 2+ antipsychotic meds to LifeShare for outreach and support as needed based on member specific needs and circumstances
- Psychiatric Medication Utilization Review program used algorithm to identify members on multiple concurrent or high dose antipsychotic medication regimens with outreach to prescribers if needed based on prescribing information
- BH CM and UM teams were trained on the measure and to look for members who may fall into the measure. If a member was identified on their caseload they were to work with the member and the member's care team to ensure other needed supports and treatment were in place or to assist with access as appropriate.

Interventions for Metabolic Monitoring for Children/Adolescents on Antipsychotics & Follow up ADHD:

- Care Management team reviewed care alerts on assigned members and addressed identified gaps with members to facilitate appropriate care

Interventions for Antidepressant Medication Management:

- CM team reviewed care alerts on assigned members and addressed identified gaps with members
- Referred members to Disease Management

The table depicted on the following page provides data on all of these measures. Sunflower demonstrated improvement from HEDIS 2016 to HEDIS 2017 on Use of Multiple Concurrent Antipsychotics in Children/Adolescents by 12.70%. Sunflower also noted YOY improvements on Metabolic Monitoring for Children/Adolescents on Antipsychotics, Antidepressant Medication Management – Acute Phase. However, there was a drop noted for Antidepressant Medication Management – Continuation Phase, Follow up ADHD for both the Initiation and Continuation and Management. Efforts are planned to continue on these measures in 2018 as well to help ensure member needs are being met.

HEDIS MEASURE	HEDIS 2016 (CY 2015) Final Rate	HEDIS 2017 (CY 2016) Final Rate	HEDIS 2018 (CY 2017) Admin Rate*	Met/Exceeded NCQA 2016 Quality Compass 50th Percentile
Use of Multiple Concurrent Antipsychotics in Children/Adolescents	5.31	4.81	4.41	No
Metabolic Monitoring for Children/Adolescents on Antipsychotics	28.86	38.00	44.58	Yes
Antidepressant Medication Management - Acute Phase	50.06	51.02	48.99	No
Antidepressant Medication Management - Continuation Phase	34.48	33.76	30.75	No
Follow Up ADHD - Initiation	54.15	53.47	53.24	Yes
Follow Up ADHD - Continuation & Management	66.31	62.01	62.80	Yes

**Awaiting final HEDIS 2018 data*

Sunflower utilizes data to determine opportunities for improvement, potential barriers and then adapts the interventions as appropriate. With the measures noted above, relationships with providers and members provide opportunities for feedback to identify where there maybe individual member needs that can be addressed to help ensure compliance, e. g. transportation challenges, and member knowledge deficits and in some instances even provider opportunities related to prescribing information. Sunflower will continue to utilize interventions from 2017 in 2018 while also exploring additional opportunities to further partner with providers and expand education to members as appropriate based on data and feedback.

PATIENT SAFETY

Quality of Care and Adverse Events

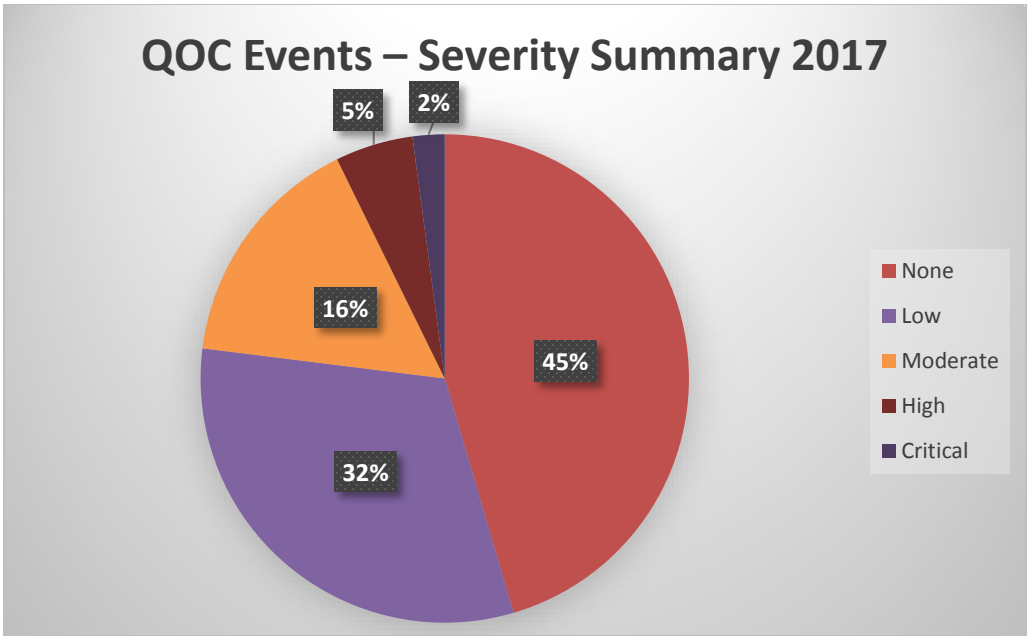
Sunflower monitors the safety of its members through identification of potential and/or actual quality of care (QOC) events and adverse incidents (AIRS). Sunflower's Quality Improvement Department monitors member and provider issues related to quality of care and adverse incidents on an ongoing basis. A QOC Severity Level table is used to classify issues into the

five levels (None, Low, Medium, High and Critical) based on the potential or actual serious effects. These issues are tracked and trended for patterns and any applicable corrective action plans put into place when issues warrant further action. All cases are entered into a database, reviewed quarterly and reported as appropriate. Practitioners or providers with multiple potential quality of care issue referrals per quarter may be subject to additional review/investigation. Providers will be reported to the Credentialing Committee at the discretion of the Peer Review Committee. Reports are provided to the QIC and reviewed by the Credentialing Department for consideration at the time of provider re-credentialing. Potential quality of care issues are defined as any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care, or that signals a potential sentinel event.

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

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

Sunflower reviews events both at an aggregate and provider/facilty level. The below graphics show the type and severity of QOCs reviewed by Sunflower in 2017. Sunflower's data on QOCs demonstrates that the majority of the cases referred for review as potential QOC are determined to not meet the criteria for a QOC. Sunflower is no longer required to provide a monthly report to the state advising of cases with high severity levels determined through the QOC process utilized internally at Sunflower. The table provided on the following page depicts the severity levels that resulted in the cases refered as potential QOC cases and their severity level based on review of records provided to Sunflower to allow for review to determine if there was a QOC concern and allow for severity level to be assigned accordingly.

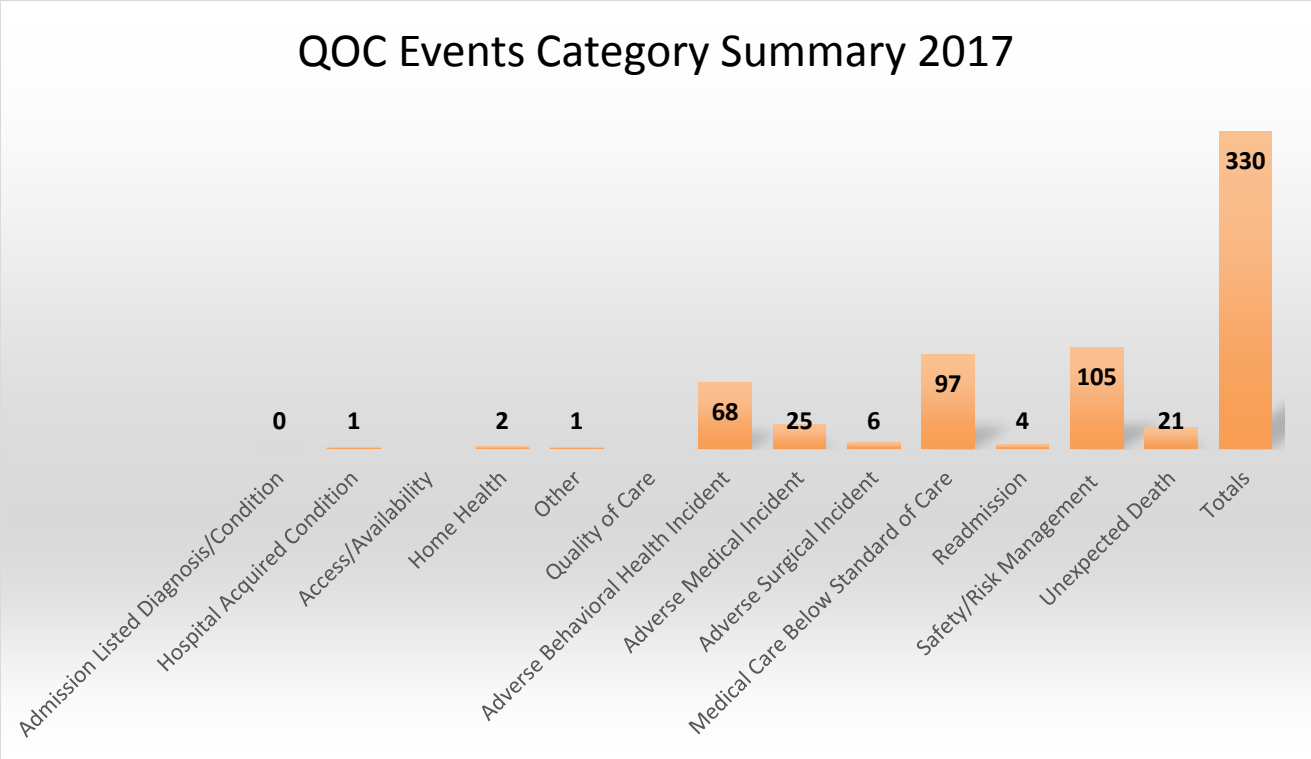


For 2017, there were a total of 330 QOC events completed which was noted to be an increase of 28% from 2016. Sunflower attributes this increase to education that was completed throughout 2017 with health plan staff on their role and responsibility to report potential Quality of Care concerns to the Quality team to allow for appropriate investigation. Of those, 150 resulted in categorized as “None” which comprised 45% of those for 2017 which was a noted decrease by 29% from 212 for 2016. For 2017, the largest increase was noted with “Low” at 104 comprising 32% for the year which was up from 12 in 2016. “Moderate” accounted for 52 or 16% for 2017 compared to 16 for 2016. There was an increase of 42% in the severity of “High” for total of 17 or 5% for the year compared to 12 the previous year. The total for “Critical” was noted to be 7 or 2% which also demonstrated an increase of 40% from 2016. The results are depicted in the table below, showing 2016 and 2017 totals for comparison.

Severity Level	QOC Events Severity Summary 2017	QOC Events Severity Summary 2016
None	150	212
Low	104	12
Moderate	52	16
High	17	12
Critical	7	5
Totals	330	257

Sunflower also looks at QOC data to determine the most common types of QOC cases. Safety/Risk Management events were noted to be the highest type of QOC referral received in 2017. The next category was noted to be Medical CareBelow Standard of Care. The third highest type of QOC case was Adverse Behavioral Health Incident. Sunflower utilizes the Peer Review Committee to review cases and make recommendations related to the next steps which

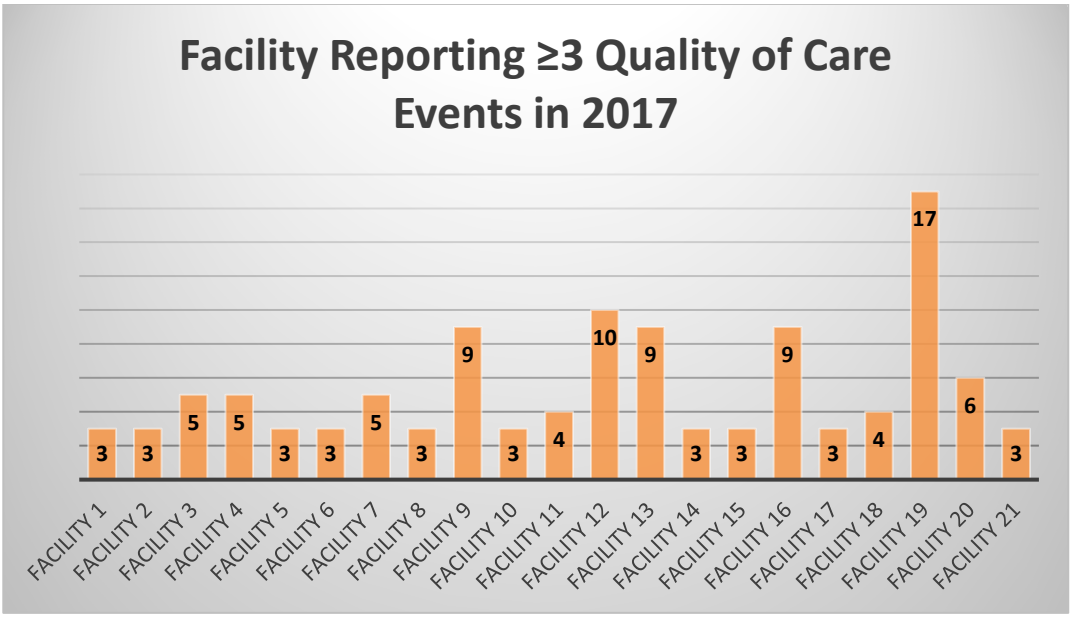
can include requesting documentation from providers to demonstrate their actions that have already been implemented to prevent further occurences and may make recommendations for education to occur with staff responsible for specified care to members to help avoid future occurences that present risk to members served. Sunflower noted an increase in Adverse Surgical events in the cases reviewed in 2017 of 25 which was up from 2 in 2016, while in 2017 there was also an increase of referrals for unexpected death from 2 in 2016 to 21 in 2017. Cases referred for Readmission decreased from 4 to 3 from the previous year. There was also a noted decrease on Admission Listed Diagnosis/Condition from 11 for 2016 down to 0 in 2017.



Sunflower's review of the QOC concerns reported in 2017 resulted in trends of greater than or equal to 3 QOCs for 21 facilities and no practitioners were identified as meeting this criteria. These 21 identified facilities generated 113 potential QOCs that were investigated, of the 330 for the entirety of 2017. Of the cases referred for these 21 providers/facilities there were none who had more than 20 reports this is in contrast to 2016 which demonstrated two providers/facilities with more than 30 each. Upon further review of the potential QOCs that were reported for Facility #19, 12 of the 17 reported were noted to not be QOC concerns. They had 1 with severity level of Medium. The remaining 4 QOCs for this facility were all determined to be of Low severity level.

The second facility was noted to have 10 total QOCs and this was Facility #12. Based on review of the potential QOCs, 1 of the 10 reported were not QOCs, 5 received a Low level rating and 4 were deemed to be of a Medium Severity level. This facility was followed by 3 others that had 9 QOCs each. Facility #9 had 2 deemed to meet criteria as QOC, 6 assigned Low Severity Level and 1 assigned Medium Severity Level. Facility # 13 had 7 that did not meet criteria as QOC and 2 assigned Low Severity Level. While Facility #16 had 5 that did not meet QOC

criteria, 1 assigned Low Severity and 3 assigned Medium Severity Level. The data points are depicted on the table following this paragraph. Sunflower will continue to evaluate both facility and provider trends with QOCs for opportunities to improve upon.



The State of Kansas has defined, and developed a system of provider reporting for events considered “Adverse Incidents”. Selected providers are required to report the defined events into a state developed portal and these reports are named Adverse Incident Report(s) or AIRS. Adverse incidents are defined by the state for the purpose of reporting an event over which health care personnel could exercise control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred. The AIRS policy and processes were refined through collaborative efforts that Sunflower actively participated in with the State and fellow MCOs in 2017. As a result, anyone can now report an Adverse Incident via the state portal.

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

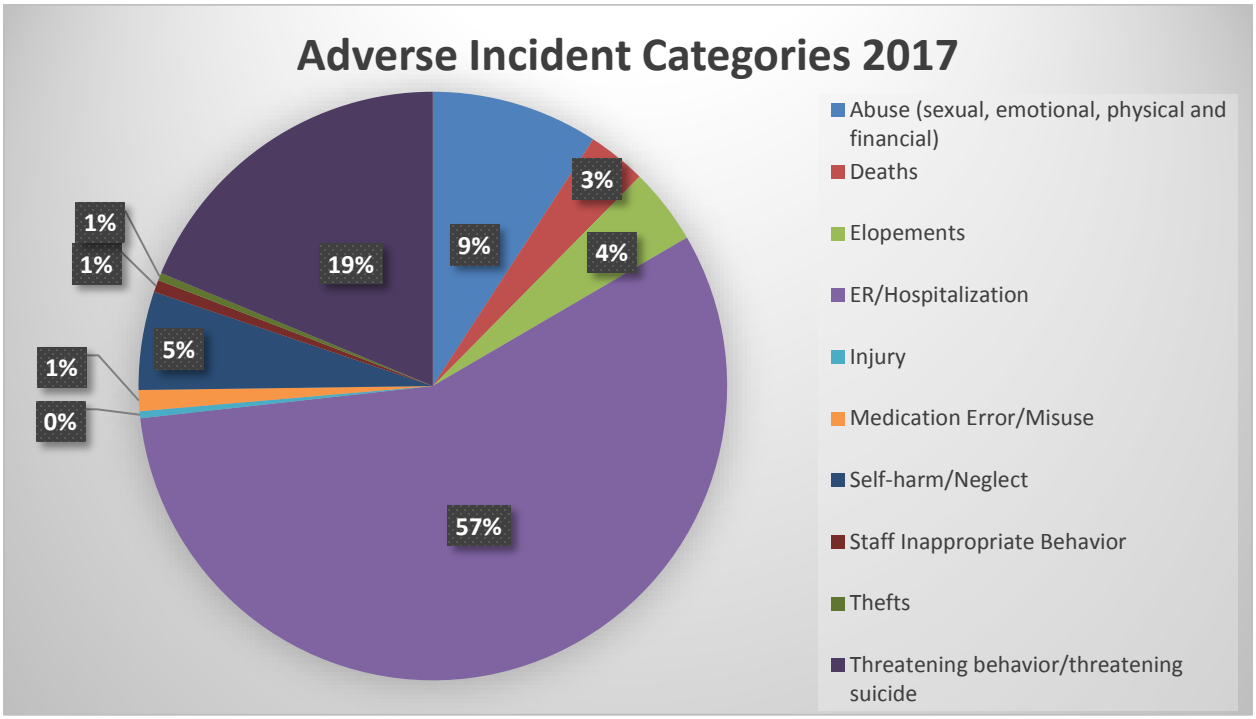
1. Death – Cessation of a participant’s life
2. Abuse - Any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to a participant which can include but is not limited to the following as defined in the state policy: physical or mental injury, sexual contact, unreasonable use of restraint, threatening or menacing conduct, fiduciary abuse, omission or deprivation of goods/services which are necessary to avoid harm to member.
3. Emergency Medical Care – The provision of unplanned medical services to a recipient in an emergency room or department. The unplanned care may or may not result in hospitalization.
4. Exploitation – Misappropriation of the participant’s property or intentionally taking unfair advantage of a participant’s physical or financial resources for another individual’s personal/financial advantage by use of undue influence, coercion, harassment, duress, deception, false representation, or false pretense by caretaker or another person.

5. Fiduciary Abuse – A situation in which any person who is caretaker of, or who stands in a position of trust to, a participant, takes, secretes or appropriates their money or property, to any use/purpose not in the due and lawful execution of such person's trust/benefit.
6. Misuse of medications - The incorrect administration or mismanagement of medication, by someone providing KDADS community services and programs which result in or could result in serious injury or illness to a consumer.
7. Neglect - The failure or omission by one's self, caretaker or another person with a duty to supply or to provide goods or services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.
8. Seclusion – The involuntary confinement of a participant alone in a room or area from which the participant is physically prevented from leaving.
9. Restraint – Any bodily force, device/object or chemical use dot substantially limit a person's movement.
10. Suicide - Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.
11. Suicide attempt - A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.
12. Serious injury – An unexpected occurrence involving the significant impairment of the physical condition of a consumer. Serious injury specifically includes loss of limb or function.
13. Elopement – The unplanned departure from an inpatient unit or facility where a consumer leaves without prior notification or permission or staff escort.
14. Natural disaster – A natural event such as a flood, earthquake, or tornado that causes great damage or loss of life. Approved emergency management protocols are to be followed, documented and reported as required by the policy in the AIR system.
15. Law Enforcement Involvement: Any communication or contact with a public office that is vested by law with the duty to maintain public order, make arrests for crimes and investigate criminal acts, whether that duty extends to all crimes or is limited to specific crimes.

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

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

In 2017, Sunflower was notified of 3,129 individual AIRs, which demonstrated a small decrease when compared to 3,287 from 2016. This decrease equated to 4.8%. Each AIR reported was reviewed and processed as discussed previously. The following graphic demonstrates the categorization type of 2017 AIR reports. Hospitalized/ER visits represent the highest category, with 1,773 AIRS related to them which is consistent with what was noted for 2016 as this being the top category. Historical practice in KS has been to report any time a vulnerable member visits the ED or is hosptialized, any unexplained abrasion, or otherwise noteworthy behavior for these vulnerable populations which could contribute to this being the most commonly received type of AIR. Threatening behavior/threatening suicide continued to be second highest category for 2017 at 586 which demonstrated at decrease of 4.87%. Abuse (sexual, emotional, physical and financial) was noted as the third highest category at 287 which was a decrease from 2016 of 4.01%. The top three categories denoted for 2017 were consistent with what was evidenced in 2016 AIR data. These details are depicted in the chart on the following page.



Recommendations for 2018 related to the quality of care and adverse incident reporting include continuing to monitor QOC and AIR data for provider trending, identifying opportunities for improvement which may include but not limited to educational opportunities for providers, health plan staff and others as identified from data, working with KDADS and providers to improve conditions for members, and provider follow up on AIR reporting. Sunflower's plan is to maintain partnership and progress toward full implementation of the state reporting system for AIRs as Sunflower demonstrated as an active participant in 2017.

Clinical Practice Guidelines (CPG)

Sunflower utilized the following clinical and preventive health practice guidelines in 2017 review of policy. Sunflower made providers aware of the guidelines and their expected use through the

provider newsletters, inclusion in the provider manual, and on the Sunflower website. Performance on CPGs is monitored through performance on applicable HEDIS measures. Below are the CPGs are provided:

- ADHD
- Adult Preventive
- Anxiety Disorder
- Asthma
- Back Pain
- Diabetes
- CHF / Heart Failure
- CAD
- COPD
- Hyperlipidemia
- Hypertension
- Hypertension in Children
- Immunizations
- Lead Screening
- Pediatric Preventive
- Perinatal Care
- Sickle Cell
- Major Depressive Disorder
- Schizophrenia
- Substance Use Disorders
- Tobacco Cessation
- Weight Management

All Clinical Practice Guidelines (CPGs) and Preventive Health Guidelines (PHGs) are reviewed annually and updated accordingly. Opportunities in 2017 related to practice guidelines were to continue and expand provider profiles in 2017 to a larger provider group to help increase knowledge, awareness and compliance.

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

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

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

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

- Member grievances
- Member appeals
- Member satisfaction survey data

Member Grievances

The Sunflower Grievance & Appeal Committee and Quality Improvement Committee reviews grievance and appeal data on a quarterly basis. Analysis is performed by the Quality Improvement Committee, which is composed of departmental leaders and network physicians, enables Sunflower to initiate quality improvement efforts to improve member satisfaction as needed. The following is a summary of the results and analysis for January 1, 2017 through December 31, 2017, compared to calendar year 2016.

The tables below displays grievance data by category and represents all member grievances resolved. All grievances are reviewed and analyzed; no sampling is used. Grievance categories were changed in April 2016 based on state reporting requirement changes and mapping was necessary to allow for optimal analysis of the data for internal purposes. Q1 2016 data is included on the first table below and then a subsequent table is provided for the remaining quarters of 2016 to allow for comparison to 2017 data with the table providing details of quantities of grievance per categories. Also, included is the mapping tool that was used to accommodate the reporting changes that were required in 2017 to allow to provide annual report and cumulative results to the Grievance and Appeal Committee in 2016.

The first table below depicts the grievance categories as they were for timeframe January 1 through March 31, 2016 due to new state reporting categories initiated for 2Q2016. Additional tables provided will demonstrate data to allow for comparison with the 2017 grievance numbers and per 1000 information.

Grievances Category	Jan 1 - Mar 31, 2016	Per 1000
Accessibility of Office	4	0.03
Attitude/Service of Staff	42	0.30
Availability	30	0.22
Billing and Financial Issues	19	0.14
Criteria Not Met -DME	2	0.01
Criteria Not Met - Inpatient	0	0.00
Criteria Not Met - Med Procedure	2	0.01
HCBS	0	0.00
Lack of Info from Provider	2	0.01
Level of Care Dispute	4	0.03
Other	13	0.09
Overpayments	1	0.01
Pharmacy	4	0.03
Prior or Post Authorizations	0	0.00
Quality of Care	7	0.05
Quality of Office, Building	0	0.00
Sleep Studies	0	0.00
Sterilization	0	0.00
Timeliness	16	0.12
Totals	146	NA*

*Annual per 1000 noted in next table

The table provided on the following page depicts the methodology for mapping the grievance categories from the previous categories to the new ones implemented effective April 1, 2016 per state reporting requirements.

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

The table provided on the following page demonstrates the grievance categories implemented effective April 1, 2016 going forward for remainder of 2016 as per the mapping changes noted in the table above. The table below also depicts the total per 1,000 for the entire year.

Grievances Category	April 1- Dec 31, 2016	Per 1000
Quality of Care (non-HCBS, non-transportation)	22	0.13
Customer Service	66	0.39
Member Rights Dignity	21	0.12
Access to Service or Care	137	0.81
Pharmacy Issues	21	0.12
Quality of Care HCBS	7	0.04
Transportation Issues (incl reimbursement, other than no-show or safety)	79	0.47
Transportation No Show	48	0.28
Transportation Safety	13	0.08
Value Added Benefits	14	0.08
Billing and Financial Issues (non-transp)	32	0.19
Other	25	0.15
Totals	485	3.73

The table included below represents the grievance totals by category in accordance with state reporting requirements and then per 1000 for the entire 2017 year. Sunflower saw a decrease in the number of member grievances for 2017 of 2.22%. This occurred despite increased education provided in 2017 by the Quality to the health plan on member grievances which included but was not limited to what a grievance is, how they should report a grievance to the Quality team for proper processing, who can report a grievance and that when a member shares dissatisfaction with any employee from Sunflower verbally or in writing that should be reported as a grievance to the Quality team to allow the matter to be documented within the health plan system, the process can be followed and accurately reported. This enables Sunflower to have the ability to accurately assess where opportunities exist to improve the experience and satisfaction of members. These opportunities also allow us to educate the members on their right to file a grievance as well.

Member Grievance Category Jan 1 – Dec 31, 2017	Totals	Per 1000
Quality of Care (non HCBS, non-Transportation)	42	0.26
Customer services	115	0.71
Member rights dignity	13	0.08
Access to service or Care	24	0.15
Pharmacy Issues	30	0.18
Quality of Care HCBS	31	0.19
Value Added Benefits	15	0.09
Billing and Financial issues (non-transportation)	37	0.23
Transportation Issues- reimbursement	93	0.57
Transportation- No Show	71	0.44
Transportation- Late	89	0.55
Transportation- Safety	30	0.18
Transportation - No Driver Available	7	0.04
Transportation- Other	13	0.08
Other	7	0.04
Total:	617	3.78

The grievance category denoting the highest volume in 2017 was Customer Service with 18.7% or 115 grievances out of 617 total for the year. These grievances related to Customer Service can encompass providers, their office staff, Sunflower staff and staff from vendors. Grievances secondary to Transportation Issues for reimbursement were the second leading category, and accounted for 15% or 93 for 2017. This was closely followed by Transportation – Late grievances which accounted for 89 or 14% for 2017. Sunflower monitors grievances both on a monthly and quarterly to identify trends as early as possible to allow for further review to determine where opportunities for improvement exist. Then efforts are made to provide education aimed at preventing reoccurrences while improving the experience and quality of care and services members receive. Sunflower expanded focus with our transportation vendor to ensure member satisfaction and experience improves to include monthly reviews and follow up on grievance trends and actions taken by the vendor to drive up the quality. Sunflower has established a goal of less than 4.50 member grievances per 1000 annually. Sunflower did

achieve that goal with 3.78/1000 for all grievances resolved in 2017. For 2018, Sunflower's grievance goal remain to be less than 4.50/1000 member grievances per 1000.

Member Appeals

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

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

The two tables that follow reflect member appeals by category for 2016. Appeal categories were changed beginning in Q2 2016 which is reflected in the first two separate tables provided below. The differences in categories were related to state reporting requirements that changed in 2016. These are followed by the table for 2017 member appeals by category.

Member Appeal Category	Jan 1 - Mar 31, 2016	Per 1000
Criteria Not Met - Inpatient	10	0.07
Criteria Not Met -DME	18	0.13
Criteria Not Met - Med Procedure	18	0.13
HCBS	13	0.09
Lack of Info From Provider	2	0.01
Level of Care Dispute	2	0.01
Other	0	0.00
Pharmacy	47	0.34
Prior or Post Authorization	24	0.17
Sleep Studies	1	0.01
Availability	1	0.01
Total **Annual per 1000 noted in following table*	136	NA*

Member Appeal Category	April 1 - Dec 31, 2016	Per 1000
Criteria Not Met - DME	34	0.24
Criteria Not Met - Med Procedure	35	0.25
Criteria Not Met - Radiology	15	0.11
Criteria Not Met - Pharmacy	194	1.40
Criteria Not Met - Dental	7	0.05
Criteria Not Met or Level of Care - Home Health	15	0.11
Criteria Not Met - OT/ST/PT	50	0.36
Criteria Not Met - IP BH	52	0.37
Criteria Not Met - OP BH Services	47	0.34
Level of Care - LTSS/HCBS	8	0.06

Other - Medical Necessity	7	0.05
Other - Non-Covered Services	15	0.11
Totals	479	3.63

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

Member Appeal Reasons Jan 1 – Dec 31, 2017	Total Resolved	Per 1000
MEDICAL NECESSITY DENIAL	669	4.10
Criteria Not Met - Durable Medical Equipment	94	0.58
Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	3	0.18
Criteria Not Met - Medical Procedure (NOS)	64	0.39
Criteria Not Met - Radiology	45	0.28
Criteria Not Met - Pharmacy	244	1.50
Criteria Not Met - PT/OT/ST	32	0.20
Criteria Not Met - Dental	20	0.12
Criteria Not Met or Level of Care - Home Health	8	0.05
Criteria Not Met - Hospice	0	0.00
Criteria Not Met - Out of network provider, specialist or specific provider request	1	0.01
Criteria Not Met – Inpatient Behavioral Health	82	0.50
Criteria Not Met – Behavioral Health Outpatient Services and Testing	35	0.21
Level of Care - LTSS/HCBS	25	0.15
Level of Care - WORK	0	0.00
Level of Care - LTC NF	0	0.00
Level of Care - Mental Health	0	0.00
Level of Care - HCBS (change in attendant hours)	3	0.18
Ambulance (include Air and Ground)	0	0.00
Other- Medical Necessity	23	0.14
Change in attendant hours	0	0.00
NONCOVERED SERVICE DENIAL	67	0.41
Service not covered - Dental	4	0.02
Service not covered - Home Health	0	0.00
Service not covered - Pharmacy	4	0.02
Service not covered - Out of Network providers	0	0.00
Service not covered - OT/PT/Speech	0	0.00
Service not covered - Durable Medical Equipment	22	0.13
Service not covered - Behavioral Health	0	0.00
Other - Noncovered service	35	0.21
LOCK IN	2	0.01
BILLING AND FINANCIAL ISSUES	0	0.00

TRANSPORTATION TIMELINESS	0	0.00
Transportation No Show	0	0.00
Transportation Late	0	0.00
AUTHORIZATION DENIAL	2	0.01
Late submission by member/provider rep	1	0.01
No authorization submitted	1	0.01
MCO TIMELINESS	0	0.00
Noncompliance with PA Authorization timeframes	0	0.00
Noncompliance with resolution of Appeals and issuance of notice	0	0.00
Total	**748**	**4.59**

For 2017, overall Medical Necessity Denials per Criteria Not Met made up the majority of member appeals at 628 or 84% of the total member appeals. When broken down further, Pharmacy continues to be the area with the highest volume which is consistent with what was noted for 2016. The volume from 2016 was 241 while in 2017 it was 244, showing a change of 1% in. Sunflower exhibited a decrease in the overturn rate of the Criteria Not Met Pharmacy from 62% in 2016 to 35.7% for 2017. The volume of those overturned in 2016 was attributed to additional documentation provided on appeal resulting in the ability to be overturned which was not demonstrated on the appeals in 2017. The Pharmacy appeals were followed by Criteria Not Met – Durable Medical Equipment and Criteria Not Met – Inpatient Behavioral Health appeals. Continued efforts at education occurred throughout 2017 with changes on medication criteria to providers to make the authorization process more efficient for both members and providers while also aiming to decrease the number of appeals that resulted. Sunflower set a goal of 3.5 appeals per 1000 members for both 2016 and 2017. Sunflower failed to meet that goal with 4.59 per 1000 members in 2017. For 2017, Sunflower's goal will be to achieve 4.35 appeals per 1000 members which would be just slightly more than a 5% improvement from 2017. The annual per 1000 value was calculated from the annual total of resolved member appeals in all categories of 748.

In 2017, Sunflower noted a change to the appeal decisions that were overturned or reversed which exhibited a decrease from 2016. The reversed appeals for 2017 was noted at 45.1% compared to 48.9% in 2016. As a result, Sunflower will continue to provide education to providers and encourage them to submit required documentation with the initial request for services/authorizations that will help in making these decisions in a more timely and efficient fashion to potentially avoid an appeal. This trend of appeals upheld, overturned or withdrawn is noted in the following table. The number of those that were withdrawn stayed relatively consistent.

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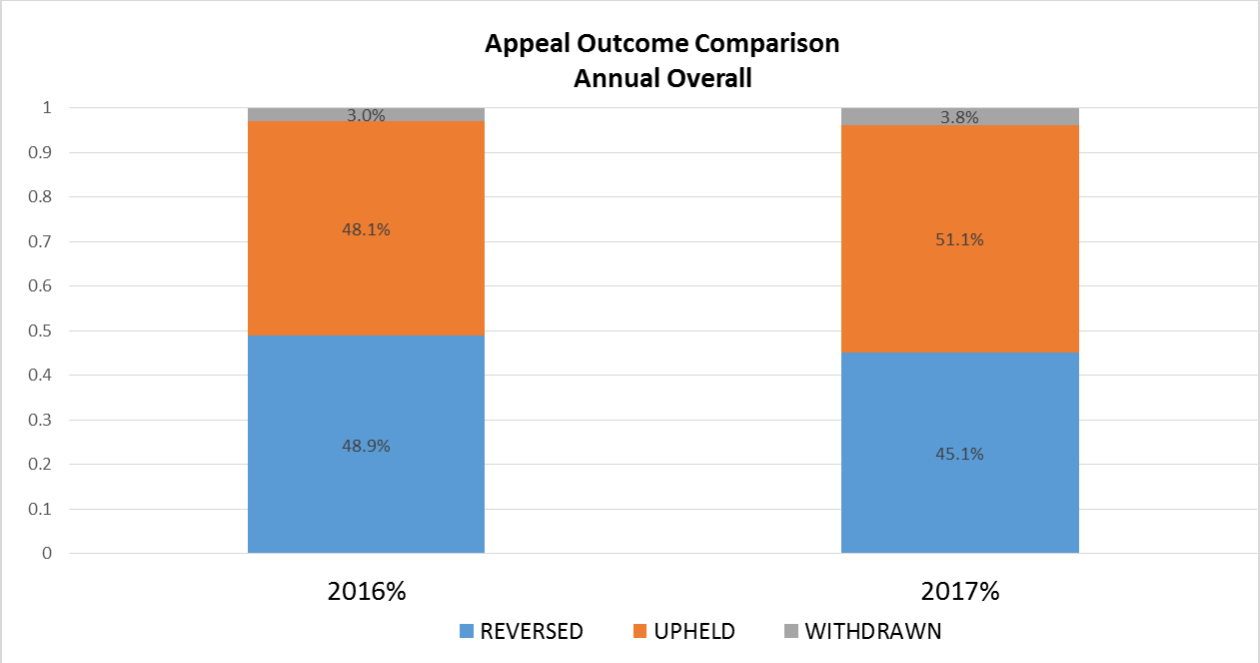

Provider Appeals

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

Sunflower established a goal of a 5% reduction in provider appeals for 2017. Sunflower noted an increase in provider appeals from 738 for 2016 to 1,258 for 2017. This increase was noted to be significant at 70%. Provider appeal rights changed in May 2017 consistent with KDHE policy which allowed the providers to skip the reconsideration step and proceed directly to appeal. Prior to 5/1/17, the reconsideration step was required prior to requesting an appeal. Upon implementation of this change, we saw an immediate increase in provider appeal volume. Thus, Sunflower did not achieve the goal set for 2017. Therefore, Sunflower's goal for 2018 will be to decrease provider appeals by 5%. In order to achieve this goal, a reduction of 63 provider appeals will be necessary in 2018 to achieve this goal.

The tables below depicts the provider appeals by category allowing for comparison of 2016 to 2017. Claim Denied- Contained Errors was by far the highest category with 267, accounting for 21% of provider appeals in 2017. The second highest provider appeal category was –Late Notification with 196 or 16%. The third highest category Criteria Not Met – Vision comprising 13% for the 2017. Together the top three provider appeal categories accounted for 627 of the 1,258 provider appeals, or nearly 50%. It is important to note that those denied for Criteria Not Met across multiple types of services made up 446 or 35%. Sunflower performs analysis of provider appeals data for trends that warrant evaluation of internal processes for potential opportunities for improvement or which can include education for providers, their office staff and

other areas on what should be submitted to fulfill medical necessity with the claim submission to lessen their need to file an appeal or if there are errors on claims submitted then education can be provided on those as well. Sunflower works to partner with vendors, providers and their office staff to improve processes and opportunities to increase efficiencies and lessen the burden.

Top 10 Provider Appeal Categories

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

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

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

Top 10 - Provider Appeals 2017	Number Resolved	Per 100,000 Claims in 2017*
Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	137	2.566
Criteria Not Met - Radiology	23	0.431
Criteria Not Met - Dental	31	0.581
Criteria Not Met - Vision	164	3.072
Criteria Not Met – Inpatient Behavioral Health	28	0.525
Other- Not Covered Service	92	1.723
Claim Denied- contained Errors	267	5.002

Claim Denied- by MCO in Error	39	0.731
Late notification	196	3.672
No authorization submitted	110	2.061
Totals	**1258**	**23.350**

**5,338,294* claims received through October 2017*

Member Satisfaction Survey

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

The 2017 Summary Rate Composite and Key Question scores for Sunflower are presented in CAHPS Adult and Child survey results provided below. These tables also demonstrate comparison of the survey results for 2017 against results for 2016along with comparison to the Quality Compass® All Plans means and percentiles. The 2017 Quality Compass® National Benchmarks is the mean summary rate from the Medicaid adult health plans that submitted data to NCQA in 2017. The Medicaid Child CAHPS is compared to the 2017 Quality Compass® National Benchmarks; this benchmark compares against other Medicaid child plans that submitted to NCQA.

Sunflower's summary rate results for 2017Composites and Key Questions for the CAHPS Medicaid Adult Survey compared to the 2017 Quality Compass National Benchmarks means and percentiles. Results for 2017 demonstrated improvement in Getting Care Quickly, Health Promotion and Education, Coordination of Care, Providing Needed Information, Shared Decision Making and How Well Doctors Communicate. Additionally, improvement was noted in the Rating of Health Care, Personal Doctor, Specialist and the rate for Health Plan stayed the same.

Medicaid Adult CAHPS Survey Results

Composite & Question Ratings	2016 Rate	2017 Rate	2017 Quality Compass Percentile Met/ Exceeded 50th Percentile
Getting Needed Care	**87.1%**	**86.2%**	**Yes**
Ease of getting care, tests, or treatment needed	86.3%	88.6%	Yes
Obtaining appointment with specialist as soon as needed	87.9%	83.8%	Yes
Getting Care Quickly	**83.4%**	**87.9%**	**Yes**
Obtaining needed care right away	86.5%	87.7%	Yes
Obtaining appointment for care as soon as needed	80.3%	88.1%	Yes
How Well Doctors Communicate	**92.6%**	**93.7%**	**Yes**
Doctors explaining things in an understandable way	92.6%	94.3%	Yes
Doctors listening carefully to you	92.0%	93.5%	Yes
Doctors showing respect for what you had to say	94.3%	93.8%	Yes
Doctors spending enough time with you	91.5%	93.1%	Yes
Customer Service	**91.0%**	**90.5%**	**Yes**
Getting information/help from customer service	86.1%	86.7%	Yes

Composite & Question Ratings	2016 Rate	2017 Rate	2017 Quality Compass Percentile Met/ Exceeded 50th Percentile
Treated with courtesy and respect by customer service	96.0%	94.3%	Yes
Shared Decision Making	**78.7%**	**79.3%**	**No**
Doctor/health provider talked about reasons you might want to take a medicine	92.2%	94.1%	Yes
Doctor/health provider talked about reasons you might not want to take a medicine	66.2%	67.6%	No
Doctor/health provider asked you what you thought was best when talking about starting or stopping a prescription medicine	77.6%	76.3%	No
Health Promotion and Education	**69.6%**	**73.5%**	**No**
Coordination of Care	**87.8%**	**90.0%**	**Yes**
Providing Needed Information	**74.6%**	**86.7%**	**Yes**
Ease of Filling Out Forms	**94.5%**	**91.7%**	**No**
Ratings Items			
Rating of Health Care	74.3%	78.0%	Yes
Rating of Personal Doctor	79.5%	84.2%	Yes
Rating of Specialist	81.7%	85.4%	Yes
Rating of Health Plan	75.4%	75.4%	No

Sunflower's 2017 summary rate results for Composites and Key Questions for the CAHPS Medicaid Child Survey by Title XIX and Title XXI compared to the 2016 Quality Compass All Plans. In 2017, Getting Needed Care, Health Promotion and Education, Coordination of Care and Rating of Specialist demonstrated improvement for both the Title XIX and Title XXI survey respondents. Customer Service, Ease of Filling out Forms, Shared Decision and Rating of Health Plan all demonstrated a reduction for both populations as well as noted on the table below. Green text depicts where there was a noted increase from the previous year while red text indicates a decrease from previous year's results.

Medicaid Child CAHPS Survey Results

Child Composite & Question Ratings	2016 Rate Title XIX	2017 Rate Title XIX	2017 Quality Compass Met/Exceeded 50th Percentile	2016 Rate Title XXI	2017 Rate Title XXI	2017 Quality Compass Met/Exceeded 50th Percentile
Getting Needed Care	**83.2%**	**88.5%**	**Yes**	**90.1%**	**90.5%**	**Yes**
Ease of getting care, tests, or treatment child needed	92.4%	91.0%	Yes	93.1%	93.6%	Yes
Obtaining child's appointment with specialist as soon as needed	74.0%	87.2%	Yes	87.1%	87.7%	Yes
Getting Care Quickly	**94.9%**	**92.9%**	**Yes**	**90.6%**	**91.9%**	**Yes**
Obtaining needed care right away	97.4%	95.2%	Yes	91.7%	94.9%	Yes
Obtaining appointment for care as soon as needed	92.3%	91.4%	Yes	89.6%	89.4%	Yes
How Well Doctors Communicate	**92.8%**	**95.9%**	**Yes**	**96.2%**	**94.9%**	**Yes**

Child Composite & Question Ratings	2016 Rate Title XIX	2017 Rate Title XIX	2017 Quality Compass Met/Exceeded 50th Percentile	2016 Rate Title XXI	2017 Rate Title XXI	2017 Quality Compass Met/Exceeded 50th Percentile
Doctors explaining things in an understandable way	93.9%	96.0%	Yes	96.2%	95.8%	Yes
Doctors listening carefully to you	92.8%	96.1%	Yes	94.3%	95.6%	Yes
Doctors showing respect for what you had to say	93.9%	96.4%	Yes	100.0%	96.9%	Yes
Doctors spending enough time with your child	90.6%	91.5%	Yes	94.3%	91.6%	Yes
Customer Service	**90.5%**	**89.0%**	**Yes**	**94.8%**	**89.7%**	**Yes**
Getting information/help from customer service	86.9%	83.8%	Yes	93.8%	82.7%	Yes
Treated with courtesy and respect by customer service staff	94.2%	93.6%	No	95.7%	94.3%	Yes
Shared Decision Making	**81.2%**	**79.1%**	**No**	**83.1%**	**80.4%**	**Yes**
Doctor/health provider talked about reasons you might want your child to take a medicine	99.0%	92.4%	No	95.2%	95.3%	Yes
Doctor/health provider talked about reasons you might not want your child to take a medicine	66.3%	66.8%	Yes	70.7%	70.0%	Yes
Doctor/health provider asked you what you thought was best for your child when starting or stopping a prescription medicine	78.2%	79.6%	No	83.3%	79.7%	No
Health Promotion and Education	68.3%	70.6%	No	64.6%	68.8%	No
Coordination of Care	78.0%	84.7%	Yes	76.6%	81.6%	No
Ease of Filling Out Forms	93.0%	94.3%	No	95.4%	93.0%	No
Rating Items						
Rating of Health Care	89.2%	88.2%	Yes	85.4%	88.9%	Yes
Rating of Personal Doctor	89.4%	90.6%	Yes	92.2%	89.6%	Yes
Rating of Specialist	87.7%	89.4%	Yes	82.8%	89.3%	Yes
Rating of Health Plan	90.1%	88.9%	Yes	92.0%	88.9%	Yes

Sunflower's goal for the 2017 CAHPS surveys was to meet or exceed the NCQA Quality Compass 50th percentile for both the Adult and Child surveys. Sunflower reached the 50th percentile on most measures and exceeded the 75th and the 90th percentile on several questions. Sunflower met the goal for most areas on the 2017 Adult and on the Child surveys. Sunflower is focusing efforts on improving member satisfaction related to the following areas, including certain areas that impact multiple domains resulting in their inclusion below as focus areas. One example is Customer Service, which impacts Rating of Health Plan, Rating of Health Care, Rating of Personal Doctor and Specialist. Additionally, Customer Service focuses on members being treated with courtesy and respect along with getting the information or help they need.

Medicaid Adult Survey:

- Shared Decision Making
- Getting Needed Care
- Customer Service

Medicaid Child Surveys:

- Customer Service
- Shared Decision Making
- Care Coordination

Sunflower utilized a new vendor, Morepace for delivery, data collection and report completion of the CAHPS surveys in 2017. The areas noted as strengths for the Adult survey are as follows:

- Getting Care Quickly
- How Well Doctors Communicate
- Care Coordination
- Getting Needed Care
- Customer Service
- Rating of Healthcare
- Rating of Personal Doctor
- Rating of Specialist

The one area noted as a relative weakness was Rating of the Health Plan. As a result Sunflower is focusing on Customer Service as an area to help drive the performance on Rating of Health Plan for the 2018 CAHPS Medicaid Adult survey.

For the 2017 Title XIX and Title XXI CAHPS child surveys, there only a relative weakness noted for Title XXI which was Care Coordination. However, the strengths that were noted to be consistent for both are listed here:

- Getting Care Quickly
- Rating of Healthcare
- Rating of Personal Doctor
- Rating of Specialist
- Rating of Health plan

To identify opportunities to improve performance, Sunflower examines all sources of member experience data to identify common issues across the various data sources. The sources utilized include grievance and appeal data and CAHPS survey results, including the strengths/weakness analysis provided by Morepace, were reviewed by representatives from key Sunflower departments, including Provider Relations, Medical Management, Quality Improvement (including the Grievance and Appeal Coordinator), Network & Contracting, Customer Services, Compliance, Pharmacy, and Medical Management team which is integrated to include LTSS/Waiver, I/DD, and Behavioral Health. The Sunflower CAHPS/member experience workgroup met and discussed barriers, opportunities to address these barriers to increase member satisfaction, and potential interventions. Some of these barriers are noted to be an ongoing challenge with the membership served.

The table below reflects the barriers identified in the results analysis:

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

- Lack of health plan staff understanding of CAHPS questions members respond to

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

- Implementation of Customer Service training to improve member experience and perception
- Empathy training and video for health plan staff
- Increase member understanding of Medicaid benefits.
- Educate providers on documents and information needed for PA request.
- Increase member engagement in provided materials.
- Increase reliability of member demographic information.
- Member education regarding transportation benefit via the member newsletter.
- Increase member knowledge of standard/expected timeframes to obtain an appointment.

Sunflower chose to use the NCQA approved combined Title XIX and Title XXI survey results for the NCQA accreditation scoring in August of 2017. The final score assigned to Sunflower was 11.3244 out of 13 possible points. Sunflower continues to strive for improvement on member satisfaction through a variety of interventions aimed at improving Customer Service and member experience.

ACCESS & AVAILABILITY

Customer Service Call Statistics

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

The Customer Service Department has state contractual requirements to meet telephone access standards. In 2017 the Customer Service Department met Sunflower's performance goals for both member and provider inbound calls. Sunflower's Customer Service department had a total call volume of 161,476 for 2017. The average speed to answer was 19 seconds in 2017 and Sunflower successfully met the goal of 80% answered within 30 seconds or less. The 2017 abandonment rate was 2.1% which demonstrates meeting the goal of less than 4%. As a result of the performance goals having been met, there are no opportunities to improve Sunflower's telephone access at this time. However, Sunflower will continue monitoring and reporting telephone access on a monthly basis to allow for tracking, trending and identifying any opportunities while striving to continue to meet or exceed the requirements.

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

Accessibility of Primary Care Services

Sunflower Health Plan (Sunflower) monitors primary care provider appointment accessibility against its standards, identifies opportunities for improvement and initiates actions as needed to improve results. Sunflower incorporates data and results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys, practitioner office surveys, member complaints/grievances, and customer service telephone triage access on a regular basis and

actions are initiated when needed to improve performance. This report describes the monitoring methodology, results, analysis, and action for each measure. The tables on the following pages denote the standards and performance.

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

Sunflower surveyed a sample of participating (in network) credentialed practitioners, both PCPs and specialists (includes OB/GYN), with Sunflower Health Plan in 2017. No practitioners were excluded from the sample. Practitioner data was pulled from Sunflower's provider management system, Portico. Data is collected by standardized survey; a total of 1074 practitioners were included for the 2015 analysis. Sunflower Health Plan's appointment availability surveys request confirmation that the practitioner can accommodate members' appointment needs based on current practitioner availability for routine and urgent appointments.

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

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

The table below demonstrates the results from 2017 assessment of providers by types to include primary care, oncologists, and OB providers. For the Primary Care Providers, a total of 346 were included in the sample initially and 185 completed the survey fully. Sunflower failed to meet the goals for primary care urgent appointments within 48 hours, primary care routine appointments not to exceed 3 weeks and wait time to exceed 45 minutes. The survey for the high impact specialists targeted 98 oncology practitioners and 79 completed the survey completely. For high-volume specialists, 361 OB/GYN providers were targeted and 171 completed the survey. The results demonstrated failure to meet the goal on high volume and high impact providers sampled on: urgent appointments within 48 hours and first routine

appointment within 30 days for OB/GYN. This was also the case for second and trimester routine appointments within 30 days for OB/GYN. However, Oncology care for routine appointments within 30 days did successfully meet the goal for 2017.

Measurement Results and Comparison to Performance Goal

Access Standard	Performance Goal	Results	Goal Met? (Yes/No)
Primary care urgent appointments within 48 hours	90% of surveyed PCPs report availability of urgent appointment within timeframe	51%	No
Primary care routine appointments not to exceed 3 weeks	90% of surveyed PCPs report availability of routine appointment within timeframe	1st available: 78% 2nd available: 84% 3rd available: 80%	No
Oncology care for urgent appointments within 48 hours	90% of high-impact specialists report availability of urgent appointment within defined timeframe	45%	No
Oncology care for routine appointments within 30 days	90% of high-impact specialists report availability of routine appointment within defined timeframe	1st available: 85% 2nd available: 93% 3rd available: 91%	Yes
OB-GYN care for urgent appointments within 48 hours	90% of high-volume specialists report availability of urgent appointment within defined timeframe	42%	No
OB-GYN care for routine appointments in the first trimester within 30 days	90% of high-volume specialists report availability of routine appointment within defined timeframe	1st available: 89% 2nd available: 88% 3rd available: 85%	No
OB-GYN care for routine appointments in the second trimester within 30 days	90% of high-volume specialists report availability of routine appointment within defined timeframe	1st available: 87% 2nd available: 85% 3rd available: 84%	No
OB-GYN care for routine appointments in the third trimester within 30 days	90% of high-volume specialists report availability of routine appointment within defined timeframe	1st available: 85% 2nd available: 84% 3rd available: 82%	No
Wait time not to exceed 45 minutes	90% of surveyed PCPs	81%	No
Volume of member grievances regarding accessibility of services	Complaint volume of less than .75/1000 members	0.19	Yes
Volume of member appeals regarding out of network service	Appeal volume of less than .75/1000 members	0.01	Yes
Adult Survey: *Getting Care Quickly* Composite	2017 Quality Compass 50th Percentile	87.9%	Yes

Measurement Results and Comparison to Performance Goal

Access Standard	Performance Goal	Results	Goal Met? (Yes/No)
Q4 Adult Survey: Percent of members who responded always or usually to "Obtained needed care right away"	2017 Quality Compass 50th Percentile	87.7%	Yes
Q6 Adult Survey: Percent of members who responded always or usually to "Obtained appointment for care as soon as needed"	2017 Quality Compass 50th Percentile	88.1%	Yes
Q61 (custom question) Adult Survey: In the last 6 months, when you phoned after regular office hours, how often did you get the help or advice you needed?	Internal Goal – Summary Rate of 80% or greater	84.8%	Yes
Child Survey: *Getting Care Quickly* Composite	2016 Quality Compass 50th Percentile	TXIX 92.9% TXXI 91.9%	Yes for Both
Q4 Child Survey: Percent of members who responded always or usually to "Child obtained needed care right away"	2016 Quality Compass 50th Percentile	TXIX 95.2% TXXI 94.9%	Yes for Both
Q6 Child Survey: Percent of members who responded always or usually to "Child obtained appointment for care as soon as needed"	2016 Quality Compass 50th Percentile	TXIX 91.4% TXXI 89.4%	Yes for Both
Q85 (custom question) Child Survey: In the last 6 months, when you phoned after regular office hours, how often did you get the help or advice you needed	Internal Goal – Summary Rate of 80% or greater	TXIX 73.8% TXXI 83.5%	TXIX – No TXXI - Yes
Member Grievances related to Appointment Access	< 5.0/1000 members	Grievance Database	Yes

Sunflower continued to assess the first, second, and third appointment availability to more thoroughly determine accessibility of routine appointments, as depicted in the table titled "Measurement Results and Comparison to Performance Goal" above. In 2017, Sunflower started utilizing SPH Analytics to perform the surveys for Appointment Access and After Hours. Sunflower established a goal to meet or exceed the 90% goal for compliance with appointment standards in 2017. The results demonstrated opportunities to focus improvement on for 2018.

Sunflower met their goals on the following measures:

- Volume of member grievances regarding accessibility of services
- Adult Survey: *Getting Care Quickly* Composite
- Volume of member appeals regarding out of network service
- Q4 Adult Survey: Percent of members who responded always/usually to "Obtained

needed care right away"

- Q6 Adult Survey: Percent of members who responded always/usually to "Obtained appointment for care as soon as needed"
- Q61 (custom question) Adult Survey: In the last 6 months, when you phoned after regular office hours, how often did you get the help or advice you needed?
- Child Survey: Getting Care Quickly Composite
- Q4 Child Survey: Percent of members who responded always/usually to "Child obtained needed care right away"
- Q6 Child Survey: Percent of members who responded always/usually to "Child obtained appointment for care as soon as needed"
- For Title XXI, Q85 (custom question) Child Survey: In the last 6 months, when you phoned after regular office hours, how often did you get the help or advice you needed

After-Hours Care

In 2017, Sunflower started utilizing SPH Analytics to perform the survey for After Hours Care. In addition to the survey results, other data sources were utilized which included the 2017 CAHPS surveys and also member grievances. The 2017 CAHPS survey questions addressing After-Hours Care; Q#60 on the Adult Survey Supplemental Questions "In the last 6 months, did you phone your personal doctor's office after regular office hours to get help or advice for yourself?", Q#61 "In the last 6 months, when you phoned after regular office hours, how often did you get help or advice you needed?"; Q#84 on the Child Survey Supplemental Questions "In the last 6 months, did you phone your child's personal doctor's office after regular office hours to get help or advice for yourself?", Q#85 "In the last 6 months, when you phoned after regular office hours, how often did you get help or advice you needed?"

CAHPS Survey Questions for After Hours	Title XIX 2016 Rate	Title XIX 2017 Rate	Title XXI 2016 Rate	Title XXI 2017 Rate	Adult 2016 Rate	Adult 2017 Rate
Child Q84/Adult Q60. In last 6 months, did you phone your child's or your personal doctor's office after regular office hours to get help/advice?	15.1%	12%	9.8%	9%	14.0%	18.0%
Child Q85/Adult Q61. In the last 6 months, when you phoned after regular office hours, how often did you get the help/advice you needed for your child or yourself?	82.1%	78.8%	86.7%	83.5%	75.0%	84.8%

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

The CAHPS data revealed that there is a small percentage of members who call providers offices after hours for help/advice. As noted, those who called their providers office after hours in the previous six months ranged from 9 % to 18% in 2016 for both child populations and the adult population. Both Title XIX and XXI populations noted a decrease in the number which had called their providers office after hours for help/advice in the last six months when compared to 2016 results. However, the adult results demonstrated an increase from 14% to 18%. Of those who did call for help/advice after hours were able to get the help or advice they needed for their child or their self by responses indicating always or usually. Of the three populations, only the adult result demonstrated an increase in getting the help or advice needed after hours for 2017 compared to 2016. Sunflower will continue to monitor this data on an annual basis to assess for opportunities for improvement from our membership.

The grievance data for after-hours access were captured in the Access-Other subcategory. Analysis of this data revealed seven grievances for 2017 in that subcategory. Upon review of these grievances it was determined that there were zero related to primary care after-hours access for 2017. Sunflower had established a goal of <0.50 member complaints for 2017. This goal was successfully met as evidenced by a rate of 0.00/1000 member complaints related to primary care after-hours access.

Access to behavioral healthcare practitioner and after-hours access is monitored on a regular basis and actions are initiated when needed to improve performance by EPC, Sunflower's NCQA-accredited behavioral healthcare vendor with respect to 2017. However, going forward in 2018 this is incorporated into the health plan process for survey, monitoring and actions as appropriate.

CAHPS Survey – Access Measures

Sunflower monitors practitioner appointment accessibility through analysis of relevant CAHPS® survey question results. Sunflower reviews results from CAHPS Question 4 "Obtaining needed care right away" and Question 6 "Obtaining care when needed, not when needed right away" in both the Adult and Child Medicaid surveys. Survey responses reported reflect the percent of members who report "Always" or "Usually" to the survey questions. Sunflower continued in 2017 to utilize additional CAHPS questions to capture data to assess primary care access information.

The table below demonstrates the Sunflower rates for CAHPS Adult member satisfaction survey results comparing 2017 to 2016. Also, the tables demonstrates the plans ranking per Quality Compass.

Composite & Question Ratings	2016 Rate	2017 Rate	2017 Quality Compass Ranking Met/Exceeded 50th Percentile
Getting Care Quickly	**83.4%**	**87.9%**	Yes
Obtaining needed care right away	86.5%	87.7%	Yes
Obtaining appointment for care as soon as needed	80.3%	88.1%	Yes

Below, the table that demonstrates Sunflowers Child CAHPS survey results for comparison of 2017 results with 2016 survey demonstrated by Title XIX and Title XXI member satisfaction survey results specific to Getting Care Quickly.

Child Composite & Question Ratings	2016 Rate Title XIX	2017 Rate Title XIX	Title XIX 2017 Quality Compass Met/Exceeded 50th Percentile	2016 Rate Title XXI	2017 Rate Title XXI	Title XXI 2017 Quality Compass Met/Exceeded 50th Percentile
Getting Care Quickly	**94.9%**	**92.9%**	**Yes**	**90.6%**	**91.9%**	**Yes**
Obtaining needed care right away	97.4%	95.2%	Yes	91.7%	94.9%	Yes
Obtaining appointment for care as soon as needed	92.3%	91.4%	Yes	89.6%	89.4%	Yes

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

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

Cultural and Linguistic Capabilities
Sunflower believes the practitioner network is able to meet the linguistic and cultural needs of the membership, based on the availability of translation services which members are accessing, the availability of practitioners in the network that speak other languages, and based on the lack of grievances regarding cultural/linguistic issues. The available data demonstrates that the current Spanish speaking capabilities among practitioners, together with the language assistance services available to members and the availability of Spanish speaking call center staff, adequately meets the cultural and linguistic needs of Sunflower's Spanish speaking members. There were no other significant cultural or linguistic needs identified for Sunflower residents. However, interpreter services and translation of written materials is available to any Sunflower member as needed.

Practitioner Availability
Practitioner availability monitoring is completed for primary care practitioners (PCPs), high volume specialty care practitioners, and high volume behavioral health practitioners. As noted above for 2017, EPC, the Plan's behavioral health vendor, was responsible for monitoring and analyzing behavioral health practitioner availability on behalf of Sunflower Health Plan.

The table below reflects the practitioner type, access standard, method of measurement and measurement frequency which is annually. The table below provides the results of access analysis as determined by Practitioner Type for 2017.

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Practitioner Type	Standard	Measurement Method	Results	Goal Met?
PCPs: All Types	95% of urban members have at least 1 PCP within 20 miles.	Quest Analytics	99.90%	Yes
	95% of rural members have at least 1 PCP within 30 miles.	Quest Analytics	99.90%	Yes
	At least 1 PCP per 2000 members	Ratio of PCPs to members	1:34	Yes
PCPs: Family Practitioners/ General Practitioners	95% of urban members have at least 1 FP or GP within 20 miles	Quest Analytics	99.90%	Yes
	95% of rural members have at least 1 FP or GP within 30 miles	Quest Analytics	99.80%	Yes
	At least 1 FP or GP per 2000 members	Ratio of FPs/GPs to members	1:100	Yes
PCPs: Internal Medicine	95% of urban members ≥19 have at least 1 internist within 20 miles	Quest Analytics	99.70%	Yes
	95% of rural members ≥19 have at least 1 internist within 30 miles	Quest Analytics	84.50%	**No**
	At least 1 IM per 2000 adult members	Ratio of internists to members	2:07	Yes
PCPs: Pediatrics	95% of urban members ≤18 years of age have at least 1 pediatrician within 20 miles	Quest Analytics	99.50%	Yes
	95% of rural members ≤18 years of age have at least 1 pediatrician within 30 miles.	Quest Analytics	74.50%	**No**
	At least 1 Pediatrician per 2000 members under age 19	Ratio of pediatricians to members	5:25	Yes
PCP Extenders: Nurse Practitioners	95% of members have at least 1 NP within 20 miles	Quest Analytics	99.90%	Yes
	95% of rural members have at least 1 NP within 30 miles.	Quest Analytics	99.70%	Yes
	At least 1 NP per 2000 members	Ratio of NPs to members	3:30	Yes
PCP Extenders: Physician Assistants	95% of members have at least 1 PA within 20 miles	Quest Analytics	99.90%	Yes
	95% of rural members have at least 1 PA within 30 miles.	Ratio of PAs to members	98.20%	Yes
	At least 1 PA per 2000 members	Quest Analytics	6:10	Yes
Obstetrics and Gynecology	95% of urban female members have at least 1 OB/GYN within 15 miles	Quest Analytics	97.40%	Yes
	95% of rural female members have at least 1OB/GYN within 60 miles.	Quest Analytics	95.20%	Yes
	At least 1 OB/GYN per 2000 members	Ratio of OB/GYN practitioners to members	3:50	Yes
Hematology/ Oncology	95% of urban members have at least 1 Hematology/Oncology provider within 25 miles	Quest Analytics	95.70%	Yes
	95% of rural members have at least 1 Hematology/Oncology provider within 100 miles.	Ratio of Hematology/Oncology providers to members	83.40%	**No**
	At least 1 Hematology/Oncology provider per 5000 members	Quest Analytics	16:37	Yes

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

Availability for all PCP types combined and by specific type for family/general practitioners, internists, and pediatricians met Sunflower's standards for members residing in urban areas. Two standards were not met for Sunflower members residing in rural areas. The two that failed to meet the standard were internal medicine and pediatricians. However, it is noted that for those rural areas there are family and general practitioners demonstrating the appropriate access to primary care. This was also noted in 2016. This may indicate that the primary care providers available in the rural area do not specialize in the care of adult, children or adolescents specifically. Sunflower also measures availability for PCP-Extenders, i.e. nurse practitioners and physician assistants, which both met the standards for urban members in 2017. Availability of physician assistants and nurse practitioners for members residing in rural areas did meet the standard of 95%, for 2017. All PCP types exceeded the numeric/ratio standards established by Sunflower: 1:2000 for all types of PCPs again in 2017.

Sunflower's standards for OB/GYN practitioners are that 95% of female members have access to at least 1 OB/GYN within 15 miles for urban areas and within 60 miles for rural areas; both standards were met for OB/GYNs in 2017. In addition to OB/GYNs, high-volume specialty care practitioners are defined as any provider greater than 150 encounters per 1,000 members. Sunflower also evaluated high-impact specialists, identified as hematology and oncology specialists, it was determined that they did meet the urban (95% of members have at least 1 specialist within 25 miles).The results for hematology and oncology access for rural members was 83.40% and did not meet the 95% goal. Sunflower will target these counties for further investigation and outreach to improve access for rural members: Finney, Seward, Grant, Sherman, Stevens, Kearney, Thomas, Rawlins, Hamilton, Haskell, Gray, and Meade. Of the counties listed above, Crawford, Finney, Geary, Grant, Gray, Hamilton, Haskell, Kearney, Meade, Rawlins, Reno, Seward, Sherman, Stevens and Thomas are all designated as Health Professional Shortage Areas (HPSAs) by the U.S. Department of Health and Human Services (DHHS).

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

In many rural areas in Kansas, hospitals are considered "critical access" and provide a variety of healthcare services, including primary care. Many rural hospitals have Rural Health Clinics (RHCs), Federally Qualified Healthcare Clinics (FQHCs) or health departments located in or near the acute care hospital that provide services to the entire county, and often to several surrounding counties as well. These arrangements, unique to rural and frontier/remote areas,

may not accurately reflect the availability of services through Quest Analytics reporting. Sunflower believes that despite not meeting the geographic standards for internists, pediatricians, and physician assistants and Hematologists/Oncologists per Quest Analytics reporting, members in rural and frontier areas of the state do have adequate access to primary and specialty care when considering the overall availability of all PCPs, including PCP-Extenders and known primary care and specialty services available through hospitals, as Sunflower is contracted with all available hospitals in the rural and frontier areas.

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

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

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

Provider Satisfaction Survey

The Centene Corporation provider satisfaction survey includes evaluation of satisfaction with communication between behavioral health practitioners and primary care practitioners. Levels of primary care practitioner satisfaction with behavioral health practitioner communication are collected through the annual provider satisfaction survey, and shared with Envolve People Care (EPC). Centene utilizes SPH Analytics, a National Committee for Quality Assurance (NCQA) Certified Survey Vendor, to conduct the provider satisfaction survey for all Centene health plans.

SPH Analytics followed a one-wave mail and internet with phone follow-up survey methodology to administer the provider satisfaction survey from September to October 2017. Sunflower's sample size was 1,500. SPH Analytics collected 221 surveys (106 mail, 26 internet, and 89 phone) from the eligible provider population. After adjusting for ineligible providers, the mail/internet survey response rate was 9.1%, and the phone survey response rate 13.3%. 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
106 (mail) + 26 (Internet) / 1,500 (sample) – 43(ineligible) = 9.1%
Phone Component
89 (phone) / 802 (sample) – 135 (ineligible) = 13.3%

For the 2017 survey, Sunflower continued to include those who could participate in providing feedback to include HCBS providers and nursing facilities. The 2017 survey results demonstrated the following: 1% of the responses were from HCBS providers, followed by 20.0% nursing facilities, 59.5% primary care providers and, 26.2% of the responses were from specialty practices. Of those who responded to the survey, 54% were responses from the office manager, 39.1% nurse/other staff responding, and 7.0% were physicians who responded on the survey.

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

Sunflower has demonstrated year over year improvement for all the composite areas except for 2017 compared to 2016. The Network/Coordination of Care focuses on the number and quality of specialists in the Sunflower provider network, timeliness of feedback/reports from specialists, timeliness of exchange of information/communication/reports from behavioral health providers and also how frequently behavioral health providers provide verbal/written communications to other providers on their patients. This is also an area continued focus from the CAHPS survey on Care Coordination for Sunflower in 2017.

Continuity and Coordination of Care between Medical and Behavioral Healthcare
Sunflower's Medical Management team demonstrates an integrated model with both Physical and Behavioral Health being focused upon. Sunflower annually assesses the following areas of collaboration between medical and behavioral healthcare:

- Exchange of information between behavioral health care and primary care practitioners and other relevant medical delivery system practitioners or providers;
- Appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care;
- Appropriate use of psychotropic medications;
- Management of treatment access and follow-up for patients with coexisting medical and behavioral disorders;
- Implementation of a primary or secondary preventive behavioral health program; and
- Special needs of members with severe and persistent mental illness.

The table below demonstrates how Sunflower specifically monitors these areas.

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

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

In the standardized survey tool administered by SPH Analytics for Sunflower's 2017 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 2017. The response for question 4E demonstrated an increase from 17.8% in 2016 to 13.3% for 2017. For question 4F, there was a noted decrease from 37.7% in 2016 to 25.4% in 2017. These data points are noted in the table below.

Provider Satisfaction Questions	2017 Percent Satisfied	2016 Percent Satisfied	2017 Responses Composite/Attribute
4E: Please rate the timeliness of exchange of information/feedback /reports from the behavioral health providers?	13.3%	17.8%	Excellent – 4.8% Very Good – 8.6% Good – 53.3% Fair – 22.9% Poor – 10.5% (n=105)
4F: How often do you receive verbal and/or written communication from behavioral health providers regarding your patients?	25.4%	37.7%	Always – 2.5% Usually – 23.0% Sometimes – 30.3% Rarely – 25.4% Never – 18.9% (n=122)

Sunflower was unable to compare performance on the 2016 survey against a benchmark, as SPH Analytics does not provide Medicaid Book of Business benchmarks for the two relevant questions since these are custom questions. Similarly, the composite for the Network/Coordination of Care section of the survey does not include these custom questions so was not reviewed for this report. Sunflower identified these as opportunities for improvement and has demonstrated a decline in performance from 2016 to 2017. Sunflower's goal for the 2017 provider satisfaction survey was an increase of 5% on each survey question. Sunflower failed to achieve the goal for both of these questions with the results demonstrated However, Sunflower will continue to work on improvement here as it is imperative to the members and their overall health.

Sunflower has integrated the behavioral health provider network and as a result will continue to promote the exchange of information through completion of an assessment for each member upon discharge for a behavioral health inpatient admission. Sunflower 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 for the records to be provided to the PCP. Care managers and care coordinators also address this with members during initial or ongoing outreach, providing education to members regarding the importance of providing consent to allow the information to be shared with their PCP.

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

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

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

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

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

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

The AMM HEDIS measure has two indicators:

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

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

Antidepressant Medical Management	HEDIS 2015 Final Rate	HEDIS 2016 Final Rate	HEDIS 2017 Final Rate	HEDIS 2018 Admin Rate*	Met/Exceeded NCQA 2017 Quality Compass 50th Percentile
Effective Acute Phase Treatment	49.09% (834/1699)	50.06% (874/1746)	51.02% (952/1866)	48.99%	No
Effective Continuation Phase Treatment	33.78% (574/1699)	34.48% (602/1746)	33.76% (630/1866)	30.75%	No

*Awaiting final HEDIS 2018 data

Sunflower's HEDIS 2017 (measurement year 2016) rate for the *Effective Acute Phase Treatment* measure did not meet the goal of reaching or exceeding the Quality Compass 50th percentile. However, this did demonstrate an increase of 0.97 percentage points. Therefore, Sunflower chose to continue to work to increase performance in 2018.

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

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

- Member knowledge deficit regarding importance of adherence, ways to manage side effects, etc.
- The treating provider may not be aware the member is not consistently taking their prescribed medication.
- Treating providers not familiar with the depression clinical practice guideline.
- Providers unaware of available behavioral health services such as the Depression DM program.

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

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

Coordinating Special Needs of Members with Serious & Persistent Mental Illness

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

Sunflower's HEDIS 2015 final rate serves as the baseline for this monitoring performance. For Sunflower's Health's baseline year (HEDIS 2015, Measurement Year 2014) the goal was to

achieve the NCQA Quality Compass HMO Medicaid 50th percentile of 79.38%. Sunflower's final rate of 72.69% failed to meet that goal. HEDIS 2016 demonstrated improvement of 2.58 percentage points over HEDIS 2015 with a rate of 75.27%, however this rate fell short of the NCQA Quality Compass Medicaid 50th percentile, not meeting Sunflower's goal for 2016. HEDIS 2017 demonstrated year over year improvement when compared to HEDIS 2016. The administrative rate for HEDIS 2018 is demonstrating improvement as well, but the final results are not expected until June of 2018.

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

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Rate	Met/Exceeded NCQA 2016 Quality Compass 50th Percentile
HEDIS 2015 Final Rate	72.69% (953/1311)	No
HEDIS 2016 Final Rate	75.27% (1239/1646)	No
HEDIS 2017 Final Rate	76.10% (1261/1657)	No
HEDIS 2018 Admin Rate*	77.96%	NA

*Awaiting final HEDIS 2018 data

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

- Knowledge deficit of members with SPMI regarding the risk of diabetes and the importance of diabetic screening
- Member confusion regarding involvement of both medical and behavioral health case managers/care coordinators
- PCPs are unaware their patients are seeing behavioral health clinicians or who the behavioral health provider is that the member is seeing.
- Members do not have an established relationship with a PCP.
- Health plan staff unable to identify the member's PCP, therefore cannot facilitate exchange of information.
- Treating providers not familiar with the diabetes screening guideline.
- Member knowledge deficit regarding diabetes screening

Sunflower implemented efforts to overcome barriers. Listed below are efforts that took place in 2017 with regard to overcoming and assisting members with improved health and quality of life.

- Member and provider newsletter articles about the availability of behavioral health services
- Integrated medical and behavioral health care management services to address medical and behavioral health needs concurrently
- Provider newsletter article regarding availability of behavioral health services and

resources available from Sunflower

- Provider newsletter article regarding Sunflower's practice guidelines and how to access the guidelines.
- Referral of all members identified as non-compliant within the SSD measure to the case management team for education, coordination of care, and support in scheduling diabetic screening appointments.
  Developed partnership with Community Mental Health Centers (CMHCs) to provide the CMHCs with a list of attributed members. The CMHCs will then provide support to their members in scheduling and completing their diabetic screening.
  Member letter to educate members of the importance in completing annual diabetic screening.

UTILIZATION MANAGEMENT PROGRAM

Purpose

The purpose of the Utilization Management (UM) Program Description is to define the structures and processes utilized within the Medical Management Department, including assignment of responsibility to appropriate individuals, in order to promote fair, impartial and consistent utilization decisions and coordination of medical and behavioral care for the health plan members.

Scope

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

Goals

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

Implementation

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

appropriate practice standards. The Primary Care Physician (PCP) is responsible for assuring appropriate utilization of services along the continuum of care.

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

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

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

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

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

Any adverse information that is gathered through interaction between the UM staff and the practitioner or facility staff is also vital to the re-credentialing process. Such information may

relate, for example, to specific case management decisions, discharge planning, precertification of non-covered benefits, etc. The information is forwarded to the QI Department in the format prescribed by Sunflower for review and resolution as needed. The Chief Medical Director or Medical Director determines if the information warrants additional review by the Plan Peer Review or Credentialing Committee. If committee review is not warranted, the information is documented and may be used for provider trending and/or reviewed at the time of the provider's re-credentialing process.

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

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

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

Complex Case/Care Management

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

Special Efforts are made to identify members who have catastrophic or other high risk conditions to ensure timely access, continuity and coordinated integration of care. This includes, but is not limited to, those members classified as children or adults with special health care needs; those with catastrophic, high-cost, high-risk, or co-morbid conditions; those who have been non-adherent in less intensive programs; or those that are frail, elderly, disabled, or at the end of life. Members are identified through multiple avenues such as, claims and data reviews, direct referrals from health providers, hospital staff, health plan staff, member, family and caregivers, community programs and supports. Once members are identified who will potentially benefit from care management they are assigned a case manager. The care manager may be either a registered nurse or social worker, or sometimes both working as an integrated team, dependent on the needs identified during the assessment with the member. The care manager will complete an assessment, develop a care plan with the member and work

with the member and the member's identified care and support team to obtain the necessary services and supports for the member. In order to optimize the outcome for all concerned, care management services are best offered in a climate that allows direct communication between the care manager, the member, and appropriate service personnel, while maintaining the member's privacy, confidentiality, health, and safety through advocacy and adherence to ethical, legal, accreditation, certification, and regulatory standards or guidelines. The care plan is developed with consideration of the member and/or caregiver's goals, preferences, and stated level of involvement in the care management plan of care.

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

- Identifying barriers to adherence to the care plan and recommended solutions for each barrier. Barriers may include but are not limited to issues such as:
  - Language or literacy issues, include general literacy limitations and health literacy
  - Visual or hearing impairment
  - Psychological/mental impairment
  - Financial and/or health insurance coverage limitations
  - Transportation
  - Cultural and/or spiritual preferences or values
  - Limited knowledge of condition(s)
  - Low motivation or ambivalence toward implementing change
  - Lack of, or limited, social or care giver support
- Prioritized goals which consider member and caregiver needs and preferences. Goals will be prioritized in numerical order or based on high, medium, or low priority. Goals will be designed to be achievable and help the member make changes towards the most optimal recovery possible.
- Interventions based on the member's problems and/or needs, agreed upon goals, and personal preferences.
- Time frame 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 care givers to help manage the member's condition(s). This may include written educational materials or verbal instructions provided by the care manager.
  - The specific information/materials and how the information was provided to the member (i.e. verbally, letter, pamphlet, etc.) are noted in the CDS.
  - When possible, self-management activities that can affect biometric data and be charted, such as weight and blood pressure, are documented in the CDS.
  - Follow up by the care manager to assess whether self-management activities have been completed.
- Documenting the plan of care in the CDS.

An abbreviated care plan is developed for members assigned to care coordination and may not include all of the components described above. 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, Q 2 weeks until complications are stabilized, barriers removed, and/or needed services are in place. Monthly contact unless condition deteriorates
Moderate	Complex condition with many health care needs; condition is mostly stable with adequate care giver support. If member assigned as high acuity previously, member is compliant with the care plan and making progress toward meeting care plan goals.	Weekly, biweekly or monthly
Low	Primarily psychosocial needs; no current unmet need for health care services but may have a history of condition that places the member at risk for potential problems or complications. If member assigned to a higher acuity level previously, member is compliant with the care plan, has met some goals, and making significant progress toward meeting remaining care plan goals.	One or two contacts and evaluation for care coordination discharge as appropriate

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

- Change in the member's medical or behavioral status.
- Change in the member's family situation or social stability.
- Change in the member's functional capability and mobility.
- The progress made in reaching the defined goals.
- The member's adherence to the established plan of care.

- Member's acquisition of self-management skills.
- Changes in member/family satisfaction with care management activities.
- The member's quality of life.
- Benefit limitations.

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

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

- The member terminates with the 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.
- The member expires.

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

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

- Claim or encounter data
- Predictive modeling software
- Hospital discharge data
- Pharmacy data
- UM data - e.g. hospital admission data, NICU reports, inpatient census, precertification/prior authorization data, concurrent review data
- Emergency Department (ED) Utilization reports

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

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

- Additional post-discharge nurse positions to contact all members not in case management after they have been discharged from the hospital.
- Continuation of dedicated Transplant Care Manager Nurses to assist transplant members.
- Continuation of a Sickle Cell Care Management Program to assess and educate all sickle cell members, assists with resources, coordinates care between providers, and any other functions necessary.
- Continuation of focused efforts on TANF and CHIP members; Sunflower has instituted efforts to assist new mothers to obtain four well-child visits within the first 6 months of life to ensure babies are receiving timely immunizations and meeting appropriate developmental milestones.
- Ongoing efforts to increase the percentage of Notice of Pregnancy forms completed on pregnant women to identify the high risk pregnancies and offer Start Smart Case Management, which includes identifying any mother at risk for pre-term deliver and working with the physician and the member to consider 17P injections to reduce the risk of a pre-term birth.
- A continued close partnership with Utilization Management staff to arrange safe discharges for NICU babies.
- Continuation of an Integrated Case Management training program for staff as well as a Sunflower based internal study group to further encourage/assist CM team members in preparing for and obtaining their CCM certification through CMSA.
- Continued strengthening of coordination of care between departments. Sunflower continues weekly rounds on inpatient members. Sunflower also continues integration with Complex Case Management Rounds, Long Term Service and Supports (LTSS) rounds, behavioral health and physical health integrated rounds to discuss, coordinate care/services with contracting providers and vendors.
- Training and implementation of Care Management Transformation, which is a coordinated care model that goes beyond the Integrated Care model and consists of a member journey and care router process to guide members to the right level of care, with integrated, coordinated care teams that holistically address physical, BH, LTSS, and social needs with appropriate staffing/expertise, utilizing evidence based, population specific care pathways.
- Sunflower 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.

- Sunflower continues to use the Krames Patient Education materials database which contains patient education materials for thousands of diagnoses, medications, and medical procedures.
- Focused outreach and efforts surrounding Opioid utilization. With this epidemic being complex in nature an IDT team has been developed to work with members and providers impacted by this. Sunflower feels this is best accomplished with an interdepartmental approach including pharmacy, provider relations, care management, both physical and behavioral, and medical affairs. In depth training will be provided to the staff so that they may better support our members. In addition, there will be focused outreach to providers to address the matters regarding prescribing practices.

Disease Management

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

- Asthma
- Diabetes
- Hypertension
- Heart disease
- COPD

Delegated Vendor Oversight

Sunflower selected delegated vendors to oversee certain activities to ensure quality of care for its members. Sunflower retains accountability for delegated services and monitors their performance through annual audits and by requiring monthly performance measures reporting. These measures include, but are not limited to:

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

The following is a listing of the delegated vendors for 2017. The first five are wholly-owned subsidiaries of Centene, as is the final listed, Dental Health and Wellness:

1. Envolve People Care (EPC, formerly EPC-CBH) - Sunflower's managed behavioral health care vendor. EPC provides utilization management, network development and maintenance, case management, credentialing of their network, and claims payment data.
2. Envolve Vision (formerly OptiCare) - Sunflower's vision care provider. Envolve Vision provides utilization management, network development and maintenance, credentialing of their network, and claims payment data.
3. Envolve Pharmacy Solutions (US Script) - Sunflower's pharmacy benefits manager. US Script provide information for prior authorizations, utilization management, verification of active licenses for all participating pharmacies, and claims payment data.
4. Envolve People Care (EPC, formerly Nurtur) - Sunflower's disease management provider. EPC provides disease management for the following programs: Asthma,

Coronary Artery disease, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, Hypertension, Hyperlipidemia and Tobacco Smoking Cessation.

5. Envolve People Care (EPC, formerly NurseWise) - Sunflower's after-hours call center and nurse advice line. EPC is a bilingual care line of registered nurses which complete health screenings and after hours nurse advice.
6. National Imaging Associates (NIA) - Sunflower's high-tech radiological imaging provider. NIA provides prior authorizations, credentialing of their network, first level appeals, and claims information.
7. Logisticare - Sunflower's transportation vendor.
8. Optum - Assists Sunflower in obtaining risk assessment information on pregnant members and facilitating utilization of 17P.
9. Envolve Dental (formerly Dental Health and Wellness) - They provide prior authorizations, utilization management, network development and maintenance and claim payment information.
10. LifeShare – Support services focused on developmentally disabled, child welfare, and marginalized members.
11. USMM – In-home healthcare services and risk adjustment.

Quarterly meetings are held with each vendor to review and monitor performance metrics and address any issues affecting Sunflower. Centene Corporation completes the annual vendor oversight audits on behalf of Sunflower and includes any Kansas specific requirements in the audit, as well as conducting applicable file reviews of Sunflower members. In conjunction with Centene Corporate and the other Centene health plans, Sunflower reviews the vendor evaluation results. As needed, the Quality Improvement Director reviews the results with the Vendor Manager and the Compliance Manager to identify any necessary interventions. All potential interventions are discussed with a multi-disciplinary Sunflower team and ultimately with the Quality Improvement Committee as needed. As necessary, action plans are implemented and improvement monitored.

Sunflower evaluates each delegated entity's capacity to perform the proposed delegated activities prior to the executing of a delegation agreement. Sunflower retains accountability for any functions and services delegated, and as such will monitor the performance of the delegated entity through annual approval of the delegated programs (Credentialing, UM, QI, etc.), routine reporting of key performance metrics and annual or more frequent evaluation to determine whether the delegated activities are being carried out according to the contract, accreditation standards and program requirements. Sunflower retains the right to reclaim the responsibility for performance of delegated functions, at any time, if the delegate is not performing adequately.

Integration of BH components from EPC to the health plan continued throughout 2017. Additionally, in 2017 Sunflower resurrected the monthly operations meetings with Logisticare which allows for focus on data analysis, follow up with actions taken based on trends identified from member grievances and other data available to both Logisticare and Sunflower. There were also three in-person meetings with Logisticare and Sunflower in 2017. Both are committed to improving the transportation grievances, member and provider experience with Logisticare.

Newly delegated entities are required to have a pre-delegation audit prior to contract implementation. All entities are subject to annual audits and submit regular reports of key functions to the Delegated Vendor Oversight Committee.

The table provided below contains the results of vendor audits conducted in 2017 and scope of the review. It is important to note while vendors are often put on QIP from the corporate audits, there were not findings specific to the Sunflower plan on all of those matters. However, Sunflower placed great focus on improvements with the transportation vendor Logisticare in 2017 specifically with regard to member grievances. Sunflower's ongoing efforts with Logisticare focus on policies, education and consistency with state contractual requirements.
This included monthly and quarterly meetings with Logisticare to review the member grievances related to transportation, trends noted in those data, this allowed for discussions and feedback along with steps taken to correct opportunities for improvement.

Vendor and Type	Date of Audit	Areas Audited	Scored Below 90% & QIP Implemented
NIA	December 2017	Credentialing	Yes
		Recredentialing	Yes
		Complaints - Member	No
		Complaints - Provider	Yes
		Customer Service Call Handling - Provider	No
Envolve Vision	October 2017	Claims	No
		Credentialing	Yes
		Denials Admin	No
		Denials Medical Appeal	No
		Denials Medical Necessity	No
		Member Calls	No
		Member Complaints	No
		Provider Calls	Yes
		Provider Complaints	No
		Provider Directory	Yes
		Recredentialing	Yes
Logisticare	September 2017	Claims	Yes
		Initial Credentialing	No
		Recredentialing	Yes
		Complaints - Member	Yes
		Complaints - Provider	Yes
		Transportation – General Requirements	Yes
Envolve Pharmacy Solutions	August 2017	Denials Administrative	Yes
		Claims	No
		Complaints	No
		Credentialing	Yes
		Provider Directory	No
		Rejected Claims	No
		Denials Medical Necessity	Yes
Envolve People Care (CBH)	N/A	N/A	N/A
Envolve People Care (STRS)	N/A	N/A	N/A
Envolve Dental	October 2017	Denials Administrative	Yes
		Claims	No
		Member Complaints	No
		Credentialing	Yes

Vendor and Type	Date of Audit	Areas Audited	Scored Below 90% & QIP Implemented
Envolve Dental (continued)		Re-Credentialing	Yes
		Provider Directory	Yes
		Provider Calls	No
		Appeals Medical Necessity	Yes
		Denials Medical Necessity	Yes
Envolve People Care (NAL & DM)	N/A	N/A	N/A
Optum	November 2017	Care Management	Yes
		Disease Management	Yes
		HRA / Wellbeing	No
		Nurse 24 Line (Triage)	No
		Complaints - Member	Yes
		Complaints - Provider	Yes
		Provider Overpayment Recoveries	No
		Credit Balance	No
LifeShare	N/A	N/A	N/A
USMM	N/A	N/A	N/A

Summary of QAPI Program Effectiveness

Throughout 2017, 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. Sunflower has continued to improve the quality of care and services provided to the membership through continuous assessment of patterns, trends and identification of barriers to desired outcomes.

Sunflower has identified strengths and opportunities for improvement which are outlined in more detail with action plans in the full annual evaluation report. Interventions included in the plan for continuation in 2018 were reviewed and continued as needed for measures requiring continued improvement.

Strengths:

- Year over year improvements on Member satisfaction results
- Continued steady improvement in HEDIS scores year over year
- Access and Accessibility
- Building maturity from the 2016 Re-design of Care Management with integration of physical and behavioral health
- Continued year over year on Provider Satisfaction survey results
- Utilizing innovation to drive Quality through Provider P4P arrangements, redesigned provider profiles and increased collaboration with providers

Opportunities for Improvement:

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

As a result 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 early positive results, and in some instances our efforts reveal negative findings as the plan matures and enforces guidelines. Sunflower has five years of complete data, placing Sunflower in a position to continue to drive Quality improvements through the analysis of data for trends which allow identification of processes that have opportunities for improvement while assessing for statistically significant changes. The findings from the analysis completed for 2017 did not indicate the need for major revisions to Sunflower's QAPI, operations, or service delivery systems. However, Sunflower will continue to work to maintain and improve on the gains achieved in 2017, and will take the necessary steps to continue to make improvements on the areas identified as priorities for improvement in 2018 with the aim to improve the health and well-being of our membership and increase partnership approach with providers. Sunflower strives to transform the health of the communities we serve, one person at a time.