
# 2020 Quality Program Evaluation
# Medicaid

# Sunflower Health Plan – 2020

## Contents

# Health Plan Quality Program Evaluation - 2020

## Introduction

The purpose of this evaluation is to provide a systematic analysis of Sunflower Health Plan's performance of the Quality Improvement (QI) activities and to evaluate the overall effectiveness of the Quality Assurance and Performance Improvement (QAPI) Program. The QI Department has established reporting QI activities outlined in the QI Work plan. This evaluation is focused on activities and interventions completed during the period of January 1, 2020 - December 31, 2020. The QAPI, Work Plan and Program Evaluation are reviewed and approved at least annually by the Quality Improvement Committee (QIC) and the Sunflower's Board of Directors (BOD).

### Mission

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

- Ensure access to primary and preventive care services in accordance with the KDHE - Division of Health Care Finance, and KDADS standards
- Ensure care is delivered in the best setting to achieve optimal outcomes and improving quality of life
- Improve access to necessary primary and 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 to meet or exceed these goals.

## Purpose

The purpose of the Quality Improvement Program is to utilize sound methodologies to objectively and systematically plan, implement and monitor ongoing efforts that demonstrate improvements in member safety, health status, outcomes, and satisfaction. This is accomplished through the implementation of a comprehensive, organization-wide system for ongoing assessments to identify opportunities for improvement utilizing the Plan-Do-Study-Act (PDSA) method for rapid cycle process improvement to drive continuous Quality Improvement across Sunflower Health Plan for both members and providers.

## Program Overview

### Quality Program

Sunflower continues to be committed to the provision of a well-designed and well-implemented (Quality Assurance and Performance Improvement) (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.

## Quality Improvement Program Integration

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

## Quality Improvement Work Plan

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

The QI Work Plan defines the activities, the person(s) responsible for the activity, the date of expected task completion and the monitoring techniques that will be used to ensure completion within the established timeframe. The QI Work Plan is presented to the QIC on an annual basis for approval, through the annual evaluation process and at regular intervals throughout the year. Additionally, the work plan is presented to the Board of Directors at least annually but more often as needed. The 2021 QI Work plan will be provided to the QIC for review and approval. The Work Plan is continuously updated and reviewed to track progress, identify risks to implementation and assess effectiveness.

## Organizational Report: Organizational changes in the evaluation year

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

Sunflower has identified strengths and opportunities for improvement, outlined in more detail in the full annual evaluation report. Interventions included in the plan was reviewed and continued as appropriate for measures where sustained improvement was warranted.

Strengths:

- Resilience, agility and innovation in response to the COVID-19 global pandemic
    - Early adoption and implementation of telehealth and tele-digital services to provide continued access to care
    - Key partnership and pilot program to bring internet access to parts of rural Kansas

    - Delivery of food, PPE (personal protective equipment) to members in need and support for the community
    - Operational efficiency in converting all staff from in office to work from home in less than 10 days, while continuing to deliver uninterrupted, high quality services to Sunflower members
- Higher than Centene average in member participation CAHPS (Consumer Assessment of Healthcare Providers & Systems) and mid-year member satisfaction surveys, despite COVID-19 barriers
- HEDIS improvements in key measures demonstrating effectiveness of targeted, focused interventions by the Pharmacy team, and integration of physical and behavioral health programs
- Incorporation of member and provider feedback for continuous improvement of services and care
- Inter-department collaboration and partnerships to drive improvements in Pay for Performance (P4P), Performance Improvement Projects (PIPs) and other HEDIS measures
- Increase on Net Satisfaction scores from the Provider Survey (0.8% increase) and Overall Satisfaction with the Health Plan (1%)
- Improvement in HEDIS data collection and management

**Opportunities for Improvement:**

- Improve member access and practitioner availability
- Provider satisfaction with Sunflower Health Plan operations
- 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, well care for members and gap closures for key HEDIS measures
- Explore additional opportunities to continue to innovate to drive quality improvement through innovation.
- Enhance integration of Social Determinants of Health (SDOH) and cultural care practices to member by providers, networks and plan operations
- Continue to align strategic alignment across the Enterprise
- Improve Corporate and Plan coordination
- Data enhancements
- Continue process improvement

Sunflower now has eight (8) years of data to review for process innovation and drive continuous quality improvements through the plan-do-study-act (PDSA) method. Sunflower will analyze data trends, review barriers and perform gap analysis to identify opportunities improvement. Sunflower Health Plan will use statistical analysis, data modeling and predictive analytics to focus interventions and programs for improvement.

The findings from 2020 data, included an impact analysis of the COVID-19 pandemic to Sunflower's quality programs, operations, and service delivery systems. Sunflower will take the necessary steps to demonstrate continuous quality improvement on the areas identified as priorities for improvement in 2021. The aim is to improve the health and well-being of our

membership and increase partnership approach with providers. Sunflower continues with the purpose to transform the health of the communities we serve, one person at a time.

## Scope of the Quality Program

The scope of the Quality Assurance and Performance Improvement (QAPI) Program is comprehensive. The QAPI addresses 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 provide members with access to quality medical care 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 maintenance and quality of life will be experienced by Sunflower members;
  - Support of members to pursue options to live within their community to enhance their quality of life;
  - Network quality of care and service will meet industry-accepted standards of performance;
  - Sunflower services will meet or exceed industry-accepted standards of performance;
- Fragmentation and/or duplications of services will be minimized through integration of quality improvement activities across Sunflower functional areas;
  - Member satisfaction will meet Sunflower's established performance targets;
- Preventive and clinical practice guideline compliance will meet established performance targets.
- This includes, but is not limited to, compliance with immunizations, prenatal and postpartum care, diabetes, asthma, early detection of chronic kidney disease and EPSDT (Early Periodic Screening, Diagnosis and Treatment Program) guidelines. Sunflower will measure compliance with clinical practice guidelines until 90% or more of relevant network providers are consistently in compliance;
- Compliance with all applicable State/Federal regulatory requirements and National Accreditation standards.

## Compliance Program Description

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

In 2020, Sunflower participated in the Balanced Budget Act (BBA) State audit, and Kansas Department for Aging and Disability Services (KDADS) member quarterly files in Q4. Additionally, in 2020 Kansas Foundation for Medical Care (KFMC), our EQRO, performed validation of HEDIS measures and other measures included in the state Pay for Performance (P4P) in Q4.

In 2020, Sunflower complied with records requests for quarterly Home and Community Based Services (HCBS) documentation audit requests for 2017 through 2019 from KDADS. Sunflower is awaiting the final results of HCBS audits from the State.

Sunflower implemented the following surveys:

- CAHPS survey, including Title XIX and XXI
- Provider survey
- Mental Health survey

## Cultural Competency Plan (CCP)

Sunflower Health Plan promotes and participates in the efforts to ensure that covered services are delivered in a culturally competent manner to all members. Sunflower remains responsive to health literacy needs of our members, including those with limited English proficiency diverse cultural and ethnic backgrounds, disabilities, regardless of gender, sexual orientation or gender identity. Sunflower is committed to developing, strengthening, and sustaining healthy provider and member relationships.

Members are entitled to receive dignified, appropriate, and quality care.

The Cultural Competency Plan (CCP) strives to reduce health disparities in clinical areas; ensure culturally relevant materials and communications; improve network adequacy to meet the needs of underserved groups; and to improve other areas of needs the organization deems appropriate to address social determinants of health (SDOH). The CCP includes the Sunflower's strategy for recruiting staff with backgrounds representative of Enrollees served.
Member cultural needs, preferences, demographics are maintained and updated at least annually. The Population Health Clinical team performs a care management population assessment of the services utilized by the entire member population and any relevant subpopulations. Customer Service representatives, Care Managers and all Sunflower staff receive Cultural Competency training as part of the new hire training plan and annually thereafter.

The Cultural Competency Plan (CCP) is available to all members and providers via the Member Handbook and Sunflower website. The CCP plan addresses member language needs and availability of interpretive services in the Welcome section of the Member Handbook. Member materials are produced in English and Spanish and other language or format requests are accomplished through translation, interpreters, or appropriate accessible formats. Centene contracts with its language line vendor, enabling Sunflower staff to communicate in the member's primary language via phone and in person, and is available 24 hours a day, 7 days a week, at no charge to the member. The Quality Improvement Committee (QIC) develops and annually updates a CCP that addresses the cultural, linguistic, and disability access needs identified in the population assessment and the Chief Medical Director is responsible for oversight of the CCP, including annual approval of the CCP.

The CCP includes the plan's ongoing strategy to meet the unique needs of Enrollees who have developmental and cognitive disabilities in its operation. This includes:

- Transportation services
- Services for home-bound enrollees
- Engagement with local organizations to collaborate on initiatives to increase and measure the effectiveness of culturally competent service delivery
- Standards and performance requirements for the delivery of culturally and linguistically appropriate health care services.

Sunflower continues to utilize a Member Advocate in Customer Service who works closely with the LTSS Member Advocate and BH Member Advocate. The Advocate assisted members with needs related to housing, food, community resources, navigating the healthcare system and with any cultural or linguistic needs. The Member Advocate collaborates with the SDOH team to integrate physical and behavioral health. Cultural Competency and Disability Awareness webinar training was offered to Network Providers on a quarterly basis instead of annually.

## Delegation

**Committee Structure**
Quality is integrated throughout Sunflower, and represents the strong commitment to the quality of care and services for members and providers. To this end, Sunflower has established various committees, subcommittees, and ad-hoc committees to monitor and support the QAPI Program. The Board of Directors holds ultimate authority for the QAPI Program. The Quality Improvement Committee (QIC) is the committee reporting to the Board of Directors, and is supported by various sub-committees. The Committee structure is listed below:

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

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

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

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

The QIC is composed of Sunflower's CEO and President, Chief Medical Director, Associate Medical Directors, and Quality Vice President, along with other Sunflower executive staff representing Population Health Clinical Operations (including Utilization Management and Case Management), Network Development and Contracting, Customer Service, Compliance, and Pharmacy departments, with other ad hoc members as necessary. Additional QIC attendees include staff responsible for Clinical Appeals and Fraud, Waste & Abuse. The first QIC meeting for Medicaid occurred December 19, 2012, prior to implementation of KanCare. The Committee continues to meet on a quarterly basis, at a minimum. For 2020, QIC met a total of five (6) times which included the quarterly meetings and one (1) ad hoc meeting.

**Credentialing Committee**
The Credentialing Committee is a standing subcommittee of the QIC and is responsible for administering the daily oversight and operating authority of the Credentialing Program. The QIC is the vehicle through which credentialing activities are communicated to the Board of Directors. The Credentialing Committee is responsible for the credentialing and re-credentialing of physicians, non-physician practitioners, facilities, long-term care providers, and other practitioners in Sunflower's network, and to oversee the credentialing process to ensure compliance with regulatory and accreditation requirements. The Credentialing Committee is facilitated through Centene's corporate office and is composed of Sunflower's Chief Medical Director and Associate Medical Director(s), Centene's Corporate Credentialing Director, network physicians, and QI Vice President. The Credentialing Committee met thirteen (13) times in 2020, including monthly and one (1) ad hoc meeting. The Credentialing Committee meets monthly and on an ad-hoc basis.

**Pharmacy and Therapeutic Committee**
The Pharmacy and Therapeutics (P&T) Committee is a standing subcommittee of the QIC and is responsible for administering the routine oversight and operating authority of the Pharmacy Program. The QIC is the vehicle through which 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 Medical Director, Pharmacy Director, network physicians, network pharmacist, and other executive staff. For 2020, P&T met once. The Pharmacy team combined quarterly updates to focus on the Opioid and Budget Balance Act (BBA) audits, implementation of a new vendor solution, automated Provider outreach and increase emergency early refills due to COVID

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

The UMC is composed of Sunflower's Chief Medical Director, Medical Director(s), Sunflower's Vice Presidents of Population Health Clinical Operations, Long Term Support Services, and other operational staff as needed. Network physicians also participate in this committee to provide input on process, policies and data. For 2020, UM Committee met five (5) times – quarterly meetings and one (1) ad hoc. The UM Committee meets quarterly.

**Quality Measures Steering Committee**
The Quality Measures 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 Quality Measures 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 and President, Chief Medical Director, Medical Directors, and Senior Leadership of Population Health Clinical Operations, with representation from Contracting/Network Management, Member/Provider Services, and Pharmacy.

The Quality Measures Steering Committee meets quarterly and met three (3) times in 2020. The Committee did not meet in Q3 due to schedule conflicts with the EQRO HEDIS audit.

**Grievance and Appeals Committee**
The Grievance and Appeals Committee (GAC) is a subcommittee of the QIC and is responsible for tracking and analysis of member grievances and appeals including type, timeliness of resolution, performing barrier and root cause analysis, and making recommendations regarding corrective actions as indicated. The GAC is composed of Sunflower's Chief Medical Director, Medical Directors, Pharmacy Director, Quality, Grievance Coordinators, Clinical Appeals Coordinators, Lead Clinical Appeals Nurse and representatives from Customer Service and Medical Management. The GAC provides summary reports to the QIC at regular intervals, but no less than quarterly. Meetings typically occur quarterly or more frequently as needed. The GAC met four (4) times in 2020.

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

A dedicated Behavioral Health PRC committee was implemented in Q4 2020 and will follow the same Charter as the Physical Health PRC. There is cross-functional attendance by a Medical & Behavioral health Medical Director in each committee

PRC for Physical Health met ten (10) times to review member initiated cases and make recommendations as appropriate in 2020. The Behavioral Health PRC, met for the first time as a stand-alone committee in December 2020.

**Performance Improvement Committee**
The Sunflower Performance Improvement Committee (PIC) is an internal, cross-functional quality improvement team that facilitates the integration of a culture of quality improvement throughout the organization. The PIC 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 PIC is also responsible for overseeing the implementation of recommended corrective actions/interventions from the QIC and/or its supporting subcommittees, monitoring the outcomes of those improvement efforts and reporting to the designated committee.

The PIC meets monthly and includes representation from each functional area within Sunflower. Membership includes staff that conducts or directly supervises the day-to-day activities of the departments, i.e. Case Management, Compliance, Community Health Services, Contracting, Customer Services, Network Development, Prior Authorization, Provider Relations, Quality Improvement or other members as determined by the topic under discussion. The PIC met eleven (11) times in 2020. This committee meets monthly.

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

**CAHPS - Member Advisory Committee**
The focus of the CAHPS/Member Experience team serves as a work group that reviews the CAHPS or member satisfaction survey results. The group worked to identify opportunities for Improvement, review barriers and brainstorm solutions to mitigate barriers. The goal of this committee is to continue to make strides improving the member experience as evidenced through improved survey results. The committee will meet quarterly and more often as necessary. A Senior Quality leader or the designated Member Experience lead from the Quality team leads the committee. Members of the committee consist of representatives from Member and Provider Services, Vendor Management, Quality Improvement, Medical Management, Pharmacy, Marketing, LTSS, Network Development/Contracting and Member Connections (Community Health Services). This workgroup typically meets on a quarterly basis but may have Ad Hoc meetings as needed. In 2020 the work group met on twelve (12) occasions.

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

The MAC includes members, community members, parents/foster parents/guardians of children who are Sunflower members including those in foster care and Children with Special Healthcare Needs (CSHCN) to allow them to provide feedback to Sunflower, and Sunflower staff, as appropriate. The Sunflower's senior leader of Member Services chairs the Committee. The MAC met four (4) times in 2020.

**Sunflower Vendor Joint Operations Committee**

The Vendor Joint Operations Committees (JOCs) are active sub-committees of the PIC. The JOC primary function is to provide guidance to, and oversight of, the operations affecting the scope of functions of delegated vendors, including review of periodic activity reports from delegated vendors, ensuring compliance with all NCQA standards and regulations related to the delegation relationship, and recommending actions to address any identified opportunities for improvement in delegated services. The purpose of the Vendor JOCs is to provide oversight and assess the appropriateness and quality of services provided on behalf of Sunflower to members. The Vendor JOCs includes representation from each Sunflower functional area as well as representation from the delegated vendors. These meetings typically occur on a quarterly basis but may occur more frequently as needed.

Below is the list of delegated vendors overseen by the Delegated Vendor Oversight (DVO) committee.

| Vendor | Number of Meetings in 2020 |
|---|---|
| National Imaging Association | 12 |
| Envolve Pharmacy | 4 |
| ModivCare | 12 |
| EPC DM / NAL | 12 |
| Envolve Dental | 4 |
| USMM | 3 |
| Optum | 3 |
| Life Share | 1 |
| Envolve Vision | 4 |
| EPC (CBH) | 43 |
| EPC (STRS) | 6 |

**Long Term Support and Services Advisory Committee**

The Long Term Support and Services (LTSS) Advisory Committee is an active subcommittee of the PIC. 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 Sunflower on opportunities to impact the LTSS members. This committee meets quarterly and different Sunflower Health Plan departments present on items that impact LTSS membership. Vice President of Long Term Support Services chairs the committee. This committee meets quarterly. In 2020, the community met monthly due to the increased need to coordinate as a result of the COVID-19 pandemic.

**Provider Joint Operations Committees (JOCs)**

The Provider Joint Operations Committees (JOCs) are active provider committees that occur at least quarterly and report to PIC. This committee meets with high volume providers to allow

these providers to provide input on the following: Sunflower policies, clinical programs and processes; payment and UM activities; provider satisfaction and profiling activities, provide assistance to identify concerns and provide input for improvement of provider relations and support. Additionally, from time to time, Sunflower may engage providers to provide input on implementation of new policies, processes, and tools. In 2020, 24 JOCs were conducted with different Network Partners.

**Behavioral Health Advisory Committee**
The Behavioral Health Advisory Committee started in 2018 to allow for communication of Sunflower's programs, policies and procedures. The Committee is comprised of Behavioral Health Providers from our Network and Sunflower Behavioral Health staff. The Committee allows for providers to make recommendations and identify key issues encountered by members and providers. The committee chair is the Sunflower Behavioral Health Medical Director or director level Sunflower staff. The meetings occur on a quarterly basis. This committee reports off to the PIC committee. In 2020, this committee met four (4) times: March, June, Sept, and December.

**Quality Improvement Department Structure and Resources**
The QI resources were evaluated. It was determined that additional resources were needed to meet the needs of the QAPI Program for 2020.

The QI department is composed of the following members:

- Chief Medical Director, serving as the Senior Executive for Quality Initiatives (SEQI) (member by position and role)
- Medical Director, Utilization Management (member by position and role, not formal reporting structure - 2)
- Medical Director of Behavioral Health (member by position and role, not formal reporting structure)
- Vice President, Quality (RN) (joined March 2020)
- QI Director (joined Dec 2020)
- QI Supervisor (RN) (joined Nov 2020)
- EPSDT Coordinator (RN)
- Accreditation Specialist
- QI Project Manager (3)
- QI Specialist (1)
- QI HEDIS Specialists (one RN and one non-clinical)
- QI Coordinator (1 non-clinical)
- Senior QI Specialist (3 – RN, and non-clinical)
- Data Analyst (1) (joined Dec 2020)
- Centene Corporate support

**2020 Quality Leadership & Staffing**
The Sunflower Chief Medical Director (CMD) served as the SEQI and provided continued leadership and oversight of the Quality team. A Vice President of Quality & Performance Improvement joined the team at the end of Q1. The CMD and VP served as the Executive team overseeing the Quality team.

Quality leadership continues to conduct routine assessments of work volume, effective of interventions and progress on Sunflower priorities. On-going reassessment and staff training

allows for reallocation of resources to maximize performance. This flexibility enables the team to address needs work volume trends, address priority areas to ensure the member and provider needs are met as integral parts of the business, while driving continuous quality improvement.

The team was restructured in August 2020. The restructure was needed to enhance team performance and scalability. There were six (6) eliminated positions, including 3 Managers, 2 staff level positions and 1 resignation. The resignation was due to relocation. The eliminations were due to performance and restructure. The eliminated positions were replaced by 1 Director, 1 Supervisor, 1 Data Analyst and 1 Coordinator.

Staffing and resources continue to be assessed on an ongoing basis to ensure Sunflower is able to accommodate member needs, contractual requirements, improve quality, and adequately address the volume of routine audits and reporting uniquely required by the State contract and maintain NCQA Accreditation

## Quality and Utilization Program Effectiveness

**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 Long-Term Care (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.

**2020 Quality Improvement Strengths and Accomplishments:**

- Quality Improvement leadership and team was restructured to optimize performance and scalability
- The new structure includes a Director, Supervisor and Data Analyst. The team consists of four (4) Registered Nurses (RNs) and a licensed behavioral health professional.
- Quality Improvement reports up to the Chief Medical Director, who is directly involved in Quality initiatives as the SEQI
- Dedicated QI Senior Quality Specialist for Medicaid Pay for Performance (P4P).
    - Cross functional workgroups focused on improvement of measures that directly impact the health and well-being of members
    - Collaboration with HEDIS Operations, Clinical teams, Customer Service and Provider teams to increase performance
    - Collaboration with providers and health departments to impact our member health and well-being through preventative care for focused measures (diabetes immunizations, cancer screenings, well-visits and other preventive services)
- Leverage data to drive interventions and improve measure performance.
    - Use of member level data, geographic segmentation and barrier analysis to enhance effectiveness of interventions.
    - Integrate Member and Provider surveys in intervention design
- Incorporate technology to close HEDIS care gaps, improve adherence and address health disparities (telehealth, remote monitoring & home kits)
- Improve existing processes, medical records review and increase supplemental data to improve HEDIS metrics and close care gaps
    - Use of immunization registry, WebIZ, Health Information Exchange (HIE)
    - Direct data feeds from Provider and Network, Electronic Health Records (EHR)
    - Provider Portal enhancements
    - Implement mid-year member experience survey (aka off-cycle CAHPS) in 2020
- Committee membership and structure continues to evaluate revised and functional support activities.
- Network providers actively participating in Quality committees to provide input and feedback to drive continuous Quality Improvement across the organization
- Continued support for Home and Community Based Services (HCBS) to meet Member and Provider needs
    - expansive network,
    - implement case management,
    - refining operations in claims processing
    - Use of Social Determinants of Health (SDOH) services
- Year over year improvements in the Member and Provider satisfaction surveys.
- Cross functional, integrated strategy for improvement opportunities
- Continued evaluation and updates to systems to incorporate State reporting criteria to reduce reporting errors and automate some reporting functions.
- Ongoing evaluation, modification, and update of templates for trending of Quality of Care concerns.
- Improve the Quality of Care (QOC) process:
    - Implement data and trending report
    - Addition of Behavioral Health Peer Review to complement Physical Health Peer Review
    - Quantify and decrease backlog

- Incorporate Grievance and Appeals review in Delegation Vendor Oversight (DVO) committee.
- Continued development and use of reports for monitoring and identification of cases at risk of not meeting turn-around time (TAT) for grievances and appeals before they are out of TAT.
- Utilize developed process in documentation system to route Adverse Incident Reporting System (AIRS) so all documentation remains in single entry/record and includes QOC and Case Management feedback.
- Implemented revisions to the Grievance Appeals Report (GAR) through collaboration with the Data Analytics team
- Medicaid Member grievance resolution TAT for 2020 was 90.5%, while acknowledgment was at 90.5%
- Medicaid Member standard appeal resolution TAT for 2020 was 99.2% and acknowledgment was at 97.3%
- 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 2762 calls weekly regarding benefit inquiries, concerns, complaints, and request for arranging services.

### 2020 Quality Improvement Opportunities:

- Sunflower continues to explore and evaluate resources and opportunities for education and incentives to improve rates with goal to meet or exceed the 75$^{th}$ Quality Compass Percentile for HEDIS measures to improve Pay for Performance (P4P) and relevant Performance Improvement Projects (PIP).
- The COVID pandemic crippled efforts to significantly engage in Member and Provider outreach in 2020.
- Continue to evaluate survey data, enhance interventions and implement new programs to improve Member and Provider satisfaction with Sunflower services.
- Continue efforts to develop and expand trending reports for data analysis and focus interventions.
- Continued efforts to strive for improvements in all six (6) Performance Improvement Projects (PIP). Additional opportunity to focus interventions to see which interventions contributed to overall improvement.
- Continue to work with the other Kansas Medicaid MCOs on issues to improve care to Medicaid beneficiaries as necessary.
- Continue efforts to improve processes, provide education and work to improve appeals and grievances for both members and providers which will also impact satisfaction for both.
- Continue to explore opportunities to expand partnerships with network providers to improve the quality of care members receive including innovation.
- Continue to refine and align strategies to improve overall Sunflower Health Plan performance.

## Population Characteristics

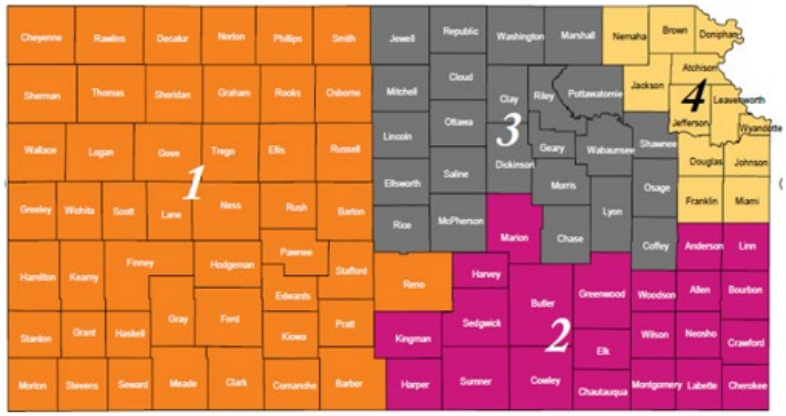
### Member Demographics and Service Area

Sunflower is in its eighth year of operations providing Medicaid services to members in Kansas. Sunflower began operation as a managed care organization serving the Kansas Medicaid population on January 1, 2013. Since its inception, efforts continue to grow membership by providing members with access to quality care and superior member experience.

Sunflower continues to enhance care management and coordination, disease prevention and management services and offer member incentives to encourage healthy behaviors and healthy lifestyles. Sunflower encourages member participation and feedback through member surveys, advisory councils and outreach programs.

The integration of Physical and Behavioral health programs, member advocates to address health disparity is yet another impactful improvement to the member experience and one way Sunflower is demonstrating a whole person care approach. Each year, Sunflower continues to evaluate our membership and population to provide the best member experience.

Sunflower's membership span across Kansas and serves urban, rural and frontier areas.




Western KS
(Region 1):
Rural and Frontier

Southern/SE KS
(Region 2):
One metro area
(Wichita)
Remaining rural

Central/N-Central KS
(Region 3):
Semi-rural

Northeast KS
(Region 4):
Metro

## Membership Characteristics

TANF and CHIP members continue to make up the majority of the Sunflower membership. These two groups together made up 74% of Sunflower membership in 2020.

Children and adolescents (0 to 17 years old) comprise more than 70% of the total population, with young children ages 0 to 10, making up the largest percentage. By contrast, adults make up 33% with the largest subset being in the IDD/SDI population.

The membership male to female ratio remains largely unchanged year over year, with females at 10% higher than males. The majoring of members reported speaking English as their primary language (95.10%), with Spanish and "unidentified" at 2.88% and 1.69%, respectively.

A comparison of 2019 and 2020 membership shows the likely impact of COVID to the Sunflower population. The shelter in place order began in March 2020 with State and National emergency mandates. The data shows a steady increase in 2020 enrollment from the same month in 2019.

**2019 and 2020 membership comparison: Medicaid**

| Year | Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2019** | 141,338 | 140,319 | 140,353 | 138,647 | 138,543 | 138,143 | 138,502 | 139,365 | 139,224 | 138,640 | 137,963 | 136,911 |
| **2020** | 140,352 | 140,339 | 140,470 | 142,120 | 143,930 | 145,902 | 147,745 | 149,296 | 150,894 | 152,330 | 153,459 | 154,230 |

**Percentage of Member Population by Product**

| Product | % of Population for 2017 | % of Population for 2018 | % of Population for 2019 | % of Population for 2020 |
|---|---|---|---|---|
| CHIP | 10% | 12% | 14% | 12% |
| Foster Care | 4% | 4% | 4% | 5% |
| IDD | 3% | 3% | 3% | 3% |
| LTC Dual | 4% | 4% | 4% | 4% |
| LTC Non-Dual | 2% | 2% | 2% | 2% |
| SSI Dual | 4% | 4% | 4% | 4% |
| SSI Non-Dual | 8% | 8% | 7% | 8% |
| TANF | 65% | 63% | 62% | 62% |
| **Total*** | **100%** | **100%** | **100%** | **100%** |

*Rounding results in some totals >100%

**Member Age Breakdown**

| Age Group | 2017* | 2018 | 2019* | 2020 |
|---|---|---|---|---|
| 0-10 | 43% | 44% | 41% | 45% |
| 11-20 | 27% | 27% | 28% | 26% |
| 21-30 | 8% | 8% | 9% | 8% |
| 31-40 | 6% | 6% | 7% | 6% |
| 41-50 | 4% | 4% | 4% | 4% |
| 51-60 | 5% | 4% | 4% | 4% |
| 61-70 | 3% | 3% | 3% | 4% |
| 71-80 | 2% | 2% | 2% | 2% |
| 81-90 | 2% | 1% | 2% | 1% |
| 91+ | 1% | 1% | 1% | <1% |

**Gender Breakdown**

| Gender | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|
| Male | 46% | 46% | 45% | 45% |
| Female | 54% | 54% | 55% | 55% |

**2020 Top Diagnosis:**

**Child and Adolescent (Outpatient)**
The top 5 diagnosis by count are listed below. The majority of claims come from the TANF, CHIP and Foster Care populations for the listed populations.

| **Top 5 Medical Diagnosis<br>Children (Ages 0-19)**<br>Populations: ALL<br>Service Date Range: January 1, 2020 - December 31, 2020 | | |
|---|---|---|
| **Diagnosis Code** | **Diagnosis** | **Subpopulation by count** |
| Z00129 | ENC RTN CHLD HLTH EX W/O ABNRM FIND | TANF, CHIP, Foster Care |
| J02.9 | ACUTE PHARYNGITIS (UNSPC) | TANF, Foster Care, CHIP |
| R50 | FEVER (UNSPC) | TANF, CHIP |
| J06.9 | ACUTE RESPIRATORY INFECTION | TANF |
| | CONTCT EXPS OTH VIRL COMMUNICATION | TANF |

**Behavioral Health: Serious Mental Illness (SMI)**

| **SMI Members Physical Health Diagnosis Prevalence**<br>Population: SMI<br>Service Date Range: January 1, 2020 - December 31, 2020 | | |
|---|---|---|
| **Diagnosis Code** | **Diagnosis** | **# Unique Member** |
| R6889 | OTHER GENERAL SYMPTOMS AND SIGNS | 4,237 |
| Z23 | ENCOUNTER FOR IMMUNIZATION | 3,768 |
| I10 | ESSENTIAL PRIMARY HYPERTENSION | 3,298 |
| H5213 | MYOPIA BILATERAL | 3,074 |
| Z00129 | ENC RTN CHLD HLTH EX W/O ABNRM FIND | 2,588 |

| **SMI Members Behavioral Diagnosis Prevalence**<br>Population: SMI<br>Service Date Range: January 1, 2020 - December 31, 2020 | | |
|---|---|---|
| **Diagnosis Code** | **Diagnosis** | **# Unique Member** |
| F331 | MAJ DEPRESS D/O RECURRENT MOD | 2,746 |
| F411 | GENERALIZED ANXIETY DISORDER | 2,458 |
| F329 | MAJ DEPRESS D/O SINGLE EPIS UNS | 2,422 |

| | | |
|---|---|---|
| F4310 | POST-TRAUMATIC STRESS DISORDER UNS | 2,113 |
| F902 | ADHD COMBINED TYPE | 1,576 |

**Pharmacy Medications**

| Top 10 Drugs by Rx Count<br>Range: January 1, 2020-December 31, 2020 | | | | |
|---|---|---|---|---|
| **Rank** | **Drug Name** | **Rx Count** | **% Total Rx** | **Utilizers** |
| **1** | Cetirizine | 46,827 | 3.30% | 12,312 |
| **2** | Albuterol | 32,288 | 2.27% | 12,397 |
| **3** | Sertraline | 27,753 | 1.96% | 5,083 |
| **4** | Amoxicillin | 21,241 | 1.50% | 17,225 |
| **5** | Methylphenid | 20,701 | 1.46% | 2,872 |
| **6** | Trazodone | 19,429 | 1.37% | 3,255 |
| **7** | Fluticasone | 19,248 | 1.36% | 7,696 |
| **8** | Gabapentin | 19,183 | 1.35% | 3,440 |
| **9** | Montelukast | 19,149 | 1.35% | 5,749 |
| **10** | Guanfacine | 18,756 | 1.32% | 2,302 |
| **Total** | **Top 10 Totals** | **244,575** | **17.23%** | **72,331** |

| Top 10 Specialty Drugs by Rx Count<br>Range: January 1, 2020-December 31, 2020 | | | | |
|---|---|---|---|---|
| **Rank** | **Drug Name** | **Rx Count** | **% Total Rx** | **Utilizers** |
| **1** | Invega Sustenna | 1,799 | 12.97% | 263 |
| **2** | Abilify Maintena | 812 | 5.85% | 140 |
| **3** | Genotropin | 728 | 5.25% | 84 |
| **4** | Norditropin | 702 | 5.06% | 95 |
| **5** | Enoxaparin | 618 | 4.46% | 227 |
| **6** | Epidiolex | 535 | 3.86% | 62 |
| **7** | Humira | 525 | 3.78% | 89 |
| **8** | Aimovig | 463 | 3.34% | 82 |
| **9** | Risperdal | 334 | 2.41% | 35 |
| **10** | Pulmozyme | 277 | 2.00% | 36 |
| **Total** | **Top 10 Totals** | **6,793** | **48.97%** | **1113** |

## Languages Spoken by Sunflower Members

Sunflower assesses members' linguistic needs based on the state eligibility files, which query members on their primary language spoken. English remains the most common language spoken by Sunflower members, followed by Spanish, "unknown" and Arabic. Note that data on member language is dependent on disclosure by the member. The category "Unknown" can be variable as Sunflower Health Plan does not have insight on this query.

| LANGUAGE | MEMBER COUNT | PERCENT |
|---|---|---|
| Arabic | 150 | .09% |
| Chinese | 50 | .03% |
| Croatian | 17 | .01% |
| English | 158,350 | 95.10% |
| French | 34 | .02% |
| German | 7 | .00% |
| Greek | 1 | .00% |
| Hindi | 26 | .02% |
| Italian | 1 | .02% |
| Japanese | 1 | .00% |
| Korean | 19 | .01% |
| Lao | 35 | .02% |
| Persian | 4 | .00% |
| Portuguese | 3 | .00% |
| Russian | 55 | .03% |
| Somali | 2 | .00% |
| Spanish | 4,793 | 2.88% |
| Tagalog | 8 | .00% |
| Thai | 3 | .00% |
| Unknown | 2,817 | 1.86% |
| Vietnamese | 128 | .08% |
| Total | 166,504 | 100% |

As part of our cultural services, Sunflower offers language assistance services to members who require translation. Services are available for both telephonic and on-site interactions. Care Management, Customer Service, or Provider/Practitioner staff for member interactions with both Sunflower staff and network providers can arrange these services. Sunflower also has Spanish-speaking staff represented in Care Management, Customer Services Representatives and Quality Improvement available. The Sunflower Customer Service team employs staff who are Spanish speaking to ensure Spanish-speaking members are served well by Sunflower Health Plan.

Spanish is the second most prevalent language spoken by Sunflower members, and is noted to be the most requested language for translation.

The following table provided represents the top requested languages via the Language Service Line from January 1, 2020 through December 31, 2020.

**Member Languages from Language Line Use**

| Language | Number of calls | Percentage of Total |
|---|---|---|
| Spanish | 4120 | 85.4 |
| Nepali | 105 | 2.2 |
| Swahili | 98 | 2.0 |
| Burmese | 104 | 2.2 |

**Member Languages from Language Line Use**

| Language | Number of calls | Percentage of Total |
|---|---|---|
| Rohingya | 51 | 1.1 |
| Vietnamese | 55 | 1.1 |
| Kinya/Rwanda | 39 | 0.8 |
| Arabic | 55 | 1.1 |
| Russian | 37 | 0.8 |
| Mandarin | 25 | 0.5 |
| Chin (Hakha) | 14 | 0.3 |
| Hindi | 13 | 0.3 |
| Karen | 14 | 0.3 |
| Karenni | 10 | 0.2 |
| French | 6 | 0.1 |
| Brazilian Portuguese | 5 | 0.1 |
| Bengali | 3 | 0.1 |
| Korean | 3 | 0.1 |
| Kunama | 3 | 0.1 |
| Bulgarian | 3 | 0.1 |
| Pashto (Afghanistan) | 3 | 0.1 |
| Tigrigna (Eritrea) | 3 | 0.1 |
| **Total** | **4827** | **100%** |

## Race and Ethnicity

The tables below reflect race and ethnicity based on member responses to the 2020 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Adult and Child member satisfaction surveys.

The data allows for comparison to the designated race/ethnicity question on the 2020 CAHPS member satisfaction surveys. The Child survey noted from 2018 through 2020 represents an aggregated report of two separate Child surveys completed for Title XIX and Title XXI. Results provided below for both the General Child Population as well as the Child with Chronic Conditions (CCC).

**CAHPS Child Race and Ethnicity**

| Child Race / Ethnicity Category | 2018 Child General Population CAHPS | 2019 Child General Population CAHPS | 2020 Child General Population CAHPS | 2018 Child With Chronic Conditions CAHPS | 2019 Child With Chronic Conditions CAHPS | 2020 Child with Chronic Conditions CAHPS |
|---|---|---|---|---|---|---|
| White | 74% | 73% | 81% | 81% | 80% | 88% |
| Black /African American | 8% | 11% | 11% | 13% | 14% | 15% |

**CAHPS Child Race and Ethnicity**

| Child Race / Ethnicity Category | 2018 Child General Population CAHPS | 2019 Child General Population CAHPS | 2020 Child General Population CAHPS | 2018 Child With Chronic Conditions CAHPS | 2019 Child With Chronic Conditions CAHPS | 2020 Child with Chronic Conditions CAHPS |
|---|---|---|---|---|---|---|
| Hispanic / Latino** | 40% | 36% | 31% | 24% | 23% | 17% |
| Asian | 4% | 4% | 3% | 2% | 1% | 1% |
| Hawaiian / Pacific Islander | 1% | 0% | 0% | 1% | 0% | 1% |
| American Indian / Alaskan | 3% | 3% | 3% | 4% | 4% | 3% |
| Other | 14% | 13% | 11% | 10% | 10% | 6% |

**CAHPS Adult Race and Ethnicity***

| Adult Race / Ethnicity Category | 2018 Adult CAHPS | 2019 Adult CAHPS | 2020 Adult CAHPS |
|---|---|---|---|
| White | 72% | 81% | 80% |
| Black /African American | 12% | 12% | 13% |
| Hispanic / Latino** | 15% | 8% | 9% |
| Asian | 3% | 2% | 1% |
| Hawaiian / Pacific Islander | 1% | 0% | 0% |
| American Indian / Alaskan | 6% | 5% | 6% |
| Other** | 10% | 5% | 8% |

* Race/Ethnicity will not equal 100% because they are separate questions on the CAHPS survey.

**"Other" includes all response options that are not shown.

The CAHPS survey was fielded at the height of the COVID-19 pandemic.

Race and ethnicity data from the CAHPS survey shows an increase in member identifying as White in 2020 for both the general and children with chronic conditions. In 2020, there was an 8% increase in both populations. There is a 6% decrease in the Hispanic/Latino population and slight increase in the Black/African American populations when compared to prior years.

In the Adult CAHPS survey, changes in reported ethnicity is slight with 1% change from prior year in those self-reporting as White, Black/African American and Hispanic/Latino. There is a 3% increase in the "Other" category. It is unknown at this time if this increase reflects the change from the other reported categories. Sunflower does not receive detailed data to conduct our internal analysis.

For both the Child and Adult populations, there is consistency with the top three (3) groups represented in Sunflower's membership year over year.

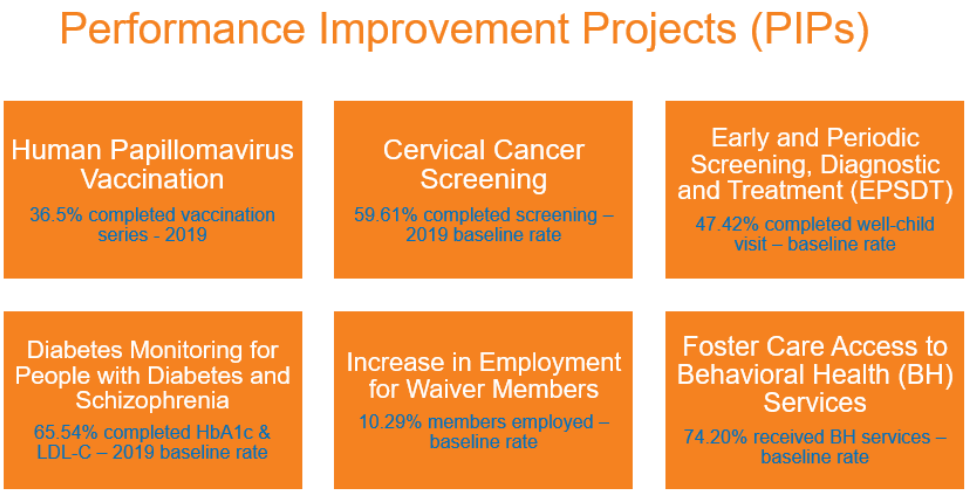
## Quality Performance Measures and Outcomes

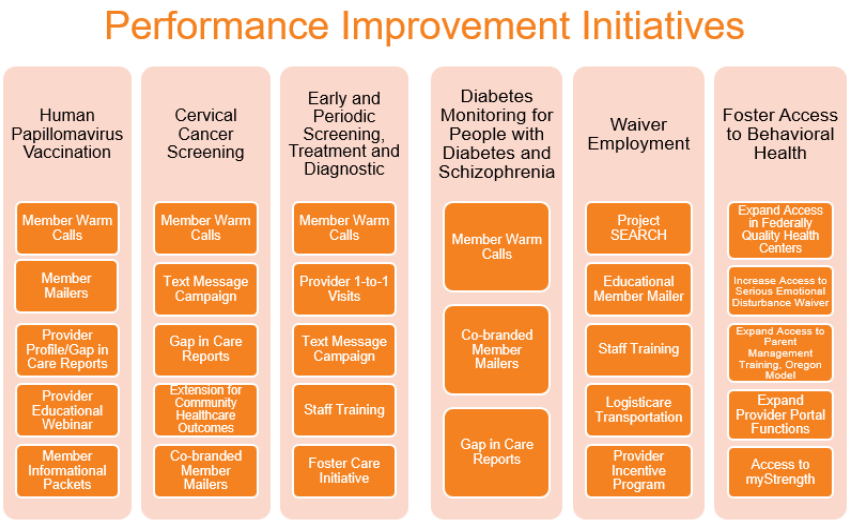
### Quality Improvement Activities

### Performance Improvement Projects (PIPs)

Sunflower is required by State contract to have Performance Improvement Projects (PIPs). In 2020, Sunflower participated in three (3) Clinical, HEDIS-based PIPs; two (2) non-clinical; and one (1) screening/diagnostic projects.

Performance Improvement Projects have inter-department collaboration via a cross-functional workgroup.




Human Papillomavirus Vaccination (HPV) was a collaborative PIP that began in 2015, when Kansas was found to have the lowest vaccination rates in the country. Sunflower Health Plan partnered with two (2) Managed Care Organization (MCOs) to improve vaccination rates.

The HPV HEDIS measure was used to measure vaccine rates with HEDIS 2017(MY2016) as the baseline rate for combined male and females. Since 2017, HPV rates have shown incremental improvements in year over year performance. The rates have almost doubled from 2017 to 2019. Final HEDIS rates for measurement year 2020 is pending; however, preliminary rates show continued improvement trends. HPV was retired after 2020.

HPV trending 2017 to 2020 (YTD)

| HEDIS® Measure | HEDIS 2017 (MY2016) Hybrid (Baseline) | HEDIS 2018 (MY2017) Hybrid | HEDIS 2019 (MY2018) Hybrid | HEDIS 2020 (MY2019) Admin* | Met/Exceeded NCQA MY2018 Quality Compass 50th Percentile (Benchmark) |
|---|---|---|---|---|---|
| HPV (male and female) | 19.23 | 31.14 | 38.44 | 34.39 | Yes |

*Pending final HEDIS 2020 rates

## National Committee for Quality Assurance (NCQA) Accreditation

The 2020 Renewal Survey was conducted virtually April 6 and 7. In early March, the State of Kansas along with most of the country, began to issue shelter in place mandates in response to the COVID-19 pandemic. The Sunflower team demonstrated agility and professionalism by shifting survey preparations from onsite to virtual in less than four (4) weeks. Sunflower Health Plan was among the first fully virtual surveys conducted by the NCQA Survey team in 2020. Sunflower was praised for expertise in the use of the Zoom virtual platform by the Survey team.

2020 survey overall strengths:

- Knowledgeable and dedicated staff
- Survey documentation and preparation
- Use of NCQA Accredited and Certified organizations
- Effective Corporate support
- LTSS program for Medicaid
- Use of virtual platform (Zoom)

| Accreditation Rating | Year |
|---|---|
| Commendable | 2016 |
| Commendable | 2017 |
| Commendable | 2018 |
| Commendable | 2019 |
| Commendable with LTSS distinction first survey (Medicaid) | 2020 |

Healthcare Effectiveness Data Information Set (HEDIS®). HEDIS® is the industry standard data set used to evaluate performance measures in the United States. HEDIS is a collection of performance measures developed and maintained by NCQA. Sunflower submits HEDIS data annually in accordance NCQA Technical Specifications. Participation in the program enables organizations to collect and submit data in a standardized format for National audit and benchmarking.

The six (6) domains of HEDIS contain a full spectrum of performance metrics encompassing:

- Effectiveness of Care
- Access and Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information
- Electronic Clinical Data Systems (ECDS) measurements

Sunflower uses HEDIS data for all applicable clinical studies as part of NCQA Accreditation, State and National reporting since the Sunflower's inception in 2013. Sunflower partners with Centene corporate teams for initial monthly data runs and conducts plan specific analysis for all lines of business. HEDIS measures are trended monthly and are used to guide performance improvement initiatives across the health plan. It is the basis for State Pay for Performance (P4P) HEDIS based metrics. Quality, Pharmacy, Behavioral and Physical health teams use HEDIS measures to guide clinical programs to drive performance.

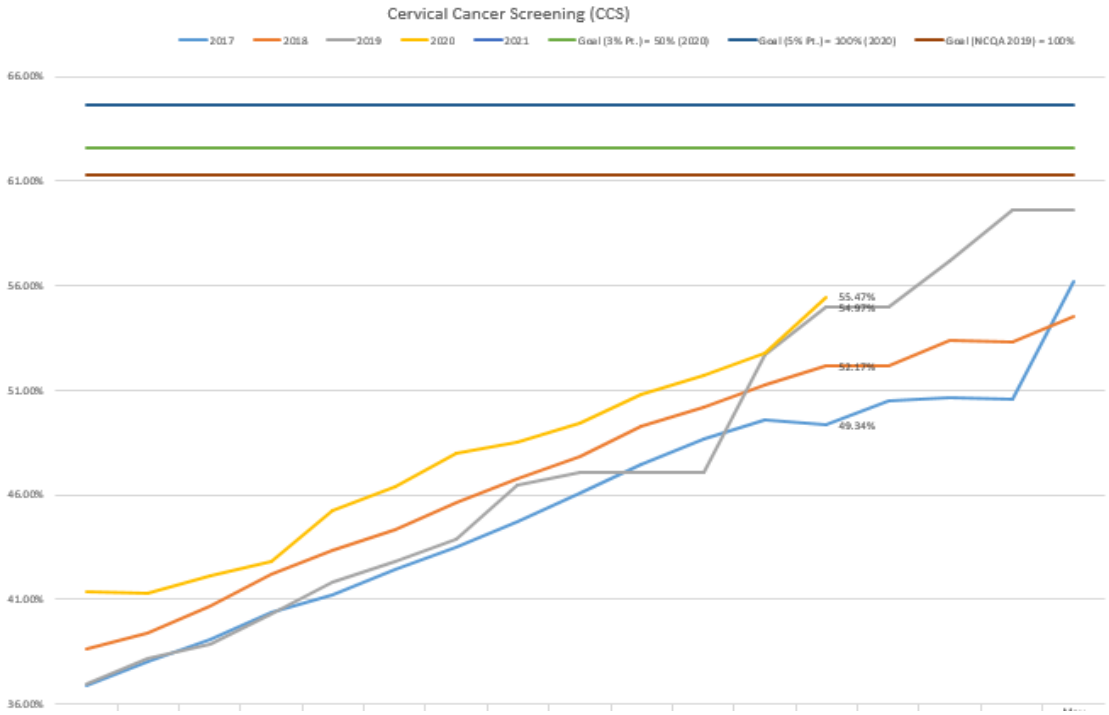
**2020 Pay for Performance (P4P)**

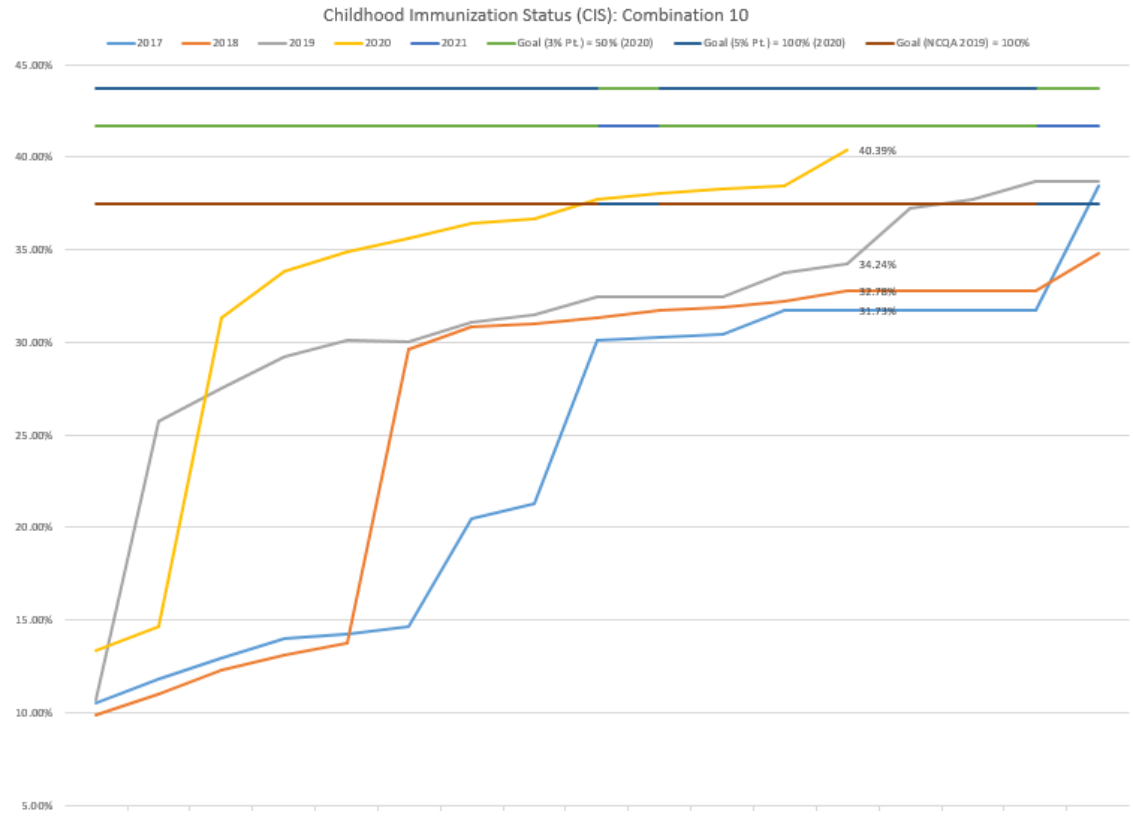
Pay for Performance (P4P) HEDIS based measures:

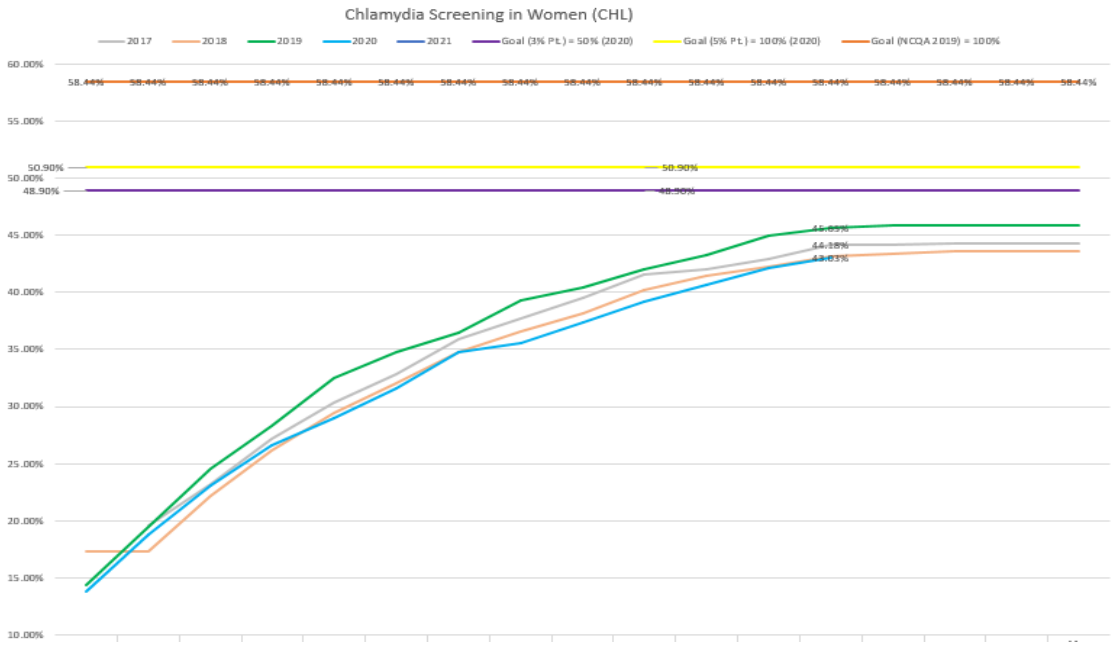
- Cervical Cancer Screening (CCS)
- Childhood Immunization (CIS)
- Chlamydia Screening (CHL)
- Comprehensive Diabetic Care (CDC)
- Lead Screening in Children (LSC)
- Prenatal and Postpartum Care (PPC): 2 separate measures
- Well-Child Visit (W34)

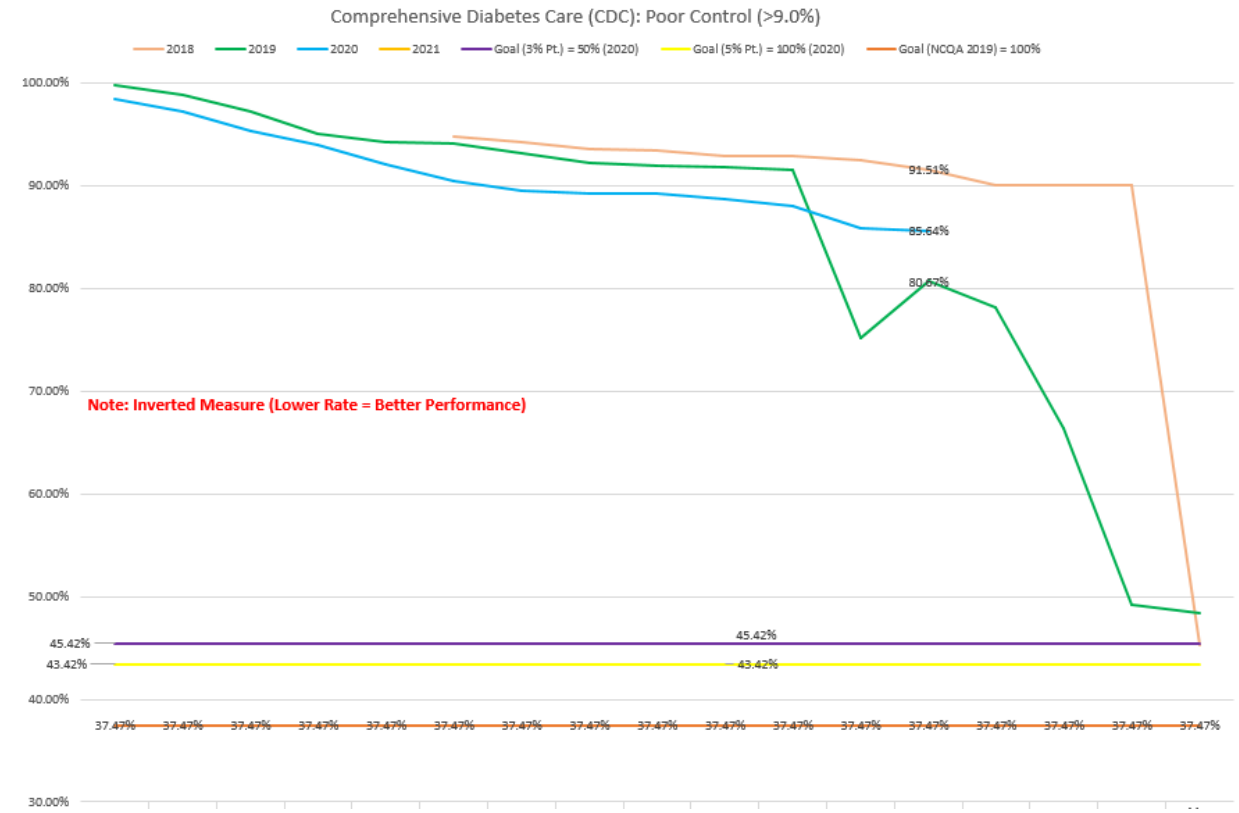
Well-Child Visit (W34) was retired by NCQA in 2020. Sunflower's P4P measure was change by the State late in Q3 2020 due to benchmarking availability for the retired W34 measure. Postpartum Care replaced the retired well child measure. Postpartum HEDIS technical specifications is measured from October of the prior year to October of the measurement year. Due to the lateness in the measure change, the Sunflower teams had less than 3 full months to impact significant change.

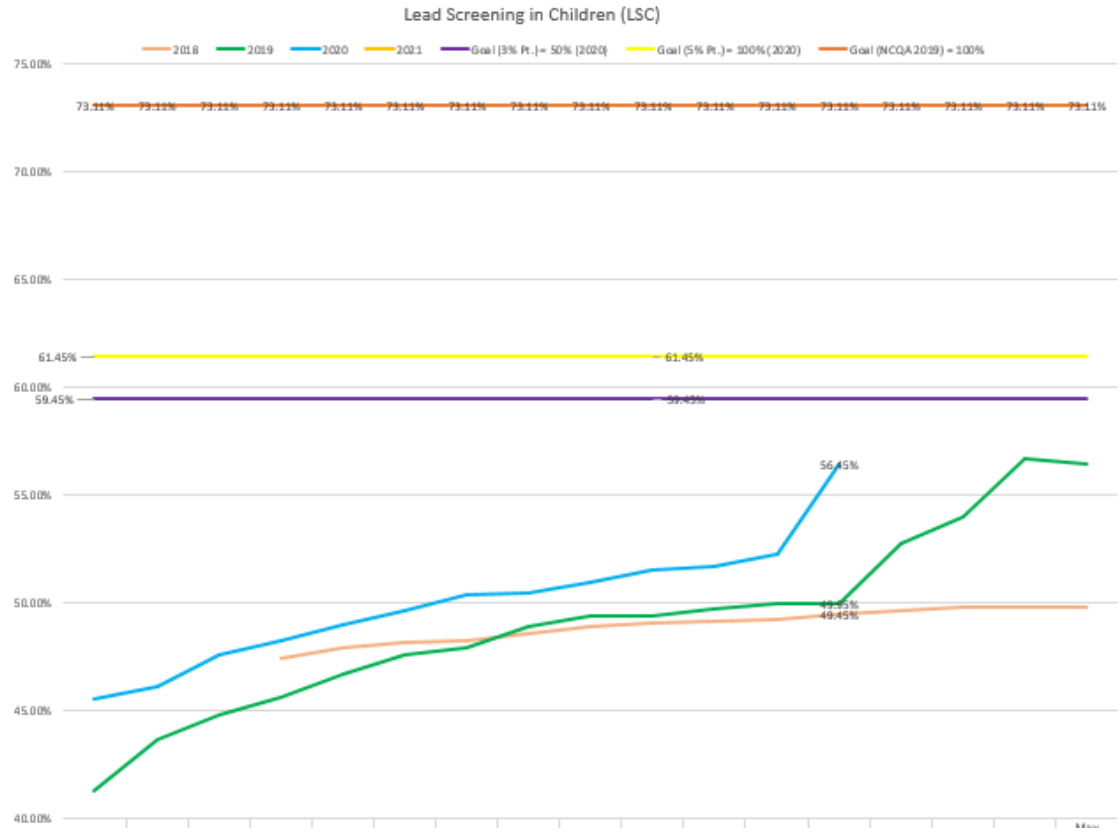
Preliminary measurement year 2020 (MY20) rates were impacted by the COVID-19 pandemic. In the spring, CMS issued a National "patients over paperwork" decree. Locally, Kansas imparted a 'shelter in place' order in March. All face to face visits to members and providers were paused for safety and public health. Once restrictions were loosened, providers saw a limited amount of face to face visits when compared to the prior year volume. Similarly, members remained hesitant to engage in face to face visits. In lieu of in office visits, telehealth utilization increased.
Please note that due to the design of the HEDIS audit timeline, 2020 rates listed are preliminary pending completion of the Hybrid audit.

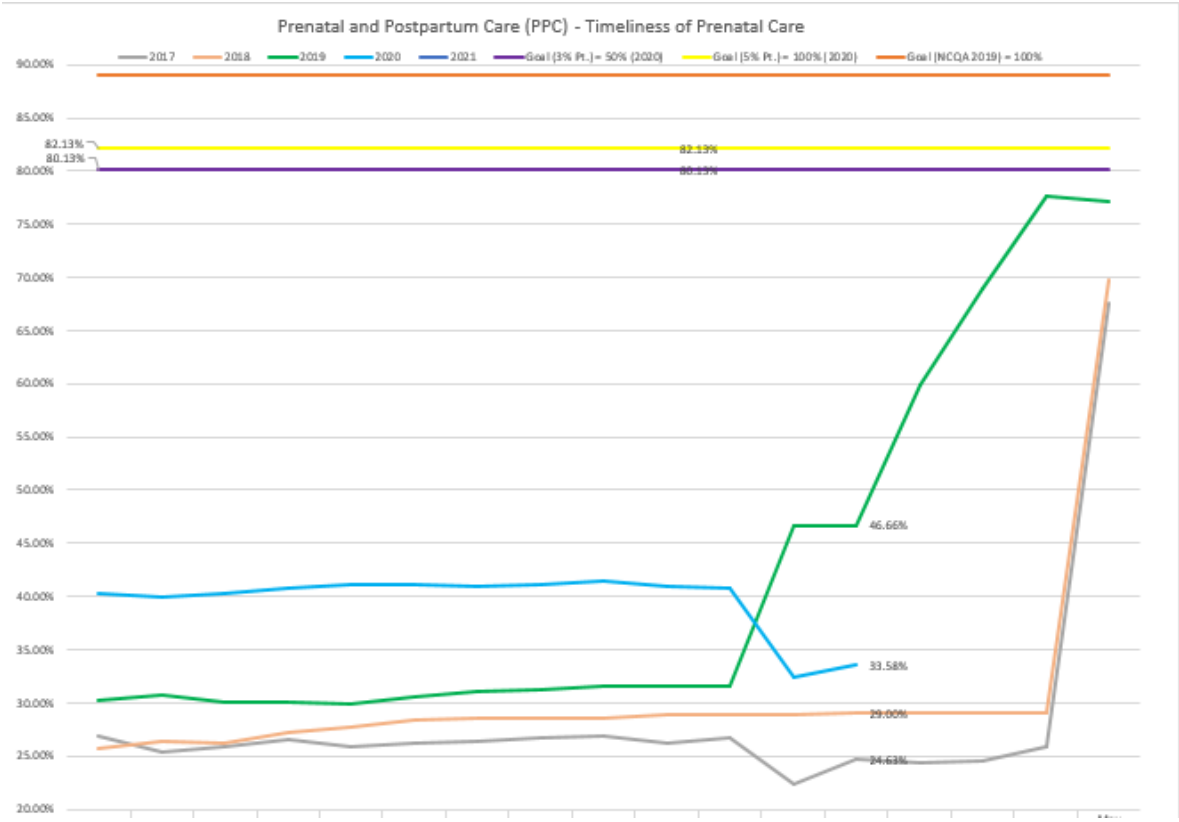


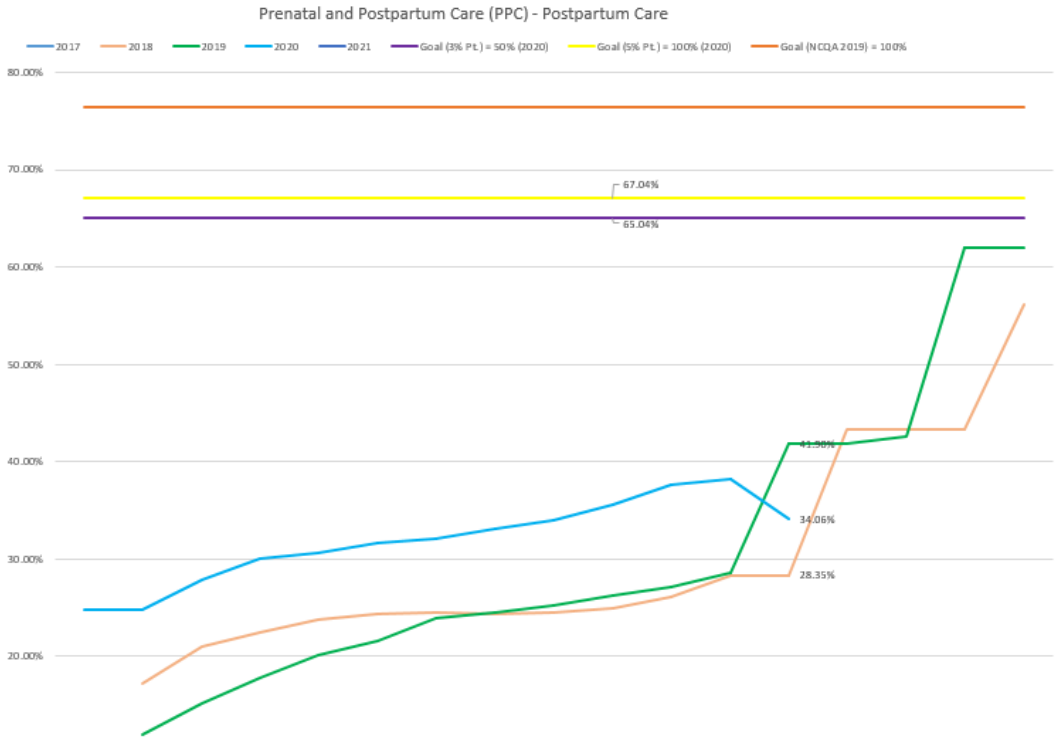










**Behavioral Health HEDIS Measures**
Sunflower's focus for 2020 were Follow-Up after Hospitalization for Mental Health, Diabetic Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications. These measures were chosen to enhance Behavioral Health services monitoring. Follow up after an inpatient event is critical to the well-being and care for the member.

The measurement year 2020 audit is in progress at the time of this report. Preliminary rates show that the strategy to integrate behavioral health and physical health is improving outcomes to the Sunflower population. As noted earlier, behavioral health diagnoses are within the top 10 conditions in our Child and Adult populations. There is an expectation that COVID impacted utilization of these measures but final rates have yet be certified. Sunflower will continue to monitor these measures.

| HEDIS MEASURE* | HEDIS 2018 (MY2017) Final | HEDIS 2019 (MY2018) Final | HEDIS 2020 (MY2019) Final | HEDIS 2021 (MY2020) Admin* | NCQA 2019 Quality Compass 50th Percentile |
|---|---|---|---|---|---|
| Follow-up after Hospitalization for Mental Illness - 7 day | 59.72 | 55.48 | 57.34 | 55.36 | YES |
| Follow-up after Hospitalization for Mental Illness - 30 day | 77.40 | 74.30 | 77.52 | 74.27 | YES |
| Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications | 80.66 | 79.85 | 80.57 | 75.43 | NO |

**HEDIS Pharmacy Measures**
Sunflower focused on multiple Pharmacy measures in 2020 with the goal to demonstrate improvement and focus on medications used to improve utilization and adherence. The aim was to improve compliance on the use of medications, appropriate monitoring secondary to antipsychotic use and then compliance with taking medications to help ensure optimal outcomes for the members.

As with other HEDIS measures, the 2020 measurement year is in the midst of the annual audit at the time of writing this report. Preliminary rates show these rates to be on par with national reporting that was negatively impacted by the COVID-19 pandemic. There is an expectation that COVID impacted most of these measures but final rates have yet be certified. Sunflower will continue to monitor these measures.

| HEDIS MEASURE | HEDIS 2018 (MY2017) Final | HEDIS 2019 (MY2018) Final | HEDIS 2020 (MY2019) Final | HEDIS 2021 (MY2020) Admin* | Met/Exceeded NCQA 2019 Quality Compass 50th Percentile |
|---|---|---|---|---|---|
| Use of Multiple Concurrent Antipsychotics in Children/Adolescents | 4.64 | 3.97 | 3.26 | 3.48 | Retired Measure |
| Metabolic Monitoring for Children/Adolescents on Antipsychotics | 47.18 | 48.91 | 46.29 | 38.74 | YES |
| Antidepressant Medication Management - Acute Phase | 49.66 | 53.15 | 51.95 | 52.90 | NO |
| Antidepressant Medication Management - Continuation Phase | 32.03 | 34.14 | 37.44 | 37.31 | NO |
| Follow Up ADHD - Initiation | 52.78 | 53.71 | 53.38 | 56.03 | YES |
| Follow Up ADHD - Continuation & Management | 62.53 | 59.91 | 62.79 | 63.55 | YES |

## Patient Safety

### Quality of Care

Sunflower monitors the safety of its members through identification of potential and/or actual quality of care (QOC) events and adverse incident reports (AIRs).

Sunflower's Quality Improvement Department monitors member and provider issues related to quality of care on an ongoing basis. A quality of care issues is 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.

A QOC Severity Leveling criteria based on potential or actual serious impact to care quality and the member's well-being. The criteria is classified into five levels: None, Low, Medium, High and Critical. Each case is reviewed, investigated, and tracked to identify patterns. Applicable corrective action plans are implemented when issues warrant further action. Practitioners or providers with multiple potential quality of care issue referrals per quarter may be subject to additional review/investigation. Providers will be reported to the Credentialing Committee at the discretion of the Peer Review

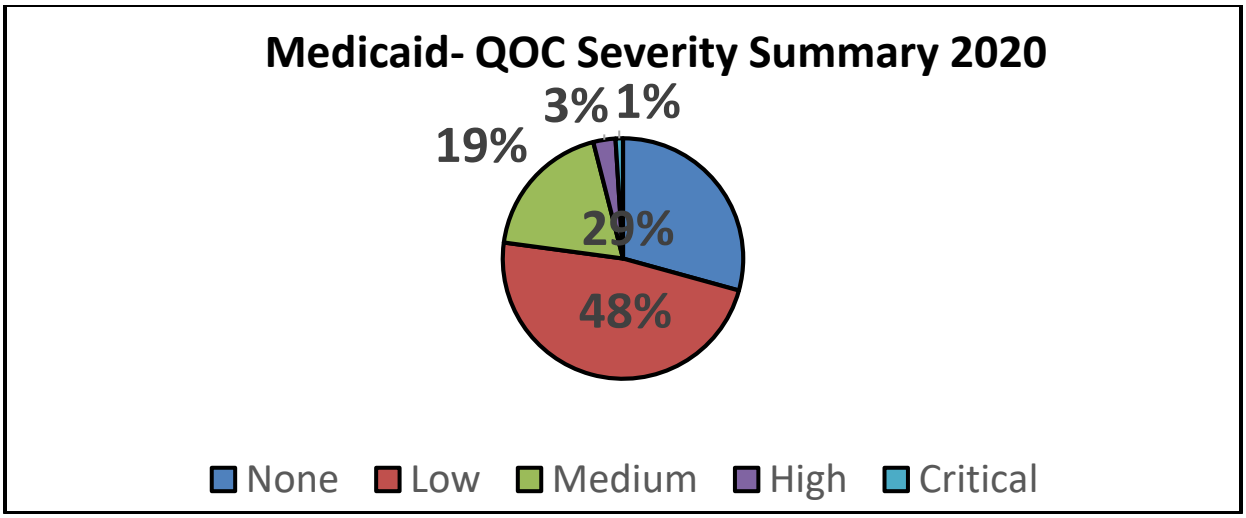
Committee. Reports are provided to the QIC quarterly and to the Credentialing Department for consideration at the time of provider re-credentialing.

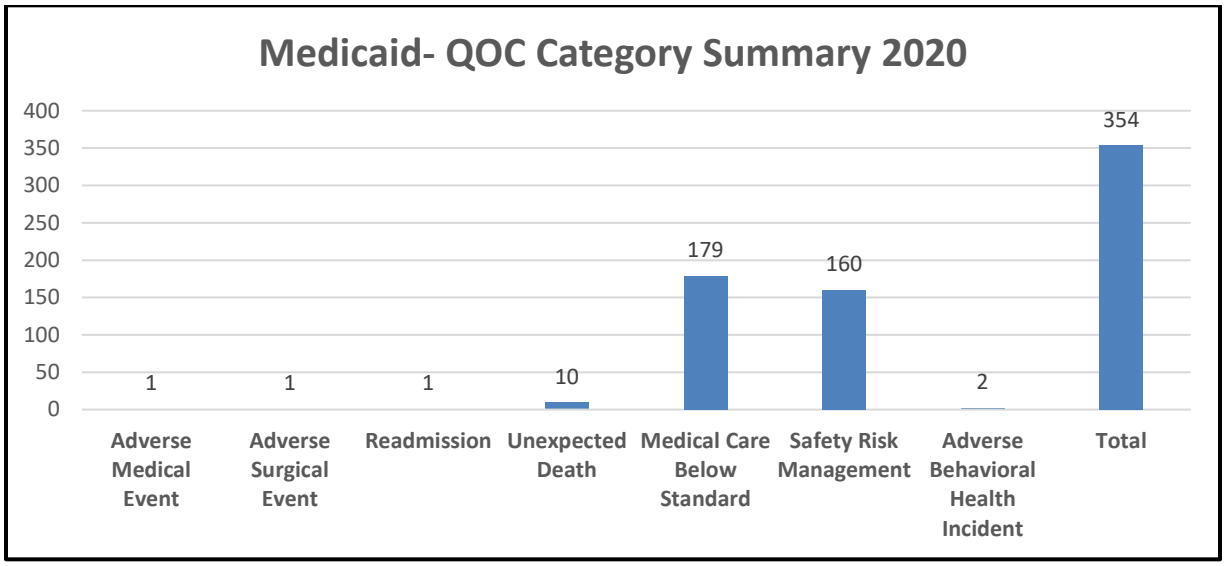
Quality of care events include but are not limited to the following:

- 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/facility level. The data below is for Physical and Behavioral health QOCs from January 1, 2020 to December 31, 2020.

After QI Auditor Review of 343 completed Medicaid events from 2020, 29% were assigned a Severity Level of None: Investigation indicates acceptable quality of care has been rendered, 48% were assigned a Severity Level of Low: Investigation indicates that a particular case was without significant potential for serious adverse effects, but could become a problem if a pattern developed, 19% assigned a Severity Level Medium: Investigation indicates that a particular case demonstrated a moderate potential for serious adverse effects, 3% assigned a Severity Level High; Investigation indicates that a particular case has demonstrated a significant potential for serious adverse effects and 1% were assigned a Severity Level Critical: Investigation indicates that a particular case demonstrated a serious, significant adverse outcome.




**Adverse Incidents**

The State of Kansas has defined, and developed a system of provider reporting for events considered "Adverse Incidents". Selected providers are required to report the defined events into a state developed portal and these reports are named Adverse Incident Report(s) or AIRs. The AIR policy and processes were refined through collaborative efforts that Sunflower actively participated in with the State and fellow MCOs in 2018. The policy and process is still in use in 2020.

Adverse Incidents include potentially serious events or outcomes as defined below:

A. Abuse**:** Any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to a participant, including:
   1) Infliction of physical or mental injury;
   2) Any sexual act with a participant that does not consent or when the other person knows or should know that the participant is incapable of resisting or declining consent to the sexual act due to mental deficiency or disease or due to fear of retribution or hardship;

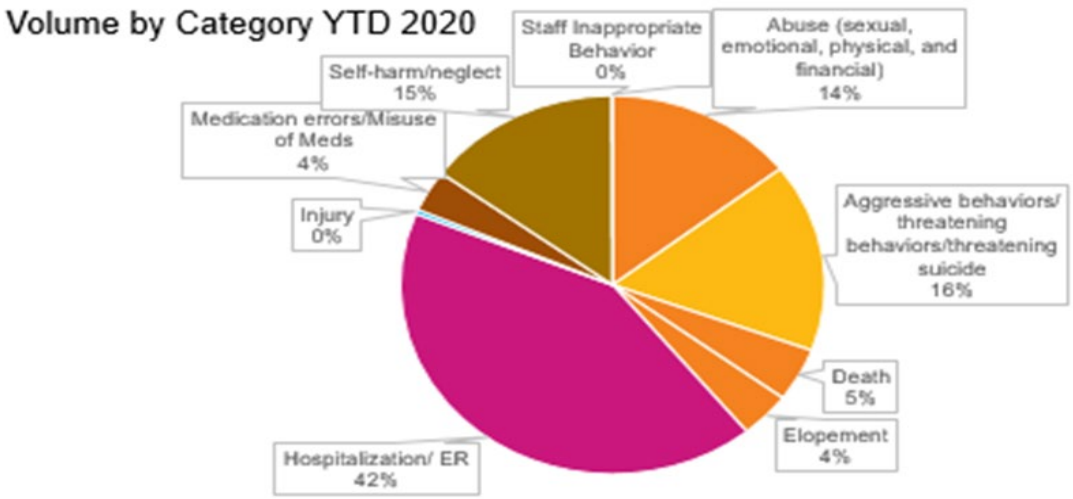
3) Unreasonable use of a physical restraint, isolation or medication that harms or is likely to harm the participant;
4) Unreasonable use of a physical or chemical restraint, medication or isolation as punishment, for convenience, in conflict with a physician's orders or as a substitute for treatment, except where such conduct or physical restraint is in furtherance of the health and safety of the participant or another individual;
5) A threat or menacing conduct directed toward the participant that results or might reasonably be expected to result in fear or emotional or mental distress to the participant;
6) Fiduciary abuse; or
7) Omission or deprivation by a caretaker or another person of goods or services which are necessary to avoid physical or mental harm or illness.

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

The State of Kansas/KDADS has developed parallel reporting mechanisms for providers to report Adverse Events to the state and MCOs through an “Adverse Incident Reporting System”. As a result, Sunflower receives reported AIRs via the KDADS system.

Sunflower’s Grievances & Appeals team documents and tracks AIRs within the automated clinical documentation system utilized by both the G&A and Medical Management teams. This process was refined in early 2015 and continues to be utilized to allow the two teams continue to work collaboratively to address needs or issues for the members to ensure member safety as a result of the AIRs received.

In 2020, the largest contributor to AIRS reporting was Hospitalization/ER, followed by Aggressive/Threatening behavior, Self-harm/neglect and Abuse. These are similar categories reported in 2019. Hospitalization/ER decreased by 8% while Aggressive/Threatening behavior increased by 1%. Self-harm and neglect increased by 4% and Abuse increased by 3%.See graph below for AIRS data:




## 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 (G&A) Committee and Quality Improvement Committee review grievance and appeal data on a quarterly basis. The following is a summary of the results and analysis for January 1, 2020 through December 31, 2020, compared to calendar year 2020 for the Medicaid line of business.

The table represents the grievance totals by category in accordance with state reporting requirements and then per 1000 members for the years 2019 through 2020.

In 2020, the G&A team conducted training that included definition and examples of a member grievance, who can report a grievance, and instruction on how other departments should report a grievance to the team for proper processing. Training also focused on the importance of accurate identification of all expressions of member dissatisfaction as grievances, with proper referral for accurate processing and reporting. Accurate identification and reporting of member grievances enables Sunflower to have the ability to accurately assess where opportunities exist to improve the experience and satisfaction of members. These opportunities also allow us to educate the members on their right to file a grievance as well. For 2020, Sunflower's grievance goal remains to be less than 4.50 member grievances per 1000 members.

| Member Grievance Category | 2019 | 2019 Per 1000 | 2020 | 2020 Per 1000 |
|---|---|---|---|---|
| Quality of Care (non HCBS provider) | 131 | 0.77 | 61 | 0.37 |
| Quality of Care – Pain Medication | 11 | 0.07 | 10 | 0.06 |
| Customer service | 68 | 0.4 | 36 | 0.22 |
| Member rights dignity | 11 | 0.07 | 8 | 0.05 |
| Access to service or Care | 78 | 0.46 | 71 | 0.43 |
| Non-Covered Services | 9 | 0.05 | 3 | 0.02 |
| Pharmacy Issues | 21 | 0.12 | 8 | 0.05 |
| Quality of Care HCBS provider | 36 | 0.21 | 15 | 0.09 |
| Value Added Benefits | * | * | * | * |
| Billing and Financial issues (non-transportation) | 43 | 0.25 | 21 | 0.13 |
| Transportation Issues- Billing and Reimbursement | 23 | 0.14 | 21 | 0.13 |
| Transportation- No Show | 84 | 0.5 | 77 | 0.46 |
| Transportation- Late | 150 | 0.89 | 71 | 0.43 |

| | | | | |
|---|---|---|---|---|
| Transportation- Safety | 33 | 0.2 | 17 | 0.10 |
| Transportation - No Driver Available | 13 | 0.08 | 11 | 0.07 |
| Transportation- Other | 143 | 0.85 | 102 | 0.61 |
| MCO Determined No Applicable | 22 | 0.13 | 5 | 0.03 |
| Other | 26 | 0.15 | 9 | 0.05 |
| **Total** | **902** | **5.35** | **546** | **3.28** |

**Member Appeals**

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

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

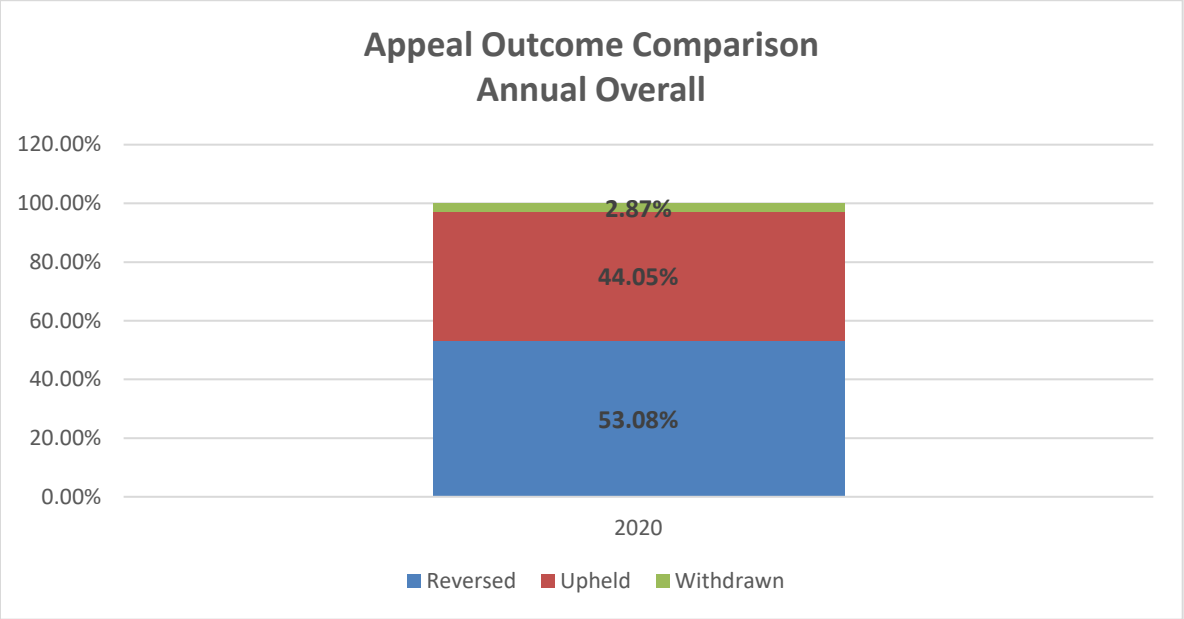
The following table demonstrates the Member Appeals resolved by category for entire year of 2019 through 2020 as well as the per 1000 calculation. The categories noted below are consistent with the state reporting requirements and account for any adjustments to those made throughout the year.

| Member Appeal Reasons | 2019 Total Resolved | 2019 Per 1000 | 2020 Total Resolved | 2020 Per 1000 |
|---|---|---|---|---|
| **MEDICAL NECESSITY DENIAL** | 863 | 5.16 | 739 | 4.43 |
| Criteria Not Met - Durable Medical Equipment | 145 | 0.86 | 126 | 0.76 |
| Criteria Not Met - Inpatient Admissions (Non-Behavioral Health) | 16 | 0.09 | 19 | 0.11 |
| Criteria Not Met - Medical Procedure (NOS) | 57 | 0.34 | 56 | 0.34 |
| Criteria Not Met - Radiology | 93 | 0.55 | 165 | 0.99 |
| Criteria Not Met - Pharmacy | 358 | 2.12 | 176 | 1.06 |
| Criteria Not Met - PT/OT/ST | 11 | 0.07 | 28 | 0.17 |
| Criteria Not Met - Dental | 16 | 0.09 | 23 | 0.14 |
| Criteria Not Met - Home Health | 12 | 0.07 | 23 | 0.14 |
| Criteria Not Met - Hospice | 0 | 0 | 0 | 0.00 |
| Criteria Not Met - Out of network provider, specialist or specific provider request | 2 | 0.01 | 2 | 0.01 |
| Criteria Not Met – Inpatient Behavioral Health | 35 | 0.21 | 45 | 0.27 |
| Criteria Not Met – Behavioral Health Outpatient Services and Testing | 6 | 0.04 | 2 | 0.01 |

| | | | | |
|---|---|---|---|---|
| Level of Care - LTSS/HCBS | 18 | 0.11 | 12 | 0.07 |
| Level of Care - WORK | 0 | 0 | 0 | 0.00 |
| Level of Care - LTC NF | 0 | 0 | 0 | 0.00 |
| Level of Care - Mental Health | 0 | 0 | 0 | 0.00 |
| Level of Care - HCBS (change in attendant hours) | 7 | 0.04 | 11 | 0.07 |
| Ambulance (include Air and Ground) | 0 | 0 | 3 | 0.02 |
| Criteria Not Met – Other Medical Necessity | 87 | 0.52 | 48 | 0.29 |
| Change in attendant hours | * | * | 0 | 0.00 |
| **NON-COVERED SERVICE DENIAL** | 84 | 0.5 | 42 | 0.25 |
| Non-covered service - Dental | 4 | 0.02 | 6 | 0.04 |
| Non-covered service - Home Health | 0 | 0 | 0 | 0.00 |
| Non-covered service - Pharmacy | 4 | 0.02 | 2 | 0.01 |
| Non-covered service - Out of Network providers | 1 | 0.01 | 0 | 0.00 |
| Non-covered service - OT/PT/Speech | 4 | 0.02 | 0 | 0.00 |
| Non-covered service - Durable Medical Equipment | 19 | 0.11 | 6 | 0.04 |
| Non-covered service - Behavioral Health | 0 | 0 | 0 | 0.00 |
| Non-covered service - Other | 50 | 0.3 | 27 | 0.16 |
| LOCK IN | 2 | 0.01 | 0 | 0.00 |
| BILLING AND FINANCIAL ISSUES | 0 | 0 | 1 | 0.01 |
| **TRANSPORTATION TIMELINESS** | * | * | * | 0.00 |
| Transportation No Show | * | * | * | 0.00 |
| Transportation Late | * | * | * | 0.00 |
| **AUTHORIZATION DENIAL** | 11 | 0.7 | 0 | 0.00 |
| Late submission by member/provider rep | 2 | 0.01 | 0 | 0.00 |
| No authorization submitted | 9 | 0.05 | 0 | 0.00 |
| **MCO TIMELINESS** | 45 | 0.27 | 2 | 0.01 |
| Noncompliance with PA Authorization timeframes | 0 | 0 | 0 | 0.00 |
| Noncompliance with resolution of Appeals and issuance of notice | 0 | 0 | 0 | 0.00 |
| Denials of Authorization (Unauthorized by Members) | 45 | 0.27 | 2 | 0.01 |
| **Total** | **1003** | **5.95** | **783** | **4.70** |

For 2020, Sunflower's goal remains to resolve 100% of standard member appeals within 30 calendar days and to resolve 100% of expedited member appeals within 72 hours of receipt. 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 showed a slight decrease.




**Provider Appeals**

Provider appeals consist of internal reviews of partial or whole claim denials made by Sunflower. These are monitored to assist in identifying opportunities to improve processes or assist providers in resolving claims issues. Sunflower reviews provider appeals data at the Grievance and Appeals Committee and Quality Improvement Committee (QIC) quarterly meetings. QIC includes departmental leadership and network physicians, which allows for discussion of the data, trends and allows initiatives to be developed to help address trends identified in the provider appeals data. These initiatives can include but are not limited to provider education, education of Sunflower 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 2020. From 2019 to 2020, there was an increase in Reversed appeals from 51.74% in 2019 to 53.08% in 2020. There was an increase in Upheld appeals from 42.10% in 2019 to 44.05% in 2020. There was a decrease in withdrawn appeals from 6.20% in 2019 to 2.87% in 2020.

As of January 1st, 2020, service providers now have the option of requesting a provider appeal after Sunflower issues a Notice of Adverse Benefit determination. This is only in the case of the denial of a new healthcare service, not for a reduction or termination of a previously authorized service. Just like other provider appeals, the provider must submit their request in writing and they do not need the member's consent. Due to this change, there are new provider appeal categories listed on the table below that were not previously reported before 2020. Sunflower maintains the goal to resolve 98% of provider appeals within 30 calendar days of receipt.

A variety of factors contributed, including inaccurate processing of provider delays in routing of appeals by corporate claims teams, claims system changes resulting in appeal misrouting, and appeals not being identified as an appeal in a timely manner. The Appeals & Grievances team worked collaboratively with members of the claims teams, mailroom, UM, and other teams involved in the processing/review of provider appeals in order to improve the timeliness. Additionally, the

Appeals & Grievances team has provided education to each of the teams involved in order to ensure those involved in handling provider appeals understand the turnaround time requirements.

| Provider Appeals Categories | Number Resolved 2018 | Per 100,000 Claims | Number Resolved 2019 | Per 100,000 Claims | Number Resolved 2020 | Per 100,000 Claims* |
|---|---|---|---|---|---|---|
| | | | | | | |
| **MEDICAL NECESSITY/LEVEL OF CARE - Criteria Not Met** | * | * | * | * | **553** | **8.70** |
| CNM - Ambulance (include Air and Ground) | * | * | * | * | 23 | 0.36 |
| CNM - Behavioral Health Outpatient Services and Testing | * | * | * | * | 5 | 0.08 |
| CNM - Dental | * | * | * | * | 24 | 0.38 |
| CNM - Durable Medical Equipment | * | * | * | * | 54 | 0.85 |
| CNM - Health Home Services | * | * | * | * | 0 | 0.00 |
| CNM - Home Health | * | * | * | * | 12 | 0.19 |
| CNM - Hospice | * | * | * | * | 1 | 0.02 |
| CNM - Inpatient Admissions (Non-Behavioral Health) | * | * | * | * | 82 | 1.29 |
| CNM - Inpatient Behavioral Health | * | * | * | * | 36 | 0.57 |
| CNM - Medical Procedure (NOS) | * | * | * | * | 48 | 0.76 |
| CNM - Other | * | * | * | * | 12 | 0.19 |
| CNM - Out of network provider, specialist or specific provider request | * | * | * | * | 0 | 0.00 |
| CNM - Pharmacy | * | * | * | * | 242 | 3.81 |

| | | | | | | |
|---|---|---|---|---|---|---|
| CNM - PT/OT/ST | * | * | * | * | 5 | 0.08 |
| CNM - Radiology | * | * | * | * | 8 | 0.13 |
| LOC - HCBS (change in attendant Hours) | * | * | * | * | 0 | 0.00 |
| LOC - LTC NF | * | * | * | * | 0 | 0.00 |
| LOC - LTSS/HCBS | * | * | * | * | 1 | 0.02 |
| LOC - Mental Health | * | * | * | * | 0 | 0.00 |
| LOC - WORK | * | * | * | * | 0 | 0.00 |
| | | | | | | |
| **NONCOVERED SERVICE** | * | * | * | * | **6** | **0.09** |
| NCS - Behavioral Health | * | * | * | * | 0 | 0.00 |
| NCS - Dental | * | * | * | * | 1 | 0.02 |
| NCS - Durable Medical Equipment | * | * | * | * | 0 | 0.00 |
| NCS - Home Health | * | * | * | * | 0 | 0.00 |
| NCS - OT/PT/Speech | * | * | * | * | 0 | 0.00 |
| NCS - Other | * | * | * | * | 1 | 0.02 |
| NCS - Out of Network providers | * | * | * | * | 0 | 0.00 |
| NCS - Pharmacy | * | * | * | * | 4 | 0.06 |
| | | | | | | |
| **CLAIM PAYMENT DISPUTES** | **2,157** | **41.8** | **4,237** | **63.65** | **3,991** | **62.80** |
| CPD - Ambulance (include Air and Ground) | 18 | 0.35 | 13 | 0.2 | 12 | 0.19 |
| CPD - Behavioral Health Inpatient | 67 | 1.3 | 26 | 0.39 | 1 | 0.02 |
| CPD - Behavioral Health Outpatient and Physician | 136 | 2.64 | 140 | 2.1 | 206 | 3.24 |
| CPD - Dental | 40 | 0.76 | 75 | 1.13 | 66 | 1.04 |

| | | | | | | |
|---|---|---|---|---|---|---|
| CPD - Durable medical Equipment | 97 | 1.88 | 149 | 2.24 | 299 | 4.70 |
| CPD - HCBS | 2 | 0.04 | 0 | 0 | 16 | 0.25 |
| CPD - Home Health | 18 | 0.35 | 103 | 1.55 | 198 | 3.12 |
| CPD - Hospice | 12 | 0.23 | 40 | 0.6 | 10 | 0.16 |
| CPD - Hospital Inpatient (Non-Behavioral Health) | 400 | 7.75 | 579 | 8.7 | 493 | 7.76 |
| CPD - Hospital Outpatient (Non-Behavioral Health) | 707 | 13.7 | 1,009 | 15.16 | 628 | 9.88 |
| CPD - Laboratory | 79 | 1.53 | 201 | 3.02 | 517 | 8.13 |
| CPD - Medical (Physical Health not Otherwise Specified) | 136 | 2.64 | 854 | 12.83 | 1,141 | 17.95 |
| CPD - Nursing Facilities - Total | 18 | 0.35 | 32 | 0.48 | 27 | 0.42 |
| CPD - Other | 40 | 0.78 | 6 | 0.09 | 29 | 0.46 |
| CPD - Out of network provider, specialist or specific provider request | 91 | 1.76 | 722 | 10.85 | 103 | 1.62 |
| CPD - Pharmacy | 5 | 0.1 | 5 | 0.08 | 0 | 0.00 |
| CPD - PT/OT/ST | 19 | 0.37 | 57 | 0.86 | 111 | 1.75 |
| CPD - Radiology | 187 | 3.62 | 144 | 2.16 | 101 | 1.59 |
| CPD - Vision | 85 | 1.65 | 82 | 1.23 | 33 | 0.52 |
| | | | | | | |
| **BILLING AND FINANCIAL ISSUES** | **22** | **0.43** | **398** | **5.98** | **367** | **5.77** |
| BFI - Recoupment | 22 | 0.43 | 398 | 5.98 | 367 | 5.77 |
| | | | | | | |
| **ADMINISTRATIVE DENIALS** | **199** | **3.86** | **156** | **2.34** | **7** | **0.11** |
| Denials of Authorization | 199 | 3.86 | 156 | 2.34 | 7 | 0.11 |

| | | | | | | |
|---|---|---|---|---|---|---|
| (Unauthorized by Members) | | | | | | |
| **Total** | **2,378** | **46.08** | **4,791** | **71.97** | **4,924** | **77.48** |

***Processed claims 2020= 6,355,269**

**Member Satisfaction Survey**

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

The 2020 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 2020 against results for 2019, then with comparison to the Quality Compass® All Plans means and percentiles. The 2020 Quality Compass® National Benchmarks is the mean summary rate from the Medicaid adult health plans that submitted data to NCQA in 2020. The Medicaid Child CAHPS is compared to the 2020 Quality Compass® National Benchmarks; this benchmark compares against other Medicaid child plans that submitted to NCQA.

Sunflower's summary rate results for 2020 Composites and Key Questions for the CAHPS Medicaid Adult Survey compared to the 2020 Quality Compass National Benchmarks means and percentiles. Results for 2020 demonstrated slight decrease in Getting Needed Care, Health Promotion and Education, Ease of Filling out Forms, Rating of Health Plan and How Well Doctors Communicate. Additionally, improvement was noted in the Getting Care Quickly, Customer Service, Coordination of Care, Providing Needed Information, Rating of Health Care and Rating of Specialist.

**Medicaid Adults CAHPS Survey Results 2020**

| Composite & Question Ratings | 2018 | 2019 | 2020 | 2019 Quality Compass Percentile Met/Exceeded 50th Percentile |
|---|---|---|---|---|
| Obtaining needed care right away | 91.1% | 88.8% | 87.4% | Yes |
| Obtaining appointment for care as soon as needed | 82.7% | 86.7% | 87.7% | Yes |
| **How Well Doctors Communicate** | **92.6%** | **92.3%** | **91.9%** | **No** |
| Doctors explaining things in an understandable way | 91.9% | 94.3% | 90.3% | No |
| Doctors listening carefully to you | 93.2% | 93.6% | 92.9% | Yes |
| Doctors showing respect for what you had to say | 94.5% | 93.3% | 93.3% | No |
| Doctors spending enough time with you | 90.6% | 91.8% | 91.4% | Yes |
| **Customer Service** | **87.5%** | **91.3%** | **91.7%** | **Yes** |
| Getting information/help from customer service | 82.4% | 88.6% | 88.5% | Yes |
| Treated with courtesy and respect by customer service | 92.5% | 94.0% | 94.9% | No |
| **Shared Decision Making** | **82.9%** | **80.1%** | **NA** | **NA** |

| | | | | |
|---|---|---|---|---|
| Doctor/health provider talked about reasons you might want to take a medicine | 94.1% | 92.7% | NA | NA |
| Doctor/health provider talked about reasons you might not want to take a medicine | 69.9% | 67.2% | NA | NA |
| Doctor/health provider asked you what you thought was best when talking about starting or stopping a prescription medicine | 84.7% | 80.5% | NA | NA |
| **Health Promotion and Education** | **72.1%** | **72.8%** | **NA** | **NA** |
| **Coordination of Care** | **86.1%** | **87.6%** | **83.6%** | **No** |
| **Providing Needed Information** | **82.4%** | **88.6%** | **88.5%** | **Yes** |
| **Ease of Filling Out Forms** | **91.6%** | **81.3%** | **94.2%** | **No** |
| **Ratings Items** | | | | |
| **Rating of Health Care** | **75.6%** | **76.1%** | **78.0%** | **Yes** |
| **Rating of Personal Doctor** | **84.3%** | **83.6%** | **84.3%** | **Yes** |
| **Rating of Specialist** | **83.8%** | **84.0%** | **81.8%** | **No** |
| **Rating of Health Plan** | **80.6%** | **77.5%** | **62.9%** | **No** |

** In 2020, NCQA removed Shared Decision Making and all related questions.

Sunflower's 2020 summary rate results for Composites and Key Questions for the CAHPS Medicaid Child Survey by Title XIX and Title XXI compared to the 2020 Quality Compass All Plans. In 2020, Health Promotion and Education, Shared Decision Making and Ease of Filling out Forms demonstrated improvement for both the Title XIX and Title XXI survey respondents. Coordination of Care demonstrated a reduction for the Child XXI population. Green text depicts where there was a noted increase from the previous year while red text indicates a decrease from previous year's results.

**Medicaid Child CAHPS Survey Results**

| Child Composite & Question Ratings | 2018 Rate Title XIX | 2019 Rate Title XIX | 2020 Rate Title XIX | 2019 Quality Compass Met/Exceeded 50th Percentile | 2018 Rate Title XXI | 2019 Rate Title XXI | 2020 Rate Title XXI | 2019 Quality Compass Met/Exceeded 50th Percentile |
|---|---|---|---|---|---|---|---|---|
| **Getting Needed Care** | **89.0%** | **90.4%** | **90.3%** | **Yes** | **88.9%** | **89.6%** | **90.3%** | **Yes** |
| Ease of getting care, tests, or treatment child needed | 92.7% | 95.4% | 97.0% | Yes | 92.6% | 94.3% | 95.3% | Yes |
| Obtaining child's appointment with specialist as soon as needed | 85.4% | 85.3% | 83.5% | Yes | 85.2% | 84.9% | 85.3% | Yes |
| **Getting Care Quickly** | **92.5%** | **95.6%** | **95.4%** | **Yes** | **91.9%** | **92.4%** | 90.4% | **Yes** |
| Obtaining needed care right away | 95.8% | 96.1% | 97.7% | Yes | 92.2% | 93.4% | **92.4%** | Yes |

**Medicaid Child CAHPS Survey Results**

| Child Composite & Question Ratings | 2018 Rate Title XIX | 2019 Rate Title XIX | 2020 Rate Title XIX | 2019 Quality Compass Met/Exceeded 50th Percentile | 2018 Rate Title XXI | 2019 Rate Title XXI | 2020 Rate Title XXI | 2019 Quality Compass Met/Exceeded 50th Percentile |
|---|---|---|---|---|---|---|---|---|
| Obtaining appointment for care as soon as needed | 89.1% | 95.2% | 93.2% | Yes | 91.6% | 91.4% | 88.4% | No |
| **How Well Doctors Communicate** | **95.8%** | **96.3%** | **96.7%** | **Yes** | **95.6%** | **96.3%** | 97.0% | **No** |
| Doctors explaining things in an understandable way | 97.0% | 98.1% | 95.4% | Yes | 96.5% | 97.6% | **99.0%** | Yes |
| Doctors listening carefully to you | 96.5% | 96.8% | 97.4% | Yes | 96.7% | 97.4% | 98.1% | Yes |
| Doctors showing respect for what you had to say | 97.6% | 96.5% | 98.3% | Yes | 96.7% | 97.1% | 98.1% | Yes |
| Doctors spending enough time with your child | 92.0% | 93.6% | 93.5% | Yes | 92.7% | 93.3% | 94.7% | Yes |
| **Customer Service** | **90.4%** | **90.3%** | 85.7% | **Yes** | **91.0%** | **91.5%** | 90.5% | **Yes** |
| Getting information/help from customer service | 86.6% | 83.7% | **80.0%** | No | 88.4% | 86.2% | **84.0%** | Yes |
| Treated with courtesy and respect by customer service staff | 94.2% | 96.8% | 91.4% | No | 93.5% | 96.8% | 97.0% | No |
| **Shared Decision Making** | **85.0%** | **81.9%** | NA | **Yes** | **77.3%** | **82.2%** | NA | **No** |
| Doctor/health provider talked about reasons you might want your child to take a medicine | 97.1% | 95.8% | NA | NA | 90.6% | 95.1% | **NA** | NA |
| Doctor/health provider talked about reasons you might not want your child to take a medicine | 71.9% | 70.1% | NA | NA | 64.4% | 67.8% | NA | NA |

**Medicaid Child CAHPS Survey Results**

| Child Composite & Question Ratings | 2018 Rate Title XIX | 2019 Rate Title XIX | 2020 Rate Title XIX | 2019 Quality Compass Met/Exceeded 50th Percentile | 2018 Rate Title XXI | 2019 Rate Title XXI | 2020 Rate Title XXI | 2019 Quality Compass Met/Exceeded 50th Percentile |
|---|---|---|---|---|---|---|---|---|
| Doctor/health provider asked you what you thought was best for your child when starting or stopping a prescription medicine | 86.0% | 79.9% | NA | NA | 76.9% | 83.7% | NA | NA |
| **Health Promotion and Education** | 70.8% | 69.4% | NA | NA | 70.9% | 69.5% | NA | NA |
| **Coordination of Care** | 86.3% | 85.6% | **83.7%** | No | 86.2% | 82.1% | **81.1%** | No |
| **Ease of Filling Out Forms** | 94.7% | 84.9% | **96.7%** | Yes | 95.4% | 85.3% | **95.3%** | No |
| Rating Items | | | | | | | | |
| Rating of Health Care | 90.6% | 89.9% | **89.0%** | Yes | 90.2% | 91.1% | **89.3%** | Yes |
| Rating of Personal Doctor | 89.9% | 88.2% | **90.5%** | No | 92.0% | 90.9% | **88.9%** | No |
| Rating of Specialist | 95.7% | 87.1% | **90.3%** | Yes | 89.7% | 91.1% | **83.9%** | Yes |
| Rating of Health Plan | 88.8% | 89.0% | **89.5%** | Yes | 90.3% | 90.6% | **90.4%** | No |

Sunflower's goal for the 2020 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 Health Plan is focusing efforts on improving member satisfaction related to the following areas, including certain areas that impact multiple domains resulting in their inclusion below as focus areas. One example is Ease of Filing out Forms, which impacts Rating of Health Plan and Rating of Health Care. Additionally, Health Promotion and Education focuses on members being informed about their health care along with getting the information or help they need.

Medicaid Adult Survey:

- Getting Needed Care
- How Well Doctors Communicate
- Shared Decision Making

Medicaid Child Surveys:

- Health Promotion and Education
- Shared Decision Making
- Ease Of Filing Out Forms

Sunflower utilized the vendor, SPH Analytics, for delivery, data collection and report completion of the CAHPS surveys in 2020. The areas noted as strengths for the Adult survey are as follows:

- Getting Care Quickly
- Customer Service
- Care Coordination
- Providing Needed Information
- Rating of Health Care
- Rating of Specialist

The one area noted as a relative weakness was How Well Doctors Communicate. As a result, Sunflower is focusing on Provider Relations as an area to help drive the performance for the 2020 CAHPS Medicaid Adult survey.

For the 2020 Title XIX and Title XXI CAHPS child surveys, there only a relative weakness noted for Title XXI, which was Coordination of Care. However, the strengths identified to be consistent for both are listed here:

- Getting Needed Care
- Getting Care Quickly
- Coordination of Care
- Rating of Health Care
- Customer Service
- Shared Decision Making
- Rating of Sunflower 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. This also included the strengths/weakness analysis provided by SPH, then were reviewed by representatives from key Sunflower departments, including Provider Relations, Medical Management, Quality Improvement (including the Grievance and Appeal Coordinator), Network & Contracting, Customer Services, Compliance, Pharmacy, and Medical Management team which is integrated to include LTSS/Waiver, I/DD, and Behavioral Health. The Sunflower CAHPS/member experience workgroup met and discussed barriers, opportunities to address these barriers to increase member satisfaction, and potential interventions. Some of these barriers are noted to be an ongoing challenge with the membership served.

The below reflects the barriers identified in the results analysis:

- Member lack of understanding of state benefits and limitations.
- Incomplete information received from providers to authorize services on initial request.
- Members unresponsive to health plan outreach via mail, phone, or text.
- Members unaware of process for scheduling transportation and that 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 2020. Sunflower continues to strive for improvement on member satisfaction through a variety of interventions aimed at improving Customer Service and member experience.

**Behavioral Health Survey**
Sunflower conducted member satisfaction surveys specific to behavioral health services accessed. The purpose of the survey is to allow for evaluation and comparison of health plan ratings. Sunflower strives to understand the problems members face in order to implement actions that achieve better performance on specific opportunities for improvement identified within the survey results. In addition, Sunflower utilizes the survey results as a data source for other performance improvement initiatives throughout the year.

In 2020, Sunflower began to use the ECHO survey tool. In prior years, MHSP and YSS-F survey were used. Because of this methodology change, 2020 will be the baseline year of this Behavioral Health Survey.

The sample size for the 2020 Medicaid Child survey consisted of 2945 child members of Sunflower Health Plan using mixed (mail and phone) survey methodology. There were 447 valid surveys from the population with 2498 deemed ineligible/non-responding. After adjusting for ineligible/non-responding members, Sunflower members identified as ineligible or non-responding), the survey response rate was 7.2%.

**BH Survey Response Rate**

| Survey Population | 2020 Response Rate |
|---|---|
| Medicaid Adult | 14.9% |
| Medicaid Child | 7.2% |

The 2020 Composite and Question scores for Sunflower's adult and child surveys are presented in the following tables.

**2020 Medicaid Adult Echo Behavioral Health**

| Medicaid *Adult* Behavioral Health Topics & Question Ratings | 2020 Rate |
|---|---|
| **Getting Treatment Quickly** | **69.6%** |
| How often did you get the professional counseling needed on the phone? | 52.1% |
| When you needed counseling or treatment right away, how often did you see someone as soon as you wanted? | 75.0% |
| Not counting the times you needed counseling or treatment right away, how often did you get an appointment for counseling or treatment as soon as you wanted? | 81.8% |
| **How Well Clinicians Communicate** | **88.8%** |
| How often did the people you went to for counseling or treatment listen carefully to you? | 89.6% |

| | |
|---|---|
| How often did the people you went to for counseling or treatment explain things in a way you could understand? | 89.1% |
| How often did the people you went to for counseling or treatment show respect for what you had to say? | 92.2% |
| How often did the people you went to for counseling or treatment spend enough time with you? | 86.0% |
| How often were you involved as much as you wanted in your counseling or treatment? | 87.2% |
| **Informed About Treatment Options** | **53.8%** |
| Were you told about self-help or support groups, such as consumer-run groups or 12-step programs? | 49.5% |
| Were you given information about different kinds of counseling or treatment that are available? | 58.0% |
| **Access to Treatment and Information from Health Plan** | **74.5%** |
| How much of a problem, if any, were delays in counseling or treatment while you waited for approval? | 89.9% |
| How much of a problem, if any, was it to get the help you needed when you called your health plan's customer service? | 59.1% |
| **Office Wait Time** | **76.9%** |
| **Informed about Medication Side Effects** | **81.4%** |
| **Received Information about Managing Condition** | **78.9%** |
| **Informed about Patient Rights** | **89.7%** |
| **Ability to Refuse Medication and Treatment** | **84.0%** |
| **Rating of Counseling or Treatment** | **73.7%** |

**2020 Medicaid Adult Echo Behavioral Health**

| Medicaid Adult Behavioral Health Topics & Question Ratings | 2020 Rate |
|---|---|
| **Getting Treatment Quickly** | **74.8%** |
| How often did you get the professional counseling your child needed on the phone? | 63.6% |
| When your child needed counseling or treatment right away, how often did he or she see someone as soon as you wanted? | 72.0% |
| Not counting the times your child needed counseling or treatment right away, how often did your child get an appointment for counseling or treatment as soon as you wanted? | 88.7% |
| **How Well Clinicians Communicate** | **90.3%** |
| How often did the people your child saw for counseling or treatment listen carefully to you? | 90.3% |
| How often did the people your child saw for counseling or treatment explain things in a way you could understand? | 88.7% |
| How often did the people your child saw for counseling or treatment show respect for what you had to say? | 93.5% |
| How often did the people your child saw for counseling or treatment spend enough time with you? | 85.5% |
| How often were you involved as much as you wanted in your child's counseling or treatment? | 93.5% |
| **Informed About Treatment Options** | |

| | |
|---|---|
| Were you given information about different kinds of counseling or treatment that ware available for your child? | 74.2% |
| | |
| How much of a problem, if any, were delays in counseling or treatment while you waited for approval from your child's health plan? | 92.0% |
| How much of a problem, if any, was it to get the help you needed for your child when you called the health plan's customer service? | 80.0% |
| | |
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### Access and Availability

### Call Statistics (Member and Provider Calls)

The Customer Service Department has state contractual requirements to meet telephone access standards. In 2020 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 143,630 for 2020. The average speed to answer was 23seconds for member calls and 23 seconds for provider calls. In 2020, Sunflower successfully met the goal of 80% answered within 30 seconds or less. The 2020 abandonment rate was 2.0% for member calls and 2.7% for provider calls, which demonstrates meeting the goal of less than 4%. As a result of the performance goals having been met, there are no opportunities to improve Sunflower's telephone access at this time. However, Sunflower will continue monitoring and reporting telephone access on a monthly basis to allow for tracking, trending and identifying any opportunities while striving to continue to meet or exceed the requirements.

## Network Adequacy

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

**Accessibility of Primary Care Services**

Sunflower monitors primary care provider appointment accessibility against its standards, identifies opportunities for improvement and initiates actions as needed to improve results. 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 Primary Care Practitioners (PCPs) are not to exceed three weeks from the date of member requests. Access to a specialty care appointment within 21 days of request is the standard. For Behavioral Health the access to care standard is 10 days for Routine care. Sunflower also monitors office wait times and defines an acceptable wait time as within 45 minutes from time member enters a practitioner office, for both PCPs and specialists.

Sunflower surveyed a sample of participating (in network) credentialed practitioners, both PCPs and specialists. Specialists included OB/GYN) and behavioral health practitioners contracted with Sunflower in 2020. There were not practitioners that were excluded from the sample. Practitioner data was pulled from Sunflower's provider management system, Portico. Sunflower's appointment availability surveys request confirmation that the practitioner can accommodate members' appointment needs based on current practitioner availability for routine and urgent appointments. At this time exact methodology for the 2020 survey is pending and will be supplied when the source data is available.

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

| Appointment Type | Standard and Performance Goal | Measurement Method | Measurement Frequency |
|---|---|---|---|
| Primary care urgent appointments within 48 hours | 90% of surveyed PCPs report availability of urgent appointment within defined timeframe | Survey sample of all PCP offices | Annually |
| Primary care routine appointments not to exceed three weeks from date of member request | 90% of surveyed PCPs report availability of urgent and appointment within defined timeframes | Survey sample of all PCP offices | Annually |
| Specialist urgent care appointments within 48 hours | 90% of surveyed specialists report availability of urgent appointment within defined timeframe | Survey sample of all specialist offices | Annually |
| Specialist routine appointments not to exceed 30 days from the date of member request | 90% of surveyed specialists report availability routine appointment within defined timeframes | Survey sample of all specialist offices | Annually |
| Behavioral Health routine appointments not to exceed 10 days from the date of the members request | 90% of surveyed Behavioral Health providers | Survey sample of Behavioral Health providers | Annually |
| Wait time not to exceed 45 minutes | 90% of surveyed PCPs<br><br>90% of surveyed specialists | Survey sample of PCP offices and specialists offices | Annually |

**Appointment Accessibility Results**
In 2020, Sunflower used 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 2020. The results demonstrated opportunities to focus improvement on for 2020 to enhance the member and provider experience

In the Adult population, several goals related to appointment availability were not met. Sunflower continues to assess the first, second, and third appointment availability to determine accessibility barriers to obtaining routine appointments.

In the Behavioral Health population, ability of established members to secure routine appointments was not met.

In the Child populations, several goals were not met related to getting care quickly and appointment availability for Title XXI members.

The following table demonstrates results from the 2020 assessment of providers by types to include primary care, oncologists, OB providers and behavioral health providers.

**Measurement Results and Comparison to Performance Goal**

| Access Standard | Performance Goal | Results | Goal Met? (yes/no) |
|---|---|---|---|
| Behavioral Health Non Prescriber Care for routine appointments Established Patients within 10 Days | 90% of high-impact specialists report availability of urgent appointment within defined timeframe | 1st available: 83%<br>2nd available: 76%<br>3rd available: 66% | No<br>No<br>No |
| Behavioral Health Non-Life Threatening Emergent Care within 6 hours | 90% of surveyed Behavioral Health Prescribers and Non-Prescribers within defined timeframe | Prescribers: 100%<br>Non-Prescribers: 99% | Yes<br>Yes |
| Volume of member grievances regarding accessibility of services | Complaint volume of less than 5/1000 members | 0.71 per 1000 | Yes |
| Volume of member appeals regarding out of network service | Appeal volume of less than 5/1000 members | 0.02 per 1000 | No |
| Adult Survey:<br>*Getting Care Quickly* Composite | 2019 Quality Compass<br>75th ≥ Percentile | 87.6% | Yes |
| Q4 Adult Survey:<br>Percent of members who responded always or usually to "Obtained needed care right away" | 2019 Quality Compass<br>90th ≥ Percentile | 87.4% | No |
| Q6 Adult Survey:<br>Percent of members who responded always or usually to "Obtained appointment for care as soon as needed" | 2019 Quality Compass<br>50th ≥ Percentile | 87.7% | Yes |
| Q43 (custom question)<br>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 | 74.4% | No |

| | | | |
|---|---|---|---|
| Child Survey:<br>*Getting Care Quickly*<br>Composite | 2019 Quality Compass<br>50th ≥ Percentile | T-XIX 95.4%<br>T-XXI 90.4% | Yes<br>No |
| Q4 Child Survey:<br>Percent of members who responded always or usually to "Child obtained needed care right away" | 2019 Quality Compass<br>50th ≥ Percentile | T-XIX 97.7%<br>T-XXI 92.4% | Yes<br>Yes |
| Q6 Child Survey:<br>Percent of members who responded always or usually to "Child obtained appointment for care as soon as needed" | 2019 Quality Compass<br>50th ≥ Percentile | T-XIX 93.2%<br>T-XXI 88.4% | Yes<br>No |

**Measurement Results and Comparison to Performance Goal**

| Access Standard | Performance Goal | Results | Goal Met? |
|---|---|---|---|
| Q78 (custom question)<br>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 83.9%<br>TXXI 80.4% | Yes<br>Yes |
| Member Grievances related to Appointment Access | < 5.0/1000 members | 0.07 per 1000 | Yes |

**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 reflect the percent of members who report "Always" or "Usually" to the survey questions.

The tables below are Sunflower rates for the CAHPS Adult and Child survey results comparing 2018 to 2020. In the Child survey, responses by Title XIX and XXI respondents are segmented. The prior year 50 percentile benchmark is used until the 2020 year is available.

| Composite & Question Ratings | 2018 Rate | 2019 Rate | 2020 Rate | 2019 Quality Compass Ranking Met/Exceeded 50th Percentile |
|---|---|---|---|---|
| **Getting Care Quickly** | **86.9%** | **87.75%** | **87.6%** | **Yes** |
| Obtaining needed care right away | 91.1% | 88.78% | 87.4% | Yes |
| Obtaining appointment for care as soon as needed | 82.8% | 86.73% | 87.7% | Yes |

| Child Composite & Question Ratings | 2018 Rate Title XIX | 2019 Rate Title XIX | 2020 Rate Title XIX | Title XIX 2019 Quality Compass Met/Exceeded 50th Percentile | 2018 Rate Title XXI | 2019 Rate Title XXI | 2020 Rate Title XXI | Title XXI 2019 Quality Compass Met/Exceeded 50th Percentile |
|---|---|---|---|---|---|---|---|---|
| **Getting Care Quickly** | **92.5%** | **95.6%** | **95.4%** | **Yes** | **91.9%** | **92.4%** | **90.4%** | **Yes** |
| Obtaining needed care right away | 95.8% | 96.1% | 97.7% | Yes | 92.2% | 93.4% | 92.4% | Yes |
| Obtaining appointment for care as soon as needed | 89.1% | 95.2% | 93.2% | Yes | 91.6% | 91.4% | 88.4% | Yes |

CAHPS survey results are reviewed and discussed in a multi-disciplinary workgroups and committees to socialize the results. These results are aggregated with other survey results and considered when reviewing opportunities to improve and enhance the member experience.

**Practitioner Availability**

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

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

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

For the 2020 Practitioner Availability Analysis, Sunflower identified high-volume specialists as Obstetrics/Gynecology and high-impact specialists as Hematology/Oncology. For this report, Sunflower used the State definition for “Hematology/Oncology”, which includes both oncology practitioners and oncologists with a specialty in hematology. Hematology/Oncology is defined to be practitioners with a specialty of “329-Oncologist” which includes these taxonomies - 207RH0003X (Hematology and Oncology), 2080P0207X (Pediatric Hematology-Oncology), and 261QX0203X (Oncology, Radiation).

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

| Practitioner Type | Standard | Measurement Method | Results | Goal Met? |
|---|---|---|---|---|
| PCPs: All Types | 95% of urban members have at least 1 PCP within 20 miles or 40 | Quest Analytics | 100% | **Yes** |
| | 95% of rural members have at least 1 PCP within 30 miles or 45 minutes. | Quest Analytics | 100% | **Yes** |
| | At least 1 PCP per 2000 members | Ratio of PCPs to members | 1:42 | **Yes** |
| PCPs: Family Practitioners/General Practitioners | 95% of urban members have at least 1 FP or GP within 20 miles or | Quest Analytics | 100% | **Yes** |
| | 95% of rural members have at least 1 FP or GP within 30 miles or 45 minutes | Quest Analytics | 100% | **Yes** |
| | At least 1 FP or GP per 2000 members | Ratio of FPs/GPs to members | 1:121 | **Yes** |
| PCPs: Internal Medicine | 95% of urban members ≥19 have at least 1 internist within 20 miles or 40 | Quest Analytics | 100% | **Yes** |
| | 95% of rural members ≥19 have at least 1 internist within 30 miles or 45 minutes | Quest Analytics | 87% | **No** |
| | At least 1 IM per 2000 adult members | Ratio of internists to members | 1:367 | **Yes** |
| PCPs: Pediatrics | 95% of urban members ≤18 years of age have at least 1 pediatrician | Quest Analytics | 99.9% | **Yes** |
| | 95% of rural members ≤18 years of age have at least 1 pediatrician within 30 miles or 45 minutes. | Quest Analytics | 85.3% | **No** |
| | At least 1 Pediatrician per 2000 members under age 19 | Ratio of pediatricians to members | 1:367 | **Yes** |
| PCP Extenders: Nurse Practitioners | 95% of members have at least 1 NP within 20 miles or 40 minutes | Quest Analytics | 100% | **Yes** |
| | 95% of rural members have at least 1 NP within 30 miles or 45 minutes. | Quest Analytics | 99.9% | **Yes** |
| | At least 1 NP per 2000 members | Ratio of NPs to members | 1:132 | **Yes** |
| PCP Extenders: Physician Assistants | 95% of members have at least 1 PA within 20 miles or 40 minutes | Quest Analytics | 100% | **Yes** |
| | 95% of rural members have at least 1 PA within 30 miles or 45 minutes. | Quest Analytics | 99.9% | **Yes** |
| | At least 1 PA per 2000 members | Ratio of PAs to members | 1:335 | **Yes** |
| Obstetrics and Gynecology | 95% of urban female members have at least 1 OB/GYN within 15 miles or 30 minutes | Quest Analytics | 83.5% | **No** |
| | 95% of rural female members have at least 1OB/GYN within 60 miles or 90 minutes. | Quest Analytics | 90.1% | **No** |
| | At least 1 OB/GYN per 2000 members | Ratio of OB/GYN practitioners to members | 1:4257 | **No** |

| Practitioner Type | Standard | Measurement Method | Results | Goal Met? |
|---|---|---|---|---|
| Hematology/ Oncology | 95% of urban members have at least 1 Hematology/Oncology provider within 30 miles or 60 minutes | Quest Analytics | 100% | **Yes** |
| | 95% of rural members have at least 1 Hematology/Oncology provider within 90 miles or 135 minutes. | Quest Analytics | 99.8% | **Yes** |
| | At least 1 Hematology/Oncology provider per 5000 members | Ratio of Hematology/Oncology providers to members | 1:1068 | **Yes** |
| Psychiatrists (BH/SUD) | 95% of urban members have at least 1 Psychiatrist within 15 miles or 30 minutes. | Quest Analytics | 99.9% | **Yes** |
| | 95% of rural members have at least 1 Psychiatrist within 60 miles or 90 minutes. | Quest Analytics | 99.8% | **Yes** |
| | At least 2 Psychiatrist per 1000 members | Ratio of Psychiatrist providers to members | 1:513 | **Yes** |
| Clinical Psychologists (BH/SUD) | 95% of urban members have at least 1 Clinical Psychologist within 30 miles or 60 minutes. | Quest Analytics | 100% | **Yes** |
| | 95% of rural members have at least 1 Clinical Psychologist within 60 miles or 90 minutes. | Quest Analytics | 100% | **Yes** |
| | At least 2 clinical psychologist per 1000 members | Ratio of Clinical Psychologist providers to members | 1:498 | **Yes** |
| Masters Level Clinicians (BH/SUD) | 95% of urban members have at least 1 Masters Level Clinician within 30 miles or 60 minutes. | Quest Analytics | 100% | **Yes** |
| | 95% of rural members have at least 1 Masters Level Clinician within 60 miles or 90 minutes. | Quest Analytics | 100% | **Yes** |
| | At least 5 master level clinician per 1000 members | Ratio of Master Level Clinician providers to members | 1:54 | **Yes** |

Geographic analysis of practitioner availability entails comparing results to the standards for primary care for members residing in urban areas (95% of members having at least 1 PCP within 20 miles or 40 minutes) and rural areas (95% of members have at least one PCP within 30 miles or 45 minutes).
Availability for all PCP types combined and by specific type for family/general practitioners, internists, and pediatricians met Sunflower's standards for members residing in urban areas.

Two standards were not met for Sunflower Medicaid members residing in rural areas: internal medicine and pediatricians. However, it is important to note that family and general practitioners met the standard in rural areas, meaning that members have access to primary care in rural areas, but may not have access to primary care practitioners that specialize in the care of adult or children and adolescent populations. Sunflower also measures availability for PCP-Extenders, i.e. nurse practitioners and physician assistants, which both met the standards for

urban and rural members. All PCP types exceeded the numeric/ratio standards established by Sunflower: 1:2000 for each type of PCPs.

Sunflower's standards for high-volume, i.e. OB/GYN practitioners, are that 95% of female members have access to at least one OB/GYN within 15 miles or 30 minutes for urban areas and within 60 miles or 90 minutes for rural areas; neither standard was met for OB/GYNs. High-impact specialists, identified as hematology/ oncology specialists, met the urban (95% of members have at least one specialists within 30 miles or 60 minutes) and rural (95% of members have at least one hematology/oncology specialist within 90 miles or 135 minutes) geographic standard. The results of the 201 practitioner availability analysis for hematology and oncology access for urban members was 96.4%; in 2019, this number increased to 100%. For hematology and oncology practitioner availability for rural members, the results of the 2018 practitioner availability analysis indicated 83.8%, increasing in 2019 to 99.8%.

Sunflower analyzed behavioral health access for 2019, as behavioral health integrated at the plan. The access standard was met for both urban and rural for non-MD Behavioral Health therapists, and psychiatry access is being met for urban and rural areas. . Sunflower is researching available psychiatrists in rural counties where we are not meeting access, which are Jewell, Smith, and Wallace.

Sunflower will target the rural counties for further investigation and outreach to improve access for rural members based on the network adequacy report that indicated the lowest access percentages for hematologists/oncologists: which are the rural counties of Cheyenne, Rawlins. For OB/GYN, the counties with the lowest access percentages were Barber, Cheyenne, Rawlins, Sherman, and Thomas. Of the counties listed above concentrated in Northwest and Southwest Kansas, all are designated as Health Professional Shortage Areas (HPSAs) by the U.S. Department of Health and Human Services (DHHS).

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

In many rural areas in Kansas, hospitals are considered "critical access" and provide a variety of healthcare services, including primary care. Many rural hospitals have Rural Health Clinics (RHCs), Federally Qualified Healthcare Clinics (FQHCs) or health departments located in or near the acute care hospital that provide services to the entire county, and often to several surrounding counties as well. These arrangements, unique to rural and frontier/remote areas, may not accurately reflect the availability of services through Quest Analytics reporting. Sunflower is contracted with all available hospitals in the rural and frontier areas.

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

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

## 24 Hour Access/Availability

In 2020, Sunflower started utilizing the vendor SPH Analytics, formerly Morpace to perform the survey for After Hours Care. In addition to the survey results, other data sources were utilized which included the 2020 CAHPS surveys and member grievances.

The 2020 CAHPS survey questions utilized for assessment of After-Hours Care are:

- Q# 42 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# 43 “In the last 6 months, when you phoned after regular office hours, how often did you get help or advice you needed?”
- Q# 77 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# 78 “In the last 6 months, when you phoned after regular office hours, how often did you get help or advice you needed?”

| 2020 After-Hours Care Medicaid Survey | | | |
|---|---|---|---|
| **Number of Providers in Sample** | **Number Fully Compliant** | **Number of Noncompliant** | **% of Providers Fully Compliant** |
| 205 | 116 | 89 | 57% |

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

| CAHPS Survey Questions for After Hours* | Title XIX 2019 Rate | Title XIX 2020 Rate | Title XXI 2019 Rate | Title XXI 2020 Rate | Adult 2019 Rate | Adult 2020 Rate |
|---|---|---|---|---|---|---|
| Child Q77/Adult Q42. In last 6 months, did you phone your child's or your personal doctor's office after regular office hours to get help/advice? | 11.4% | 8.9% | 9.4% | 11.3% | NA | 15.7% |
| Child Q78/Adult Q43. 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? | 83.9% | **83.9%** | 83.1% | **80.4%** | 81.0% | **74.4%** |

Access to behavioral healthcare practitioners and after-hours access is monitored on a regular basis and actions are initiated when needed to improve performance by Sunflower as the behavioral health component was incorporated into Sunflower in 2019. Sunflower handles all aspects related to survey monitoring and any actions needed as appropriate. Access to healthcare practitioners and after-hours is monitored on a regular bases and actions are initiated when needed to improve performance by Sunflower. There was a significant drop in 24-hour access for adults by 6.6% and title XXI drop by 2.7% in 2020. Sunflower will provide education on the expectations of 24-hour access to our contracted practitioners in 2021. Communication and education around the accessibility expectations will be revisited with targeted practitioners and practices. Any member grievances around accessibility will be targeted as well for further education on the expectations.

### Provider Satisfaction Survey

SPH Analytics (SPH), a National Committee for Quality Assurance (NCQA) Certified Survey Vendor, was selected by Sunflower Health Plan to conduct its 2020 Provider Satisfaction Survey. Information obtained from these surveys allows plans to measure how well they are meeting their providers' expectations and needs. Based on the data collected, this report summarizes the results and assists in identifying plan strengths and opportunities.

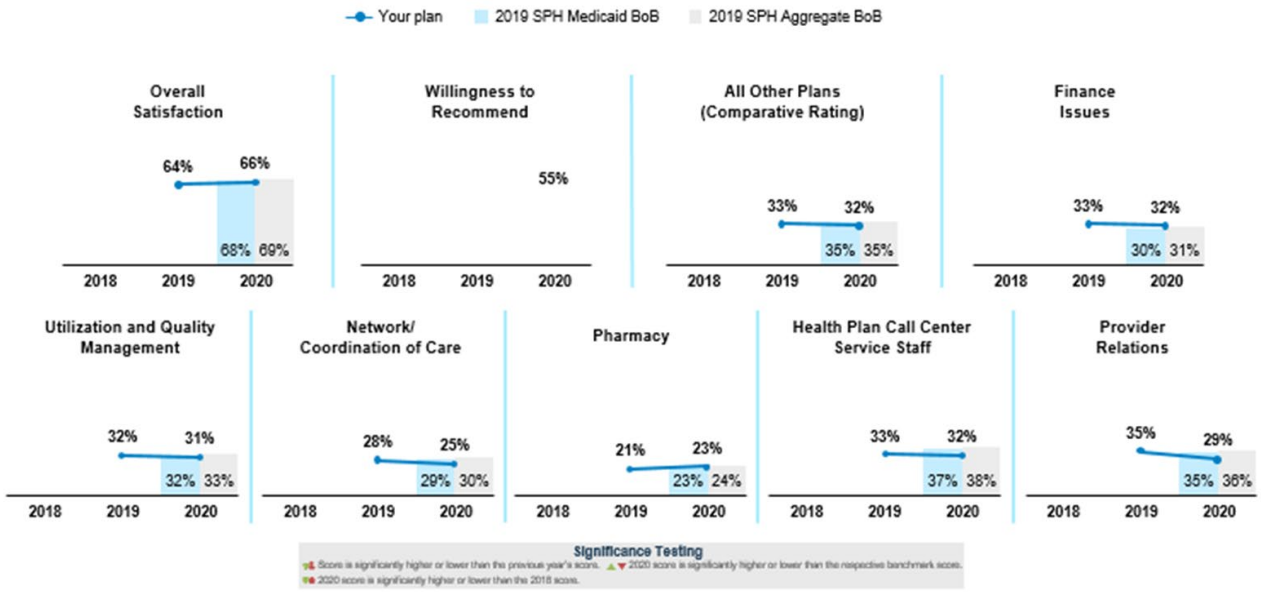
SPH Analytics followed a two-wave mail and internet with phone follow-up survey methodology to administer the provider satisfaction survey from

Year over year trending shows an overall increase in Overall Provider Satisfaction by 2.2% and 2% increase in Pharmacy. Despite these gains, Sunflower fell in overall competitor ranking from first (1st) to second (2nd) place in 2020.

Areas of 2021 opportunities include the following areas:

- Provider Relations: Net drop 6.2%
- Network and Coordination of Care: Net drop 3%
- Finance: Net drop 1.4%
- Utilization and Quality Management: Net drop 1.2%
    - Preventive care and wellness coverage

| 2020 Provider Satisfaction Composite Scores | 2020 Summary Rates | 2019 Summary Rate | 2018 Summary Rate | 2017 Summary Rate | 2016 Summary Rate |
|---|---|---|---|---|---|
| Overall Satisfaction | 66% | 63.80% | 66.30% | 61.2% | 58.9% |
| Comparative Rating of Sunflower compared with all other contracted health plans | 32% | 32.90% | 35.20% | 34.6% | 32.2% |
| Finance Issues | 32% | 33.40% | 33.60% | 37.3% | 33.8% |
| Utilization & Quality Management | 31% | 32.20% | 28.70% | 29.6% | 26.7% |
| Network/Coordination of Care | 25% | 28.0% | 20.70% | 22.4% | 21.6% |
| Pharmacy | 23% | 21.0% | 13.10% | 16.6% | 14.7% |
| Health Plan Call Center Service Staff | 32% | 32.90% | 27.90% | 30.8% | 29.7% |
| Provider Relations | 29% | 35.20% | 40.90% | 36.5% | 36.1% |
| Recommended to Other Physicians Practices | 55% | 54.00% | 38.20% | NA | NA |




An importance analysis is used and involves a multi-step process:

- Factor analysis is used to summarize the predictor set into a more manageable number of composite variables.
- Regression Model I is used to make preliminary estimates and identify leverage points and outliers.
- Leverage points and outliers are eliminated.
- Regression Model II is run on the remaining data to derive final estimates of the importance of the various satisfaction elements.

*Factor analysis.* Factor analysis is used to reduce the number of items in the predictor set to a smaller set of underlying constructs, or factors. It is necessary to go through this process because of the high degree of collinearity in the original data. This is a problem for the

regression analysis to follow because regression assumes non-collinearity between predictor variables.

*Regression analysis.* Regression analysis is then used to predict overall satisfaction on the factors created in the previous step. As noted above, regression analysis is run in two steps. The first step is used to derive preliminary estimates of the importance of the various satisfaction elements and to identify outliers and leverage points. Those outliers and leverage points are eliminated before running the second regression model which produces final estimates of the importance of each satisfaction element.

*Derived importance.* The relative importance of each survey item is derived from the combined results of the factor and regression analyses. The correlations of each question with each factor are squared and then multiplied by the standardized (beta) regression coefficients associated with each of those factors. This sum is then rescaled so that the largest value (most important item) is rescaled to 100 points, the smallest value is rescaled to 0 points and the median value is rescaled to 50 points.

Relative performance (the top-two-box rating) is calculated for each survey variable. Ratings are rescaled on a 100-point basis (like importance values) so that the highest rating is set to 100 points, the lowest rating is set to 0 points and the median rating is set to 50 points.

The SatisActionTM key driver statistical model was used to identify the key drivers of overall satisfaction with the health plan. The statistical model is a powerful, proprietary statistical methodology used to identify the key drivers of overall satisfaction with the health plan and provide actionable direction for satisfaction improvement programs.

The model provides the following:

- Identification of the elements that are important in driving overall satisfaction with the health plan.
- Measurement of the relative importance of each of these elements.
- Measurement of how well providers think the plan performed on those important elements.
- Presentation of the importance/performance results in a matrix that provides clear direction for provider satisfaction improvement efforts by the plan.

Results of the key driver modeling are presented in a classification matrix. The importance and performance results for each item in the model are plotted in a matrix. This matrix provides a quick summary of the most important drivers of overall satisfaction and how your plan is doing on those items. The matrix is divided into four quadrants. The quadrants are defined by the point where the medians of the importance and performance scales intersect. The four quadrants can be interpreted as follows:

- Power. These items have a relatively large impact on overall satisfaction and your plan performance levels on these items are high. Promote and leverage strengths in this quadrant.
- Opportunity. Items in this quadrant also have a relatively large impact on overall satisfaction but your plan performance is below average. Focus resources on improving processes that underlie these items and look for a significant improvement in the satisfaction score.

- Wait. Though these items still impact overall satisfaction, they are somewhat less important than those that fall on the right-hand side of the chart. Relatively speaking, your plan performance is low on these items. Dealing with these items can wait until more important items have been dealt with.
- Retain. Items in this quadrant also have a relatively small impact on overall satisfaction but your plan performance is above average. Simply maintain performance on these items.

## Disease Management Programs

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

- Asthma
- Diabetes
- Tobacco Cessation
- Hypertension
- Weight Management
- Heart disease/Congestive Heart Failure
- COPD
- Hyperlipidemia
- Puff Free Pregnancy
- Blood Disorders/Hemophilia

## Clinical Practice Guidelines (CPG)

Sunflower utilized the following clinical and preventive health practice guidelines in 2017 review of policy. Sunflower made providers aware of the guidelines and their expected use through the provider newsletters, inclusion in the provider manual, and on the Sunflower website. Performance on CPGs is monitored through performance on applicable HEDIS measures. Below are the CPGs are provided:

- ADHD
- Adult Preventive
- Anxiety Disorder
- Asthma
- Back Pain
- Diabetes
- CHF / Heart Failure
- CAD
- COPD
- Hyperlipidemia
- Hypertension
- Hypertension in Children
- Immunizations
- Lead Screening
- Pediatric Preventive

- Perinatal Care
- Sickle Cell
- Major Depressive Disorder
- Schizophrenia
- Substance Use Disorders
- Tobacco Cessation
- Weight Management

All Clinical Practice Guidelines (CPGs) and Preventive Health Guidelines (PHGs) are reviewed annually and updated accordingly. Opportunities in 2017 related to practice guidelines were to continue and expand provider profiles in 2018 to a larger provider group to help increase knowledge, awareness and compliance.

Efforts Undertaken in 2020
Sunflower continues to complete annual review of CPGs and PHGs, review and update as appropriate based on the policy and procedure requirements.

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

**Continuity and Coordination of Care**
**Please note: 2020 final data is pending in some areas.*

Sunflower's annual continuity and coordination of medical care review, for calendar year 2019, continues to monitor the following areas and initiate actions for improvement in the delivery of continuity and coordination of medical care:

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

**Monitor 1-** The total number of newborns that have a follow-up visit with an outpatient provider within 30 days of discharge after delivery.

In 2017, Sunflower identified this as a new monitor and generated an administrative claim and encounter report to serve as the baseline measurement for Monitor 1.

- The population from which the measure is drawn remains the total number newborns who become our members from member mothers who have a new patient appointment with a primary care physician within 30 days of discharge after delivery.
- The denominator is the total number of newborns discharged after delivery, by a member mother, during the 12-month measurement period. Administrative claims and encounters are used to evaluate the measurement period.
- The numerator is the total number of newborn discharges in the measure that successfully completed a follow-up new patient appointment with a practitioner within 30 days; primary care providers and specialists are included. Claims for office visit follow-up include paid, pending, and denied claims.
- Sunflower's performance goal will be to increase the 30-day follow-up rate by 5 percent each measurement period.

**Results- Monitor 1**

| Measurement Period | Numerator | Denominator | Rate | Goal | Goal Met? |
|---|---|---|---|---|---|
| 1/1/2017 – 12/31/2017 | 2696 | 3287 | 82.02% | Baseline | N/A |
| 1/1/2018 - 12/31/2018 | 3013 | 3381 | 89.12% | 86.12% | Yes |
| 1/1/2019 – 12/31/2019 | 3703 | 4162 | 88.97% | 88.97% | No |

**Analysis- Monitor 1**

Sunflower established a performance goal to increase post discharge visit follow-up appointments with a primary care provider or specialist by at least 5 percent above the baseline value, and another 5 percent annually thereafter. Sunflower did not meet the goal for MY 2019, as the rate fell from 89.12% to 88.97%. No new barriers were identified, Sunflower will continue with the opportunities and actions found in the table labeled, "Barriers/Interventions – Monitor 1" found below in an effort to demonstrate continued success.

Sunflower identifies the following barriers related to the number of newborns having a follow-up visit with an outpatient provider within 30 days of discharge after delivery:

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

**Barriers/Interventions – Monitor 1**

| Priority | Barriers | Opportunity | Select for Improvement? | Actions/Interventions | Date Initiated |
|---|---|---|---|---|---|
| 2 | Caregivers do not establish PCP care for newborn within the first 30 days. | Assist caregiver in establishing a relationship with provider for newborn. | Yes | For those members who opt-in to the SSFB CM program, plan CM staff make telephonic outreach to link caregivers to newborn providers and educate caregivers regarding the importance of establishing a | Q1 2018 *ongoing* |
| 3 | Caregivers knowledge deficit regarding newborn follow-up post delivery | Educate caregiver on importance of newborn visits | Yes | For those members who opt-in, in addition to telephonic outreach, text and/or emails will be sent to educate on various health topics including the importance of well-child visits | Q1 2018 ongoing |
| 4 | Caregiver knowledge deficit related to recommended Preventative Pediatric Health Care. | Educate caregiver on AAP recommendations and on the benefits of routine care for the newborn and importance of established | Yes | When Sunflower is notified of a delivery, the member will be mailed a newborn welcome packet which will include information regarding recommended well-child visits | Q1 2018 ongoing |
| 1 | Staff knowledge deficit related to recommended preventive care | Educate SSFB staff on AAP recommendations | Yes | Provide SSFB staff with current AAP recommendations handout for reference when making outreach to members | Q4 2018 Annually |

**Monitor 2-** The total number of inpatient discharges resulting in a follow-up visit with an outpatient provider within 30 days.

Sunflower continues to monitor the total number of inpatient discharges that resulted in a follow-up visit within 30 days with a generated administrative claim and encounter report for calendar year 2019. Sunflower's goal is to demonstrate improved coordination and continuity of care as members move from the acute care setting, to ensure members have appropriate access to needed follow-up care, home care services, and medications. Improved coordination and

continuity of care is likely to prevent secondary health conditions or complications, re-institutionalization, re-hospitalization, and/or unnecessary emergency room use.

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

**Results- Monitor 2**

| Measurement Period | Numerator | Denominator | Rate | Goal | Goal Met |
|---|---|---|---|---|---|
| 1/1/2017 – 12/31/2017 | 9,126 | 15,189 | 60.08% | 64.38% | No |
| 1/1/2018 – 12/31/2018 | 8,979 | 14,818 | 60.60% | 65.08% | No |
| 1/1/2019 - 12/31/2019 | 10,366 | 17,914 | 57.87% | 60.76% | No |

**Barriers/Interventions – Monitor 2**

| Priority | Barriers | Opportunity | Select for Improvement? | Actions/Interventions | Date Initiated |
|---|---|---|---|---|---|
| 3 | Members do not recognize the importance of follow-up care and medication adherence after discharge. | Educate members regarding the importance of follow- up care following discharge. | Yes | CM's will reinforce follow-up care with members during post-discharge follow up calls and assist with scheduling of an appointment as needed. | Q1 2016 *Ongoing best practice* |

| | | | | | |
|---|---|---|---|---|---|
| 2 | Unsuccessful outreach to members and no consistent process for outreach to members discharged. | Revamp discharge planning and retrain staff | Yes | Discharge Planning process revised, enhance outreach efforts, pilot new process to make improvements and retrain staff | Q2 2020 |
| 1 | Staff knowledge deficit related to transitions | Staff training regarding safe transitions and prevention of readmission | Yes | All post discharge staff will complete a 1 hour CEU on care transitions. | Q1 2019 *Annually* |

**Monitor 3-** The total number of members discharged from an inpatient setting following a live birth who had a postpartum visit with a primary care provider (PCP) or OB-GYN within 21- 56 days following discharge.

For Monitor 3, Sunflower utilized the 2018 and 2019 HEDIS PPC data set for trending and reporting.

- The population from which the measure was drawn is the total number of live births during the calendar year.
- The numerator is the number of members discharged from the inpatient setting with a follow-up visit with the PCP or OB-GYN within 21 and 56 days.
- The denominator is the number of members discharged from an inpatient setting following a live birth during the measurement period.
- Goal is to meet or exceed the NCQA Quality Compass 50$^{th}$ percentile.

**Results- Monitor 3 (Prenatal and Postpartum Care-Postpartum)**

| Measurement Period | Numerator | Denominator | Rate | NCQA QC | Goal Met? |
|---|---|---|---|---|---|
| HEDIS 2018 (MY 2017) | 237 | 411 | 57.66% | 65.21% | No |
| HEDIS 2019 (MY 2018) | 231 | 411 | 56.20% | 60.54% | No |
| HEDIS 2020 (MY 2019) | 255 | 411 | 62.04% | 59.01% | Yes |

**Analysis – Monitor 3**

The HEDIS 2020 rate of 62.04% is an increase over the HEDIS 2019 rate of 56.20% and met the NCQA Quality Compass 50th percentile goal. Interestingly the denominator has remained the same during the three-year review cycle.

An ongoing challenge is the frequent post-delivery focus on the infant, rather than the follow-up care for new mothers. The Sunflower Care Management team works with new mothers to ensure that a follow-up appointment occurs. These members receive a mailer that provides a checklist of conversations and examinations that need to occur during their first doctor visit post-delivery. “Healthy Moves” newsletters are mailed and posted on the Sunflower Health Plan website to inform members of the Start Smart for Your Baby program.

Barriers remain with practitioners’ reluctance to schedule a second appointment within 21-56 days, if the member already completed a visit prior to 21 days and no issues were present. Sunflower continues efforts to focus on engagement and education of members, with emphasis on the importance of prenatal and post-partum visits, to ensure the best outcomes for the mother and newborn.

Sunflower persists in focused attention on improving health outcomes for new mothers and their infants. Potential root causes, barrier analysis, interventions, and opportunities selected for improvement are presented in the table below. Many of the same barriers identified in previous reporting year’s analysis remain relevant, as the population continues to struggle with understanding the significance of appropriate postpartum care.

**Barriers/Interventions - Monitor 3**

| Priority | Barriers | Opportunity | Select for Improvement? | Actions/Interventions | Date Initiated |
|---|---|---|---|---|---|
| 3 | Lack of member awareness of the importance of timely follow-up visit for the mother, i.e. mothers who have delivered and feel "healthy" or see child as "healthy", do not see value in f/u visits for themselves post-delivery. | Member education regarding the importance of a timely follow-up visit. | Yes | CMs remind members about the importance of post-partum follow-up, irrespective of whether they experience post-delivery complications. CM's mail members the Postpartum Checklist "Taking Care of You" in English or Spanish. | Q2 2016 Ongoing Best Practice |
| 2 | Sunflower timely notification of a member's pregnancy, i.e. timely notification allows early outreach to provide sufficient support to the member, including assistance in scheduling a postpartum follow-up appointment for the mother. | Educate providers regarding the importance of submitting a timely Notification of Pregnancy (NOP) to SHP. | Yes | Hired a dedicated provider communications and training specialist | Q2 2020 |
| 1 | CM nurse knowledge deficit regarding pregnancy and delivery. | Educate CM nurse on pregnancy and deliver and importance of post-partum care. | Yes | Training with staff specializing in Labor and Delivery. Staff participate in ongoing training. | Q2 2017 Ongoing Best Practice |
| | | | Yes | Annual refresher and CE direct available for staff. | Q1 2019 Annually |

**Monitor 4-** Practitioner satisfaction with the communication between primary care providers and specialists.

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

SPH Analytics completed a survey between August and October of 2019. The survey followed a one-wave mail and internet with phone follow-up survey methodology to administer the provider satisfaction survey. A sample of 2000 providers were pulled for survey and a total of 348 surveys (91 mail, 26 internet, and 231 phone) were collected from the eligible provider population. After adjusting for ineligible providers, the mail/internet survey response rate was 6.3%, and the phone survey response rate was 28.4%. A response rate is only calculated for those providers who are eligible and able to respond.

**Mail/Internet Component**

$$\frac{91(\text{mail}) + 26(\text{Internet})}{2000\ (\text{sample}) - 143\ (\text{ineligible})} = 6.3\%$$

**Phone Component**

$$\frac{231\ (\text{phone})}{1035\ (\text{sample}) - 222\ (\text{ineligible})} = 28.4\%$$

The table below shows the response rates for the 2017, 2017, and 2019 Sunflower Provider Satisfaction Survey.

| Year of Survey | Component | Completed Surveys | Response Rate |
|---|---|---|---|
| 2017 | Mail and Internet | 132 | 9.1% |
| | Phone | 89 | 13.3% |
| 2018 | Mail and Internet | 159 | 7.5% |
| | Phone | 247 | 15.5% |
| 2019 | Mail and Internet | 117 | 6.3% |
| | Phone | 231 | 28.4% |

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

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

Question 4C and 4D surpassed the 5 percentage point improvement goal for 2019. The 2019 rate for question 4C improved from 21.6% to 29.2%, while the 2019 rate for question 4D increased from 22.4% to 28.9%. The table below provides detail on the responses to question 4C and 4D. See table:

| Composite/ Attribute | 2017 Responses | 2018 Responses | 2019 |
|---|---|---|---|
| **4C** - The timeliness of feedback/ reports from specialists in this health plan's provider network. | Well below average/ Somewhat below average – 8.0% | Well below average/ Somewhat below average – 7.9% | Well below average/ Somewhat below average – 9.3% |
| | Average – 69.0% | Average – 70.6% | Average – 61.5% |
| | Somewhat above average – 14.0% | Somewhat above average – 14.4% | Somewhat above average – 15.9% |
| | Well above average – 8.0% | Well above average – 7.2% | Well above average – 13.3% |
| | (n =147) | (n =153) | (n =195) |
| **4D** - The frequency of feedback/ reports from specialists for patients in your care. | Well below average/ Somewhat below average – 12.0% | Well below average/ Somewhat below average – 6.0% | Well below average/ Somewhat below average – 6.7% |
| | Average – 67.0% | Average – 71.0% | Average – 64.4% |
| | Somewhat above average – 15.0% | Somewhat above average – 15.0% | Somewhat above average – 17.0% |
| | Well above average – 6.0% | Well above average – 7.0% | Well above average – 11.9% |
| | (n = 178) | (n =139) | (n =194) |

**Analysis – Monitor 4**

Sunflower's data on provider satisfaction with the timeliness and frequency of PCP and specialist communication demonstrated great improvement in 2019. There was a larger response rate to the survey in 2019 than previous years, and the number of responses via phone more than doubled. It is likely that those providers who responded to the phone survey responded more positively to these questions. While the responses to the 2019 were certainly more favorable, there is still room for improvement.

Sunflower continues to increase focus on care coordination, member education and integration. To improve member communication with providers a brochure was planned for 2019, but was development was moved to 2020 due to other pressing communications. In an attempt to remove barriers to communication between practitioners, Sunflower Health Plan has been encouraging the use of the provider portal as an opportunity for providers to review timely information regarding the members' treatment from other providers. In Q2 2020, Sunflower Health Plan hired a dedicated provider communications and training specialist continues to work with providers on an interdisciplinary approach to addressing the needs of members.

Utilizing a medical home may enhance exchange of information with specialists. Kansas Medicaid implemented a medical home program, called OneCare Kansas, on April 1, 2020. Members with asthma and another at-risk chronic condition qualify for this program. Sunflower encourages qualified members to participate in the program and Sunflower case management team coordinates with OneCare Kansas providers.

Potential root causes, barrier analysis, interventions and opportunities selected for improvement were explored by a cross-functional department team, including Medical Management, Quality Improvement, and Provider.

| Priority | Barriers | Opportunity | Select for Improvement | Actions/Interventions | Date Initiated |
|---|---|---|---|---|---|
| 3 | Specialists unaware of the need to communicate with the member's PCP | Educate specialty groups regarding the importance of communicating with the member's assigned PCP on a frequent and | Yes | Information posted to Sunflower website and include information on need to coordinate care between providers. | Q4 2016 *Ongoing best practice* |
| 1 | PCPs are not aware of which specialists their assigned members are seeing. | Educate PCPs on how to determine if a member is seeing a specialist. | Yes | Educate PCPs by annual email blast to contact Sunflower for assistance needed in identifying specialty providers member is receiving treatment. | Q4 2016 *Ongoing best practice* |

| | | | | | |
|---|---|---|---|---|---|
| | | | | Increase provider knowledge and use of provider portal | Q1 2019 *Ongoing* |
| | | | | Hired a dedicated provider communications and training specialist | Q2 2020 |
| 2 | Lack of systematic approach to coordination between specialists and | Develop systematic approach for coordination | Yes | Implement medical home approach (OneCare Kansas) | Q2 2020 |
| 3 | Members not communicating between providers | Provide member education about the importance of informing their PCP of specialists they are seeing. | Yes | Care managers and Customer service to educate members on the importance of telling PCP who they are seeing for specialty care. | Q1 2017 *Ongoing best practice* |
| | | | Yes | Person Centered Planning approach implemented during face-to-face visits to aid in identifying member barriers and goals. | Q4 2017 *Ongoing* |
| | | | Yes | CM to provide face-to-face Care Gap visits and assessments with members to address collaboration with | Q4 2016 *Ongoing* |
| | | | Yes | Develop member brochure educating on the importance of sharing information about other providers and signing releases of information. | Q4 2020 |

| | | | | | |
|---|---|---|---|---|---|
| 4 | Provider knowledge deficit regarding the results of the Provider Satisfaction Survey and availability of Sunflower staff to provide assistance with | Inform providers of the results of the Provider Satisfaction Survey. | Yes | Annual provider newsletter article regarding the survey results, and how Sunflower can assist with issues related to communication between practitioners. | Q2 2017 *Ongoing best practice* |

**Continuity and Coordination of Care between Medical and Behavioral Healthcare**

Sunflower Health Plan (Sunflower) monitors and analyzes continuity and coordination of care between medical and behavioral healthcare on an annual basis. This report 2019, describes the methodology, results, analysis, and identifies opportunities for improvement for each monitor, for calendar year 2019. Sunflower 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 primary or secondary preventive behavioral health program; and
- Special needs of members with severe and persistent mental illness.

**Table 1 - Monitors**

| Monitor # | Specific Area Monitored | Description of Monitor |
|---|---|---|
| Monitor 1 | Exchange of Information | Rate of practitioner satisfaction with behavioral health practitioner communication as reported through the annual provider satisfaction survey |
| Monitor 2 | Appropriate Diagnosis, Treatment and Referral of BH Disorders Commonly Seen in Primary Care | Antidepressant Medication Management (AMM) HEDIS Measure: Acute Phase & Continuation Phase |
| Monitor 3 | Appropriate Use of Psychotropic Medications | Follow-up Care for Children Prescribed ADHD Medication-Initiation Phase (ADD) |
| Monitor 4 | Screening and Management of Coexisting Disorders | Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) |
| Monitor 5 | Preventive Behavioral Program | Risk of Continued Opioid Use (COU) |

| | | |
|---|---|---|
| Monitor 6 | Special Needs of Members with Serious and Persistent Mental Illness | Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) HEDIS measure. |

**Monitor 1- Exchange of Information**

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. Sunflower utilized SPH Analytics (SPHA), a National Committee for Quality Assurance (NCQA) Certified Survey Vendor, to conduct the annual provider satisfaction survey.

SPHA followed a one-wave mail and Internet with phone follow-up survey methodology to administer the provider satisfaction survey from August 2019 to October 2019. Sunflower's sample size was 2,000. SPHA collected 348 surveys (91 mail, 26 internet, and 231 phone) from the eligible provider population. After adjusting for ineligible providers, the mail/internet survey response rate was 6.3%, and the phone survey response rate was 28.4%. A response rate is only calculated for those providers who are eligible and able to respond.

**Mail/Internet Component**
91 (mail) + 26 (Internet) / 2,000 (sample) – 143 (ineligible) = 6.3%
**Phone Component**
231 (phone) /1035 (sample) – 222 (ineligible) = 28.4%

The table below shows the response rates for the Sunflower provider satisfaction survey for 2019 and the previous two years. The number of telephonic surveys more than doubled from 2018, from 111 in 2018 to 231 in 2019. While the number of mail/internet combined returned surveys remained similar from 132 in 2017 to 111 in 2018 and 117 in 2019.

**Table 2 – Response Rate**

| Year of Survey | Component | Completed Surveys | Response Rate |
|---|---|---|---|
| **2017** | Mail and Internet | 132 | 9.1% |
| 221 completed surveys | Phone | 89 | 13.3% |
| **2018** | Mail and Internet | 111 | 7.5% |
| 219 completed surveys | Phone | 108 | 15.5% |
| **2019** | Mail and Internet | 117 | 6.3% |
| 348 completed surveys | Phone | 231 | 28.4% |

In the standardized survey tool administered by SPHA, 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 following table:

| Provider Satisfaction Questions | 2017 Percent Satisfied | 2018 Percent Satisfied | 2019 Percent Satisfied | 2019 Goal met | 2019 Goal |
|---|---|---|---|---|---|
| 4E: Please rate the timeliness of exchange of information/ communication/ reports from the behavioral health | 13.3% | 16.1% | 15.7% | No | 5% Improvement (16.9%) |
| 4F: How often do you receive verbal and/or written communication from behavioral health providers regarding your patients? | 25.4% | 24.1% | 31.3% | Yes | 5% Improvement (25.3%) |

Sunflower was unable to compare performance on the 2019 survey against a benchmark, as SPHA does not provide Medicaid Book of Business benchmarks for the two relevant questions since these are custom questions. The data representing the rate of providers who were satisfied is a combination of the top two responses from the survey questions.

The responses to the question of timeliness of exchange of information between practitioners showed a satisfaction rating of 15.7% in 2018 compared to 16.1% in 2017. This is a decrease of 0.4% percentage points from the 2018 rate, not reaching the goal of 5% improvement. There was, however, an increase of 7.2 percentage points in the satisfaction rate regarding providers receiving verbal and/or written communication from behavioral health providers, with a 2018 rate of 24.1% compared to 31.3% for 2019. Therefore, Sunflower met the goal of having a 5% increase.

Sunflower's goal for the 2020 provider satisfaction survey will again be to increase the satisfaction rating by 5 percent. Sunflower reviewed the individual survey responses from the 2017, 2018 and 2019 provider satisfaction surveys, which highlight the changes in practitioner satisfaction.

**Table 4 – Satisfaction table**

| Composite/Attribute | Response Options | 2017 | 2018 | 2019 |
|---|---|---|---|---|
| 4E: Please rate the timeliness of exchange of information/communication/reports from the behavioral health providers? | Excellent | 4.8% | 3.2% | 3.9% |
| | Very Good | 8.6% | 12.9% | 11.8% |
| | Good | 53.3% | 57.3% | 52.3% |
| | Fair | 22.9% | 17.7% | 23.5% |
| | Poor | 10.5% | 8.9% | 8.5% |
| | | (n=105) | (n=124) | (n=125) |
| 4E: How often do you receive verbal and/or written communication from behavioral health providers regarding your patients? | Always | 2.5% | 3.8% | 6.1% |
| | Usually | 23.0% | 20.3% | 25.1% |
| | Sometimes | 30.3% | 45.1% | 31.8% |
| | Rarely | 25.4% | 24.8% | 25.1% |
| | Never | 18.9% | 6.0% | 11.7% |

Question 4E looks at the timeliness of exchange of information from behavioral health providers, while 4F looks at the frequency of communication from the behavioral provider.

The number of respondents increased each year for question 4E, with 105 respondents in 2017, 124 respondents in 2018, and 125 respondents in 2019. For 4F, the number of respondents decreased in 2019, with 97 respondents compared to 122 respondents in 2017 to 133 respondents in 2018.

Sunflower identified some of same barriers as previously identified in past years' analysis due to the nature of these complex circumstances. The information being exchanged between the behavioral health provider and PCP often contains sensitive protected health information related to HIV/AIDS or substance abuse treatment and are not eligible for re-disclosure to the member's PCP unless the member provides specific written consent to release the information. Case managers and care coordinators address this with members during initial or ongoing outreach.

Case managers and care coordinators provide education to members regarding the importance of giving consent to allow the information to be shared with their PCP. However, obtaining consent from members has been difficult, resulting in a number of discharge assessments not being sent to practitioners. Many of the members who have a substance use diagnosis change phone numbers and addresses frequently or do not respond to case management outreach attempts, making it difficult to outreach to them in a timely fashion.

In order for providers to exchange information, they must be aware of the other providers with whom to exchange. While providers often rely on member disclosure to identify the other treating providers, if providers access the provider portal they may easily identify other providers. Ongoing provider education regarding the portal and exchange of information is an important aspect of Sunflower's approach.

Lack of a systematic approach to coordination between behavioral health and medical is an ongoing barrier. Utilizing a medical home may enhance provider exchange of information. Kansas Medicaid implemented a medical home program, called OneCare Kansas, on April 1, 2020. Members with severe bipolar disorder or paranoid schizophrenia qualify for this program. Sunflower encourages qualified members to participate in the program and Sunflower case management team coordinates with OneCare Kansas providers.

Sunflower identified the following barriers and opportunities regarding the exchange of information between medical and behavioral healthcare providers:

**Table 5 – Monitor 1 Barrier and Opportunity Table**

| Barrier | Opportunity | Selected for Improvement | Priority |
|---|---|---|---|
| Member knowledge deficit regarding importance of and process for providing consent to share treatment records that include HIV/AIDS or substance abuse treatment information | Member education regarding providing consent for information to be shared | Yes | 1 |

| | | | |
|---|---|---|---|
| Physicians are unaware their patients are seeing behavioral health clinicians and/or who the behavioral health providers are. Behavioral health clinicians may not be aware of who the PCP is | Provider education regarding how to find information about, and exchange information with, other treating providers | Yes | 2 |
| Lack of systematic approach to coordination between behavioral health and medical care | Introduce a medical home approach | Yes | 3 |

Most of the actions previously in place have continued. As identified last year, Sunflower still intends to develop a member brochure targeted at this population of members who have experienced mental health conditions and treatment may provide an additional educational avenue. The brochure will address the impact of mental health on all aspects of health, the importance of sharing contact information, the importance of sharing information with providers about any other providers from whom they receive treatment, and the importance of signing releases between those providers. However, the development was delayed due to some other pressing communications.

In addition to this action, Sunflower identified a couple of additional action plans to address several of the opportunities. In Q2 2020, Sunflower hired a dedicated provider communications and training specialist. Also in Q2, Sunflower participated in the implementation of the OneCare Kansas medical home program.

**<u>Monitor 2-</u> Appropriate Diagnosis, Treatment and Referral of Behavioral Disorders Commonly Seen in Primary Care**

Sunflower collects and analyzes data regarding appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care through assessment of the *Antidepressant Medication Management* (AMM) HEDIS measure. Sunflower monitors 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 members who remained on an antidepressant medication for at least 84 days (12 weeks).
- *Effective Continuation Phase Treatment* - the percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

| Antidepressant Medication Management (AMM) | | | | |
|---|---|---|---|---|
| **AMM Indicator** | **HEDIS 2018** | **HEDIS 2019** | **HEDIS 2020** | **Goal*** |
| **Effective Acute Phase Treatment** | 49.66% (876/1764) | 53.15% (945/1778) | 51.95% (1028/1979) | 53.65% |
| **Effective Continuation Phase Treatment** | 32.03% (565/176) | 34.14% (607/1778) | 37.44% (741/1979) | 38.37% |

**Quality Compass HEDIS 2020 Medicaid 50th percentile*

Sunflower's HEDIS 2020 rate for the *Effective Acute Phase Treatment* measure 51.95% did not meet the goal of reaching or exceeding the Quality Compass 50th percentile, 53.65%. There was a 1.2 percentage point decrease from the previous year's rate of 53.15%. While the *Effective Continuation Phase Treatment* rate increased from 34.14% the previous year to 37.44%, the rate was not sufficient to meet the goal of Quality Compass 50th percentile 38.37%.

The three-year trend for the *Effective Acute Phase Treatment* rate shows relatively consistent results. The highest rate was seen in HEDIS 2019 at 53.15%. The lowest rate was in HEDIS 2018 with a rate of 49.66%. The three-year trend for the *Effective Continuation Phase Treatment* rate shows a slight, steady increase from HEDIS 2018 through HEDIS 2020 (5.41 percentage points).

Sunflower offered Depression Disease Management (DM) to members with depression. Outreach was made to members identified with a diagnosis of depression to engage members in the DM program. Referrals were made by Sunflower staff. Adherence to treatment plans, including antidepressant medications, was a primary focus of the program. Many members received a depression diagnosis from a primary care physician. The DM program provided these members with education and support in locating needed services to treat and manage symptoms.

In May 2016, Sunflower began mailing education materials to members in the HEDIS AMM measure. Sunflower continued this initiative in 2019. The mailers were sent in the months of March and May. In Q4 2018, Sunflower began mailing letters to members who were non-compliant with their depression medication each month, and this has continued in 2019. The materials include information about common side effects and common uses for antidepressant medications. The materials also encourage members to remain compliant with the medication schedule given to them by their prescriber. Members were encouraged to keep all appointments and notify their prescriber if they had suicidal thoughts or concerns. Sunflower's contact information is provided in the materials. Provider Profiles are sent to prescribing providers which will include their AMM adherence metrics.

### Monitor 2- Appropriate Diagnosis, Treatment and Referral of Behavioral Disorders Commonly Seen in Primary Care – Barrier Analysis

**Table 7 – Monitor 2 Barrier and Opportunity Table**

| Barrier | Opportunity | Selected for Improvement | Priority |
|---|---|---|---|
| Maintaining staff knowledge on depression management treatment and best practices | All Behavioral Health Medical Management staff will participate in a Continuing Education course on diagnosis of depression and evidence-based practices for | Yes | 4 |
| Treating providers not familiar with the depression clinical practice guideline | Educate providers about Sunflower's adopted clinical practice guidelines, including the depression guideline | Yes | 3 |
| Member's knowledge deficit regarding the importance of adherence with antidepressant medication and ways to manage side effects | Targeted outreach to members with a depression diagnosis and recently prescribed/fill of a new antidepressant medication | Yes | 2 |
| Treating provider not aware the member is not consistently taking prescribed medication | Utilize pharmacy data to identify members who are non-adherent in filling prescriptions and provide written notice to prescribers to inform of member non-adherence | Yes | 1 |

**Monitor 3- Appropriate Use of Psychotropic Medications**

Sunflower Health Plan monitors the use of psychotropic medications by all Sunflower members. This is measured through the HEDIS measure called *Follow-up Care for Children Prescribed ADHD Medication- Initiation Phase (ADD).* The ADD-Initiation Phase measure looks at members 6-12 years of age who were diagnosed with ADHD and had one follow-up visit with a practitioner with prescribing authority within 30 days of their first prescription of ADHD medication. In 2020, Sunflower identified this measure to monitor for performance. The table below shows Sunflower's three-year trend along with the HEDIS 2020 goal. The goal identified for this measure is the Quality Compass 50th Percentile.

**Table 8 - ADD**

| Follow-up Care for Children Prescribed ADHD Medication (ADD) | | | | |
|---|---|---|---|---|
| **ADD Indicator** | **HEDIS 2018** | **HEDIS 2019** | **HEDIS 2020** | **Goal** |
| Initiation Phase Rate | 52.78% | 53.71% | 53.38% | 43.05% |

The HEDIS 2020 rate of 53.38% exceeded the HEDIS 2020 Quality Compass 50th percentile. The three-year trend demonstrates that the performance remains fairly stable, with 1.07 percentage point spread.

Sunflower Health Plan will assess the existing pharmacy interventions and determine if action adjustment to the interventions is required.

**Appropriate Use of Psychotropic Medications – Barrier Analysis**
As this is a new metric to monitor, the main barrier recognized at this point is lack of insight into as to the driver for the performance. Sunflower will continue to assess interventions and monitor performance.

**Table 9 – Monitor 3 Barrier and Opportunity Table**

| Barrier | Opportunity | Selected for Improvement | Priority |
|---|---|---|---|
| Lack of insight at Health Plan as to particular drivers of the performance. | Assess interventions and monitor performance. | Yes | 1 |

## Monitor 4- Management of Treatment Access and Follow-up for Members with Coexisting Medical and Behavioral Disorders

Diabetes is among the top 10 leading causes of death in the United States.[1] Persons with serious mental illness who use antipsychotics are at increased risk of diabetes, monitoring of these conditions is important. Lack of appropriate care for diabetes for people with schizophrenia who use antipsychotic medications can lead to worsening health and death. Addressing these physical health needs is an important way to improve health, quality of life and economic outcomes downstream.
Sunflower collects and analyzes data related to the coordination of special needs for members with serious and persistent mental illnesses through the use of *Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)* HEDIS measure. This measure assesses adults 18– 64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year. This metric was identified in 2020 to monitor performance and aligns with performance improvement project collaborative the Kansas Department of Health and Environment (KDHE). The table below shows Sunflower's baseline data on this measure:

**Table 10 - SMD**

| | Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) | | | |
|---|---|---|---|---|
| **SMD Indicator** | **HEDIS 2018** | **HEDIS 2019** | **HEDIS 2020** | **Goal** |
| Rate | 59.25% | 64.92% | 65.54% | 70.73%* |

**Quality Compass Medicaid 50th percentile for HEDIS 2020*

While the three-year trend shows continual improvement from 59.25% HEDIS 2018 to 65.54% HEDIS 2020, the rate falls short of the HEDIS 2020 Quality Compass goal of 70.73%.

Feedback from members have indicated that helpful reminders from their health plan about recommended preventive screenings are appreciated as some

members may lose track of timelines associated with those recommendations due to busy lifestyles or family obligations. Some of the members identified barriers in getting a prompt appointment.

The initial interventions identified this first year that Sunflower is monitoring this metric specifically for performance improvement opportunities include:

1. Warm outreach calls to members. Sunflower Case Management Staff will make outreach calls to members who have not completed an LDL-C test and a HbA1c test according to the SMD measure specifications. Monthly lists of these members will be pulled and filtered for the distribution to those Case Managers and Medical Management employees making outreach calls.

2. Sunflower will provide CMHCs and PCPs with reports that include the member's compliance status with the SMD measure.

3. Co-branded letters. Sunflower will partner with willing PCP/CMHC offices to offer co-branded member facing letters to encourage members to complete their recommended.

**<u>Monitor 4-</u> Management of Treatment Access and Follow-up for Members with Coexisting Medical and Behavioral Disorders – Barrier Analysis**

**Table 11 – Monitor 4 Barrier and Opportunity Table**

| Barrier | Opportunity | Selected for Improvement | Priority |
|---|---|---|---|
| Members lose track of timeliness of follow-up tests. | Provide prompts for members. | Yes | 1 |

| Barrier | Opportunity | Selected for Improvement | Priority |
|---|---|---|---|
| Providers may need assistance in tracking and following-up with members who are due for tests. | Provide tools to providers to assist with tracking and outreaching to target members. | Yes | 2 |

**<u>Monitor 5-</u> Primary or Secondary Preventive Behavioral Healthcare Program**

Continued opioid use for non-cancer pain is associated with increased risk of opioid use disorder, opioid-related overdose, hospitalization and opioid overdose-related mortality. Sunflower monitors members who are at risk of developing opioid use disorder, specifically using the metric Risk of Continued Opioid Use (COU). This measure assesses members with a new episode of opioid use who are dispensed opioids for a period of time (15+ days

or 31+ days) that puts them at an increased risk of continued use. This is an inverse metric, meaning the lower the percentage, the more desirable.

Sunflower's goal is to support education of members and providers, and screenings of members at risk of continued opioid use, to reduce the risk of opioid use disorders.

Sunflower provides a preventive behavioral health program targeting members at risk for opioid misuse and opioid use disorder. This goal of the program, called OpiEnd, is to identify members at high risk of opioid misuse and enroll them in a case management program that includes assessment of the member's medical and psychosocial status, assess pain rating, evaluation functional status and social support, monitor prescription fills, and collaborate with provider regarding appropriateness of medication assisted treatment (MAT). While the structure of this program has been in place, active referrals to the program had subsided.

In Q3 2020, the program was revitalized, the work process was revised and identification and interventions were enhanced. Sunflower hopes to see increased utilization of this more robust program starting Q4 2020.

Sunflower has implemented integrated rounds where discussions regarding members who may at risk of continued opioid use may be identified and reviewed to identify interventions.

Additionally, Sunflower's shared service pharmacy partners are piloting a Psychotropic Medication Utilization Review (PMUR) initiative for Opioid Use. The initiative is still in planning phases, so Sunflower will monitor the progression and assess the potential to leverage this pilot.

The table below demonstrates Sunflower's baseline performance on COU metric for HEDIS 2020:

**Table 12 - COU**

| Risk of Continue Opioid Use-15+ and 31+ | | |
|---|---|---|
| **COU Indicator** | **HEDIS 2020** | **Goal** |
| Total 15 | 6.55% (404/6164) | Baseline |
| Total 31 | 4.64% (286/6164) | Baseline |

The following barriers and opportunities were identified regarding management of members with coexisting medical and behavioral health disorders.

**<u>Monitor 5-</u> Primary or Secondary Preventive Behavioral Healthcare Program Implementation – Barrier Analysis**

**Table 13 – Monitor 5 Barrier and Opportunity Table**

| Barrier | Opportunity | Selected for Improvement | Priority |
|---|---|---|---|
| Lack of robust program to identify and outreach to at-risk members | Build more robust protocols for identification of and outreach to at-risk members | Yes | 1 |

## Monitor 6- Coordinating Special Needs of Members with Serious & Persistent Mental Illness

Sunflower collects and analyzes data related to the coordination of special needs for members with serious and persistent mental illnesses through the use of the Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) HEDIS measure. This measure looks at members 1-17 years of age who have received two or more antipsychotic prescriptions during the calendar year. APM measures how many of these members have had metabolic testing. To meet measure requirements a member must have had a glucose test or HbA1c and a test for LDL-C or cholesterol. The table below shows Sunflower's three year trend on this measure along with the HEDIS 2019 goal. The goal for measurement year 2018 is to maintain or exceed Quality Compass 75$^{th}$ percentile benchmark.

**Table 14 - APM**

| Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) | | | | |
|---|---|---|---|---|
| **APM Indicator** | **HEDIS 2018** | **HEDIS 2019** | **HEDIS 2020** | **Goal** |
| Blood Glucose and Cholesterol Total Rate | 47.18% (954/2022) | 48.91% (921/1883) | 46.29% (986/2130) | 35.49%* |

**Quality Compass 50$^{th}$ Percentile HEDIS 2020*

The HEDIS 2020 total rate for glucose and cholesterol testing decreased 2.62 percentage points from the previous year, from 48.91% to 46.29%. The denominator was the largest over the three-year period at 2,130, which would impact the rate. Despite the decrease, the goal of meeting the Quality Compass 50$^{th}$ percentile was met.

While Sunflower is performing well on this measure, the goal is to continue to maintain high performance. Sunflower case management staff review all cases referred to them for care alerts within Sunflower's medical records system. Sunflower's Impact Pro and Interpreta systems provide the case management staff with a care alert for members who fall within the APM measure and need metabolic monitoring. Case management staff use this information to guide discussions with members/guardians about care needs the member may have. This discussion includes the member's ability to access available services. If there are any barriers, the case management staff will provide support to the member in researching options to overcoming those barriers. The case management team can provide ongoing coordination and communication to members/guardians and providers.

**Table 15 – Monitor 6 Barrier and Opportunity Table**

| Barrier | Opportunity | Selected for Improvement | Priority |
|---|---|---|---|
| Low member understanding about the importance of having regular screenings while on antipsychotic medications | Review of member predictive modeling report to educate identified members | Yes | 1 |
| Prescribers not aware of status of diabetic screenings for youth on antipsychotics | Provider education on using the portal to determine care gaps | Yes | 2 |
| Lack of coordination/ communication between physical health and behavioral health providers | Provider education about importance of coordination/communication between physical health and | No | N/A |

Sunflower case management staff review all cases referred to them for care alerts within Sunflower's medical records system. Sunflower's Impact Pro and Interpreta systems provide the case management staff with a care alert for members who fall within the SMD measure and need monitoring.

Case management staff use the information to guide discussions with members/guardians about care needs the member may have. This discussion includes the member's ability to access available services. If there are any barriers, the case management staff will provide support to the member in researching options to overcoming those barriers. The case management team can provide ongoing coordination and communication to members/guardians and providers.

**Continuity and Coordination of Care between Medical and Behavioral Healthcare 2020 Analysis – Actions**

**Table 16 – Comprehensive Actions table**

| Monitor | Barrier Addressed | Action | Date Initiated |
|---|---|---|---|
| | Physicians are unaware their patients are seeing behavioral health clinicians and/or who the behavioral health providers are. Behavioral health clinicians may not be aware of who the PCP is. | Provider relations conduct targeted education on using the portal to gather information about other providers | Q1 2019 (Ongoing) |
| | | Dedicated Provider Engagement Training Specialist Hire | Q2 2020 |

| | | | |
|---|---|---|---|
| **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 | Member education regarding importance of sharing information between providers | Q1 2016 (Ongoing) |
| | | Plan CMs to provide coordination for members to obtain specific releases of information | Q1 2016 (Ongoing) |
| | | Develop member brochure to explain the importance of sharing information between providers | Q4 2020 |
| | Lack of systematic approach to coordination between behavioral health and medical care | Implement OneCare Kansas medical home model | Q2 2020 |
| **Appropriate Diagnosis, Treatment, and Referral of BH Disorders Commonly Seen in Primary Care** | Member's knowledge deficit regarding importance of adherence with antidepressant medication and ways | Send mailer to newly identified members of the AMM HEDIS measure with information regarding tips, good habits and side effects related to the taking of antidepressant medications | Q2 2016 (Ongoing) |
| | Treating providers not familiar with the depression clinical practice guideline | Provider newsletter to include article with information regarding depression management | Q2 2017 (Ongoing) |
| | | Dedicated Provider Engagement Training Specialist hired | Q2 2020 |
| | Maintaining staff knowledge of depression management treatment and best practices | All Medical Management staff will participate in a Continuing Education course on the diagnosis of depression and evidence-based practices for depression | Q1 2019 (Annually) |
| | Treating provider not aware the member is not consistently taking prescribed medication | Send provider profiles to prescribing providers | Q1 2019 |
| | | Send list of non-compliant members to their health departments | Q4 2019 |
| **Appropriate Use of Psychotropic Medications** | Lack of insight at Health Plan as to particular drivers of the performance | Assess existing interventions and monitor performance to determine what adjustments to interventions are needed. | Q4 2020 |

| | | | |
|---|---|---|---|
| **Management of Treatment Access and Follow-up for Members with Coexisting Medical and Behavioral Disorders** | Members lose track of timeliness of follow-up tests. | Sunflower Case Management Staff will make outreach calls to members who have not completed an LDL-C test and a HbA1c test | Q2 2020 |
| | Providers may need assistance in tracking and following-up with members who are due for tests. | Sunflower will provide CMHCs and PCPs with reports that include the member's compliance status with the SMD measure. | Q2 2020 |
| | | Co-branded letters. Sunflower will partner with willing PCP/CMHC offices to offer co-branded member facing letters to encourage members to complete | Q2 2020 |
| **Primary or Secondary Preventive Behavioral Healthcare Program** | Lack of robust program to identify and outreach to at-risk members | Revitalizing utilization of the OpiEnd program; with revised work processes, staff training, and enhanced outreach | Q4 2020 |
| | | Implementation of Integrated Rounds | Q2 2020 |
| **Special Needs of Members with Serious & Persistent Mental Illness** | Low member understanding of the importance of having regular screenings while on antipsychotic medications | Review of predictive modeling report for all members who have been referred to the CM team | Q1 2017 (Ongoing) |
| | | CM outreach and education to the member regarding regular antipsychotic medication | Q1 2017 |
| | Prescribers not aware of status of diabetic testing | Enhanced education of providers regarding using the portal to determine care gaps | Q1 2019 |

## Utilization Management (UM) Program Evaluation- 2020

The purpose of the Utilization Management (UM) Program 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.

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, care 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.

## Program Overview

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 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, through the QIC, on an annual basis.

The Plan Medical Directors have operational responsibility for and provide support to the Plan's UM Program. The Medical Directors, 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, quality improvement, review activities pertaining to utilization review, 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 appropriate specialists are involved in the implementation, monitoring and directing of specialty health aspects of the UM program. A pharmacist oversees the implementation, monitoring and directing of pharmacy services.

The 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
- Assures that the Medical Necessity criteria are applied in a consistent manner
- Assures that reviews of cases that do not meet Medical Necessity criteria are conducted by appropriate physicians in a manner that meets all pertinent statutes and regulations and takes into consideration the individual needs of the involved members
- Reviews, approves, and signs denial letters for cases that do not meet Medical Necessity criteria after appropriate review has occurred in accordance with Plan policy
- Assures the Medical Necessity appeal process is carried out in a manner that meets all applicable contractual requirements, as well as all federal and state statutes and regulations, is consistent with all applicable accreditation standards, and is done in a consistent and efficient manner
- Provides a point of contact for practitioners calling with questions about the UM process
- Communicates/consults with practitioners in the field as necessary to discuss UM issues
- Coordinates and oversees the delegation of UM activity as appropriate and monitoring that delegated arrangement meets all applicable contractual requirements and accreditation standards

- Assures there is appropriate integration of physical and behavioral health services for all Plan members
- Participates in and provides oversight to the UM committee and all other physician committees or subcommittees
- Recommends and helps to monitor corrective action as appropriate for practitioners with identified deficiencies related to UM
- Reports UM activities to the QIC as needed

**Utilization Management Committee (UMC)**

Routine and consistent oversight and operating authority of utilization management activities is delegated to the UMC, which reports to the Plan's QIC and ultimately to the Plan BOD. The UMC is responsible for the review and appropriate approval of medical necessity criteria and protocols and utilization management policies and procedures. The UMC coordinates annual review and revision of the UM Program Description, Work Plan, and the Annual UM Program Evaluation.

These documents are presented to the QIC and/or BOD for approval. The UMC monitors and analyzes relevant data to detect and correct patterns of potential or actual inappropriate under or over utilization, which may impact health care services, coordination of care and appropriate use of services and resources, as well as member and practitioner experience with the UM process. Analysis of the above tracking and monitoring processes, as well as status of corrective action plans, as applicable, are reported to the Plan's QIC.

## UM Committee Members

The Plan actively involves participating network practitioners in utilization review activities as available and to the extent that there is not a conflict of interest. The Plan's UM Program Description and policies define when such a conflict may exist and describe the remedy when conflicts occur. Participation in the Plan's UMC is one of the primary ways in which network practitioners participate in Plan utilization review activities.

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

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

**UMC Meeting Frequency and Documentation of Proceedings**

The UMC meets at least four (4) times per year and the VPMM maintains detailed records of all UMC meeting minutes, UM activities, care management program statistics and recommendations for UM improvement activities made by the UMC. In 2020, the UMC met on February 7, April 23, August 6, and November 20, with an ad hoc meeting on June 12. The UMC submits to the QIC meeting minutes and reports on UM studies and activities.

## Utilization Management Process

The utilization management process encompasses the following program components: 24-hr nurse triage, referrals, second opinions, prior authorization, pre-certification, concurrent review, ambulatory review, retrospective review, discharge planning and care coordination. All approved services, both medical and behavioral, must be medically necessary. The clinical decision process begins when a request for authorization of service is received at the Plan level. Request types may include authorization of specialty services, HCBS services, second opinions, outpatient services, ancillary services, behavioral health services, scheduled inpatient services, or emergent/urgent inpatient services, including obstetrical deliveries. The process is complete when the requesting practitioner and member (when applicable) have been notified of the determination.

## Scope of the UM Program

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.

## Compliance Program Description-Program Integrity

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 care 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 Sunflower and UM staff and the practitioner or facility staff is also vital to the re-credentialing process. Such information may relate, for example, to specific care 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 works 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

**Delegation of UM Activities**

The Plan will delegate various UM activities to entities that demonstrate the ability to meet the Plan's UM standards and standards for delegation, as outlined in the UM plan and policies and procedures. The Plan conducts ongoing oversight and annual review of each delegate's UM program as outlined in the Oversight of Delegated UM policy. Delegation is dependent upon the following factors:

- A pre-delegation review is necessary to determine the ability to accept delegation.
- Once the delegate is determined to be capable of fulfilling the responsibilities of delegation, a Delegation Agreement is executed with the organization to which the UM activities have been delegated, clarifying the responsibilities of the delegated group and the Plan. This agreement will specify the reporting requirements, and the standards of performance to which the contracted group has agreed.
- The delegated group must conform to the Plan's UM standards; including timeframes outlined in the Plan's policy and procedure Timeliness of UM Decisions and Notifications.
- The delegated group is responsible for providing the Plan with a written UM Program Description/Plan for annual review and approval by the Plan's QIC.
- The delegated group is responsible for submitting utilization reports, to include monthly utilization summaries, high cost days, and quality assurance/improvement issues.

The Plan retains accountability for any functions and services delegated and, as such, will monitor the performance of the delegated entity through the following vehicles:

- Annual approval of the delegate's UM program (or portions of the program that are delegated), as well as any significant program changes that occur in between
- Routine reporting of key performance metrics that are required and/or developed by Plan's Chief Medical Director, and the Utilization Management Committee
- Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to Plan standards and state program requirements

In the instance where the delegate is NCQA Accredited, the Plan may assume that the delegate is carrying out responsibilities in accordance with NCQA standards and revise the annual audit or evaluation, per state or CMS contract requirements. At the time of pre-delegation the Plan must evaluate the compatibility of the delegate's UM Program with the Plan's UM Program. Once delegation is approved, the Plan will require that the delegate provide the appropriate

reports as determined by the Plan to monitor the delegate's continued compliance with the needs of the Plan. The Plan will annually review the delegate's ongoing accreditation status.

The Plan has delegated UM activities to the following subcontractors:

- Envolve Vision Solutions: Vision Services
- Envolve Dental Solutions: Dental Services
- Envolve Pharmacy Solutions: Pharmacy Services
- National Imaging Associates (NIA): High Tech Imaging & Therapy to include PT, OT, ST

**Delegation to NIA for Therapy (PT, OT, & ST)**

**Physical Medicine Program**

To help ensure that physical medicine services (physical, occupational and speech therapy) provided to our members are consistent with nationally recognized clinical guidelines, Sunflower Health Plan partnered with National Imaging Associates, Inc. (NIA) to implement a prior authorization program for physical medicine services. Effective May 1, 2020, NIA provides utilization management services for outpatient physical, occupational and speech therapy services on behalf of Sunflower Health Plan (Medicaid) members.

**How the Program Works**

Outpatient physical, occupational and speech therapy requests are reviewed by NIA's peer consultants to determine whether the services meet policy criteria for medically necessary and appropriate care. The medical necessity determinations are based on a review of objective, contemporaneous, and clearly documented clinical records that may be requested to help support the appropriateness of care. Clinical review helps determine whether such services are both medically necessary and eligible for coverage. Although prior authorization for the therapy evaluation alone is not required, additional services provided at the time of the evaluation and for any ongoing care is required through NIA. There is no need to send patient records in advance. NIA will contact the provider via phone and fax if additional clinical information is needed to complete the request. If the clinical documentation fails to establish that care is medically necessary, is not received, or is not received in an appropriate amount of time, it may result in non-certification of the authorization request.

**Delegation to Turning Point for musculoskeletal services**

Sunflower Health Plan partnered with Turning Point to implement a prior authorization program for musculoskeletal services. Effective May 1, 2020, Turning Point provides utilization management services for various musculoskeletal services including outpatient and surgical services.

**How the Program Works**

Requests for musculoskeletal services are directed to Turning Point for medical necessity review and determination. Turning Point completes the initial review, and medical director review, including any denials if medical necessity is not met. Any appeals following initial denial are handled by Sunflower Health Plan appeals team and medical director review.

## Utilization Management Measures and Outcomes

**Medical Necessity Criteria**
The goal in utilization management is to help guide best practice medicine in the most efficient and economical manner while addressing patient-specific needs. To that end, the clinical decision criteria utilized aligns the interests of the health plan, the practitioner, and the member. The UM criteria are nationally recognized, evidence-based standards of care and include input from recognized medical experts. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate. Utilization review criteria are utilized as an objective screening guide and are not intended to be a substitute for physician judgment.

Utilization review decisions are made in accordance with currently accepted medical or behavioral health care practices, while taking into consideration the individual member needs and complications at the time of the request, in addition to the local delivery system available for care. The Medical Director reviews all potential medical necessity denials for medical appropriateness and is the only one with authority to implement an adverse determination which results in reduction, suspension, denial, or termination of services.

In general, Sunflower uses McKesson's InterQual guidelines to determine medical necessity and appropriateness of physical and behavioral health care. InterQual is a recognized leader in development of clinical decision support tools, and is used by 3000 organizations and agencies to assist in managing health care for more than 100 million people. InterQual is developed by generalist and specialist physicians representing a national panel from academic, as well as community based practice, both within and outside the managed care industry. InterQual provides a clear, consistent, evidence-based platform for care decisions that promote appropriate use of services, enhance quality, and improve health outcomes.

Sunflower utilizes InterQual Criteria for behavioral health inpatient, residential/PRTF, partial hospitalization, intensive outpatient and outpatient therapy services. Sunflower may also use ASAM criteria for substance abuse. For determination of the community based services for behavioral health, Sunflower uses InterQual and developed medical necessity criteria based on the service description as needed; this criteria is submitted and approved by the state and with network practitioner input as appropriate. InterQual guidelines are updated annually which includes training and successful testing by all staff who utilize InterQual criteria in determining medical necessity as noted in the IRR section.

**Timeliness of Decision Making**
Utilization management decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care.

Established timelines are in place for practitioners to notify Sunflower of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner.

For all pre-scheduled services requiring prior authorization, the provider must notify Sunflower within five (5) days prior to the requested service date. Prior authorization is never required for emergent or urgent care services. Facilities are required to notify Sunflower of all inpatient admissions and long-term care facility admissions within one (1) business day following the admission. Once the member's emergency medical condition is stabilized, certification for urgent or emergent hospital admission or authorization for follow-up care is required as stated above.

Sunflower Health Plan makes determinations for standard, non-urgent, pre-service prior authorization requests within 14 calendar days of receipt of the request. A determination for urgent pre-service care (expedited prior authorization) will be issued within 72 hours of receiving the request for service. Sunflower will make determinations for urgent concurrent, expedited continued stay and/or post stabilization review within 24 hours of receipt of the request for services, unless an extension is allowed in accordance with NCQA standards, not to exceed a total of 72 hours from receipt of the request. A request made while a member is in the process of receiving care is considered to be an urgent concurrent request if the care requested meets the definition of urgent, even if the earlier care was not previously approved by Sunflower. If the request does not meet the definition of urgent care, the request may be handled as a new request and decided within the time frame appropriate for the type of decision (i.e., pre-service and post-service). Medical necessity of post-service decisions (retrospective review) will be limited to special circumstances and subsequent member/practitioner notification will occur no later than 30 calendar days from receipt of request.

**Medical**

| TAT | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Year |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 72 hr | 100% | 100% | 100.0% | 100.0% | 100.0% | 99.9% | 99.9% | 99.9% | 99.9% | 99.9% | 100% | 100.0% | 100% |
| 14 day | 99% | 99% | 99.0% | 99.0% | 99.0% | 99.4% | 99.4% | 99.4% | 99.1% | 98.8% | 99% | 99.0% | 99% |

Pharmacy for Medicaid has a 24 hour turn-around time. The health plan specifically manages bio-pharmacy.

**Pharmacy**

| Pharmacy TAT | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Received | 594 | 571 | 589 | 506 | 432 | 523 | 586 | 555 | 547 | 618 | 510 | 624 | 6655 |
| Initial PA requests | 11 | 7 | 2 | 5 | 3 | 1 | 3 | 4 | 4 | 4 | 4 | 1 | 49 |
| | | | | | | | | | | | | Avg | 99.26% |

Sunflower met the goal of 98% turn-around time for both 72 hour (100%) and 14 day (99%) turn-around time for medical authorizations. The goal was met for pharmacy TAT (99.26%). Sunflower continues to review prior authorizations to determine if there are any authorization requirements that could be eliminated. Sunflower is also researching technological solutions such as automation and bots to assist with administrative tasks to free up more staff time for processing authorization requests. Sunflower uses two delegated vendors, NIA for PT/OT/ST and Turning Point for musculoskeletal services. Sunflower continues to monitor and assess the potential benefits or costs of vendors for impact on overall performance.

**Denials**

| Denials | Inpatient | Outpatient | HCBS | Pharmacy (bio-pharm) |
|---|---|---|---|---|
| **Denied** | 1,235 | 5,219 | 28 | 2,205 |
| **% Denied** | 4.97% | 20.30% | 0.01% | 33.27% |
| **Approved** | 23,623 | 20,493 | 297,343 | 4,422 |
| **% Approved** | 95.03% | 79.70% | 99.99% | 66.73% |
| **Total** | 24,858 | 25,712 | 297,371 | 6,627 |

The greatest denial rate was for pharmacy at 33.27%, followed by outpatient at 20.30%, then inpatient at 4.97%. HCBS has the lowest denial rate at 0.01%, as the process for authorization includes member and provider engagement at the time the person-centered plan is developed. Sunflower monitors denial rates for outlier data to determine the need for process improvement or internal or external education. Sunflower pharmacy team has assessed that most denials are because the request lacks all the necessary components of information for an approval. Therefore, Sunflower is working on implementing medication-specific forms that list all of the required components for each medication to avoid the denial and appeal process.

**Appeals**

| Appeals | Pharmacy | Other |
|---|---|---|
| **Upheld** | 39 | 268 |
| **% Upheld** | 27.66% | 50.00% |
| **Overturned** | 102 | 268 |
| **% Overturned** | 72.34% | 50.00% |
| **Total** | 141 | 536 |

Pharmacy experienced a higher overturn rate for appeals at 72.34% than other appeal types at 50.00%. Most appeals are overturned because more information is provided upon appeal than upon request for services. As mentioned, Sunflower is in the process of implementing medication-specific forms in hopes of avoiding the need for the appeal process.

**New Technology Assessment**

In instances of determining benefit coverage and medical necessity of new and emerging technologies and the new application of existing technologies or application of technologies for which no InterQual Criteria exists, the Medical Director shall first consult Centene's available Medical Policy Statements. The Centene Clinical Policy Committee, with representation from Sunflower and Centene Health Plans, develops these statements. The Corporate Clinical Policy Committee (CPC) is responsible for evaluating new technologies or new applications of existing technologies for inclusion in the benefit plan. The CPC shall develop, disseminate and annually update medical policies related to: medical procedures, behavioral health procedures, pharmaceuticals and devices. The CPC or assigned designee shall review appropriate information to make the coverage decision including published scientific evidence, applicable government regulatory body information, CMS's National Coverage Decisions database/manual and input from relevant specialists and professionals who have expertise in the technology. Practitioners are notified in writing through the provider newsletters and the practitioner web portal of new technology determinations made by Sunflower. As with standard UM criteria, the treating practitioner may, at any time, request the medical policy criteria pertinent to a specific authorization by contacting the Medical Management Department or may discuss the UM decision with the Medical Director.

**Member and Practitioner Satisfaction with UM**

**Grievances related to UM**

Grievances received by Sunflower members were also reviewed as they relate to the UM Program satisfaction. Review of 2020 member grievances/complaints revealed that there were no grievances regarding the utilization management program or care management process.

| UM Member Grievances | Grievance Rate | Goal | Goal Met |
|---|---|---|---|
| **UM Related Member Grievances** | 6 | <5:100 | Yes |
| **% UM Member Grievances / Total Member Grievances** | 1.10:100 | | |
| **Total Member Grievances** | 546 | | |

Sunflower met the goal of less 5 of 100 grievances related to UM at the rate of 1.10:100. Sunflower continues to educate members on how to file a grievance.

**Member Experience with UM**

Sunflower annually monitors member experience with UM thorough analysis of relevant CAHPS® survey question results. These results, barriers and action plan are fully described in the separate report "Member and Practitioner Experience with UM", however summarized here. The table below reflects the baseline Medicaid CAHPS Survey Results for 2019:

| Composite & Question Ratings | 2019 Rate | 2020 Rate |
|---|---|---|
| Access to Care | 53% | 74% |
| Q23: Easy to get care believed necessary | 55% | 77% |
| Q39: Easy to get appointment with specialist | 41% | 67% |
| Q: Getting care as soon as needed | 59% | 77% |
| Q21: Getting appointment as soon as needed | 56% | 76% |

2019 was the initial CAHPS survey for Sunflower's Medicaid plan. 2019 Ratings establish a baseline for improvement efforts. The composite rating for Access to Care increased from 53% in 2019 to 74% in 2020, with improvement of 18 percentage points or more for each question. Along with the CAHPS survey results, Sunflower also looked at UM denials and appeals data to assess member experience with the UM process.

The interventions determined to make an impact in improving upon the identified barriers are noted below:

- Educate members on minimum data elements needed for clinical review prior to submitting a prior authorization.
- Member education regarding UM process and how decisions about care are made.
- Determine if specific network gaps exist and increase contracting efforts in those geographic areas for specific specialty types through analysis of request for and utilization of out-of-network providers.
- Member and provider education regarding the PDL and medication prior authorization requirements.
- Member education on how to find participating providers for the levels of care that are needed.
- Provider education regarding standards for timeliness of appointments.
- Increase member knowledge of standard/expected timeframes and resources on how to obtain an appointment.
- Educating members on available resources for urgent care/after-hours providers who can meet their needs on a more immediate basis versus using the emergency room.
- Enhance internal work processes to streamline UM/CM processes to meet the member's needs timely.

**Provider Experience with UM**

Sunflower monitors practitioner experience with the UM process on an ongoing basis through internal quality monitoring, and annually through analysis of relevant questions on the practitioner satisfaction survey. Below are goals for evaluation of provider experience as well as select initiatives tied to increasing the provider experience:

| Topic | Measurement | Goal |
|---|---|---|
| Provider satisfaction survey overall satisfaction with UM* | 5% improvement over 2018 result on overall composite for Utilization and Quality Management, as well as each question area. | Pharmacy goal met. Composite result increase from 21.0 in 2019 to 23 in 2020. Goal not met for UM/Quality, composite result increase from 32.2% in 2019 to 33% in 2020. |

Provider satisfaction rates are seen in the following table, and are inclusive of all products.

| Composite & Key Questions | 2018 Summary Rate | 2019 Summary Rate | 2020 Summary Rate | Goal Achieved |
|---|---|---|---|---|
| Utilization & Quality Management | 28.7% | 32.2% | 33% | No |
| 3A. Access to knowledgeable UM staff. | 30.1% | 32.4% | 30% | No |
| 3B. Procedures for obtaining pre-certification/ referral/ authorization information. | 26.2% | 27.8% | 30% | Yes |
| 3C. Timeliness of obtaining precertification/referral/authorization information. | 22.5% | 27.1% | 29% | Yes |
| 3D. The health plan's facilitation/support of appropriate clinical care for patients. | 27.0% | 29.0% | 30% | No |

| | | | | |
|---|---|---|---|---|
| 3E. Access to Case/Care Managers from this health plan. | 31.6% | 32.6% | 35% | Yes |
| 3F. Degree to which the plan covers and encourages preventive care and wellness. | 34.9% | 44.1% | 33% ↓ | No |
| 3G. Extent to which UM staff share review criteria and reasons for adverse determinations. | 22.6% | 28.0% | 26% | No |
| 3H. Consistency of review decisions. | 23.6% | 29.1% | 26% | No |
| Pharmacy | 13.1% | 21.0% | 23% | Yes |
| 5A. Consistency of the formulary over time. | 12.8% | 20.0% | 25% | Yes |
| 5B. Extent to which formulary reflects current standards of care. | 14.4% | 21.6% | 27% | Yes |
| 5C. Variety of branded drugs on the formulary. | 12.5% | 20.8% | 21% | No |
| 5D. Ease of prescribing your preferred medications within formulary guidelines. | 14.6% | 22.0% | 21% | No |
| 5E. Availability of comparable drugs to substitute those not included in the formulary. | 11.4% | 20.6% | 21% | No |

Sunflower continues to experience a year over year increase in the overall provider satisfaction rate related to Utilization and Quality Management, as well as the overall score for Pharmacy. The goal of 5% improvement in each area was achieved for both Utilization & Quality Management and Pharmacy. However, some specific questions did not meet the 5% increase, and some scores dropped. Notably, question 3F: Degree to which the plan covers and encourages preventive care and wellness, is significantly lower in 2020 at 33% compared to 44.1% in 2019.

Sunflower identified the following interventions as opportunities that could help improve the provider experience survey results based on these results and feedback:

- Educate providers on the UM process, request forms, medical necessity criteria, and how to contact UM staff.
- Provider education regarding the array of resources available on the provider website including the prior authorization checker and the provider manual.
- Enhance the provider portal to increase usability.
- Educate providers on minimum data elements needed for clinical review prior to submitting a prior authorization.
- Continue review of PA list and processes at least biannually to determine if there are items that can be removed from the list to reduce provider burden.
- Educate providers on the need for complete clinical information to make a timely decision, so member care is not delayed.
- Member and provider education regarding the PDL and medication prior authorization requirements.
- Enhance training of UM staff for interrater reliability.
- Educate providers on our new appeal and reconsideration link on our website.

**Provider Grievances related to UM**

Grievances received by Sunflower providers were also reviewed as they relate to Utilization Management satisfaction. Review of 2019 provider grievance data reveals that there were no provider grievances regarding Sunflower's Medicaid Utilization Management. Sunflower will continue to monitor provider grievances in an ongoing manner and identify any trends or opportunities for improvement in UM practices identified through provider grievance data.

| UM Provider Grievances | Grievance Rate | Goal | Goal Met |
|---|---|---|---|
| **UM Related Provider Grievances** | 6 | <25/100 | Yes |
| **% UM Provider Grievances / Total Provider Grievances** | 8.00% | | |
| **Total Provider Grievances** | 75 | | |

The goal for provider grievances related to UM is less than 25 of every 100 grievances. Six (6) of the 75 provider grievances in 2020 were related to UM. Sunflower continues to educate providers on how to file grievances.

**ER Utilization**

Sunflower Health Plan recognizes that the over use of the emergency department leads to poor coordination with the primary care physician and erratic follow-up, poor preventative care, and medication errors. Sunflower Health Plan monitors movement from the acute care setting to ensure members have appropriate access to needed follow-up care, home care services and medication with the goal of preventing secondary health conditions or complications, re-institutionalization, re-hospitalization or unnecessary emergency room use.

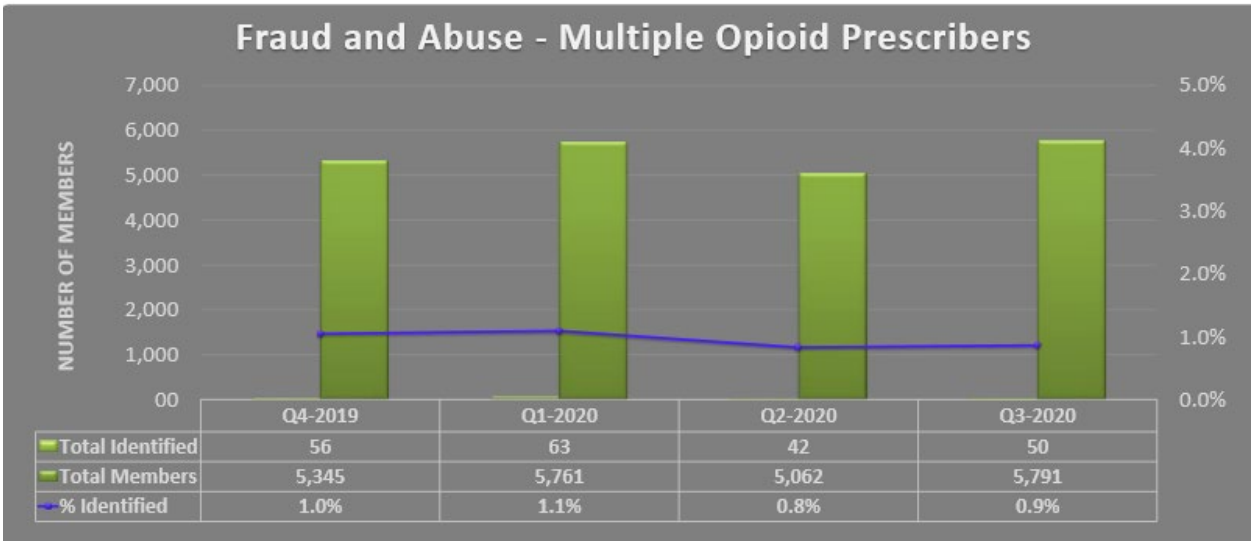
Sunflower's strategies including review of monthly reports of member using the ED, triaging that list for referrals to Disease Management or Case Management, and sending education flyers to members.

| ED Utilization Ages: 18 + | 2019 | 2020 | Goal |
|---|---|---|---|
| **Observed ED Visits** | 29,364 | 17,764 | 4% reduction |
| **Members** | 26,917 | 33,778 | |
| **Observed ED Visits per 1,000 Members** | 1090.91 | 525.90 | |

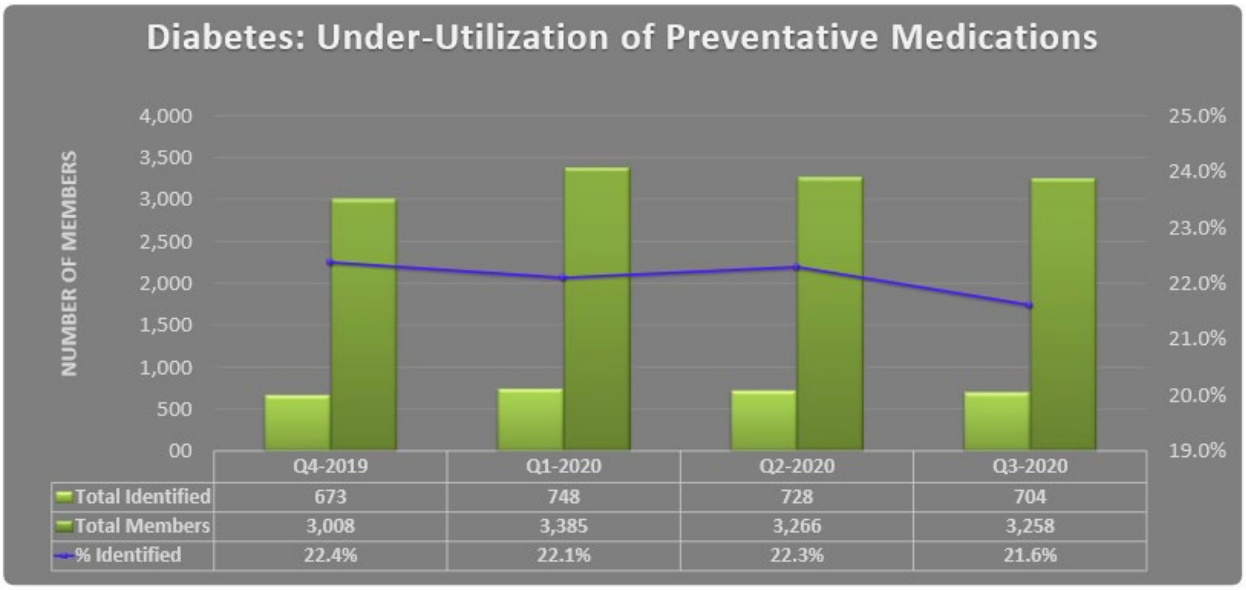
Sunflower experienced a dramatic decrease in ED utilization from 1090.91 per 1000 in 2019 to 525.90 in 1000 in 2020. That is a 51% decrease, far exceeding the goal of 4% reduction.

**Pharmaceutical Management**

Sunflower Health Plan's has a robust pharmacy program including drug utilization review to promote better health outcomes and patient safety. Among the drugs reviewed are opioids and diabetes medications.




Recommendations: During Q3 2020, there were 50 (less than 1%) members identified as having used three or more prescribers to obtain opioid analgesics. Although this may be appropriate if all of the prescribers are in the same practice, the use of a single prescriber is recommended to prevent over-prescribing and to streamline the medication regimen. Typically, spikes at certain times of the year are not uncommon and may be explained by occurrences of member travel/outpatient procedures/etc., such as during the summer and winter months.




Recommendations: During Q3 2020, there were 704 (21.6%) members inferred diabetic that were not using preventative medications with an angiotensin-converting enzyme (ACE) inhibitor or an angiotensin receptor blocker (ARB) medication.

Additional follow-up and physician outreach is recommended for all members identified but specifically for the 307 members that were identified every month of the quarter. Please refer to your Intervention Package for details on the chronic members.

**Inter-Rater Reliability**
The purpose of inter-rater reliability is to evaluate the consistency with which utilization management (UM) staff involved in the UM process apply InterQual criteria in decision-making. Sunflower's goal is for 100% of Sunflower's UM and Appeals staff to pass all applicable IRR tests with a score of 90% or higher. At least annually, Sunflower will conduct IRR tests as distributed by the Corporate Medical Management Department. All UM and Appeals staff must reach a final passing score (there are two allowed attempts). All staff that fail an IRR subset initially go through InterQual retraining for that subset before re-taking the IRR.

Staff were assigned products for testing that are reflective of the end users role, to ensure accurate reporting data. Sunflower Medical Management/Training teams assign the product specific tests in which each staff member conducts medical necessity review. InterQual product tests include: Acute Adult, Acute Pediatric, LTAC, Rehabilitation, Sub acute/SNF, Home Care, Procedures, Imaging, and DME and Behavioral Health (BH) Child/Adolescent and Adult/Geriatric.

Forty-six Sunflower Medical Management and Quality Improvement staff members completed the annual InterQual IRR testing based on role and function. The Centene Corporate process was followed regarding training and testing implementation. The Sunflower Medical Management Department senior leadership was directly engaged and apprised of all training and testing conducted in relation to the 2020 InterQual IRR annual testing. Seventeen staff members scored less than 90% on at least one product on the initial tests. Corrective action for these staff members included re-training on those products and subsequent re-testing per Centene Corporate process. Six of these staff members successfully passed the re-tests. Eleven staff members scored less than 90% on the re-takes. For those who did not pass the re-take the management team is developing and implementing a corrective action plan that includes re-training, precepting, and auditing, as indicated. We experienced a change in the process for IRR Provision this year. As a result, we identified some areas for process improvement. We will coordinate closely with our Learning and Development Team to ensure improved outcomes for our next reporting year.

| Measurement | Goal | Evaluation |
|---|---|---|
| IRR testing results* | 100% staff pass rate with 90% or greater | Goal not met, 76% of staff passed with >90% upon either initial or retest |

**Summary**
To determine if its UM program remains current and appropriate, the organization annually evaluates:

- The program structure.
- The program scope, processes, information sources used to determine benefit coverage and medical necessity.
- The level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM program.

Sunflower has identified strengths and opportunities for improvement in our UM Program through these data, focused reports, routine monitoring of our work plan, and metrics presented at UMC.

Priority monitors included in the CM and UM Program Descriptions were reviewed and will be continued as needed, as well as additional metrics added as goals for 2019 based on the following identified strengths and opportunities for improvement.

**Strengths:**

- Team member engagement
- Stability of leadership
- Member satisfaction results
- Management of high utilizing members
- Process innovation and agility (documentation, workflows, etc.)
- Physical and behavioral health care management integration
- Skill and knowledge of team
- Prior authorization processes and timeliness

**Opportunities for Improvement:**

- Continued focus on Provider satisfaction
- Member engagement in care management
- Efficiency and communication of documentation (HCBS)
- Efficiencies in prior authorization and concurrent review processes
- Enhanced training, especially with new staff and integrated behavioral health staff, on these processes.

As a result of this analysis, it is apparent that processes and operational systems are starting to stabilize, producing mostly positive results. The findings did not indicate the need for major revisions to Sunflower's UM or CM program descriptions, operations, or service delivery systems. Additionally, the level of involvement from the Chief Medical Director and designated Behavioral Health practitioner were found to be sufficient to meet the UM program needs. Sunflower will continue to work to maintain and improve on the gains achieved in 2020, and will take the necessary steps to improve on the areas noted with priority opportunities for improvement in 2021.

## Credentialing and Recredentialing

### Structure and Resources

The Credentialing Department is responsible for ensuring all practitioners are appropriately licensed and experienced in their field. This is accomplished through applying rigorous standards that verifies practitioner's license, education, training, experience, certification, malpractice history, work history, and quality of care attributes. To become a participating provider in the 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 with local Market support.

### Statistics

Sunflower's number of practitioners in network for 2020 was 38,079 which included those delegated for dental and vision providers. In 2020, 1760 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 1216. Provider credentialing turnaround time averaged 6 days from application completion to

committee. Overall, the credentialing process has improved steadily year over year. The total number of network practitioners have increased.

The table below reflects the 2020 Credentialing report for Sunflower.

| | |
|---|---|
| Total number of practitioners in network (includes delegated providers) | 38,079* |
| | |
| Number initial practitioners credentialed | 1760 |
| Average Credentialing TAT from Complete Application to Committee (Days) | 6 days |
| | |
| Number of practitioners re-credentialed | 1216 |
| Number of practitioners re-credentialed within a 36 month timeline | 1216 |
| % re-credentialed timely | 100% |
| | |
| Number with cause | 2 |
| Number denied | 1 |

* Includes Medicaid, Envolve Vision and Dental

## Member Rights and Responsibilities

Member's Rights and Responsibilities are given to the member on enrollment by the State and upon enrollment with Sunflower Health Plan in the Member Handbook. Members receive an updated Sunflower Member Handbook annually. Member's Rights and Responsibilities are provided to the Sunflower participating provider network through its Provider Manual. Member Rights and Responsibilities are a part of the training curriculum for all new Customer Service Representatives.

## Delegation Oversight

Sunflower Health Plan 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, the following:

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

The following is a listing of the delegated vendors for 2020. The first five vendors are wholly owned subsidiaries of Centene:

1. Envolve Vision – Sunflower's vision care manager. Envolve Vision provides utilization management, network development and maintenance, credentialing of their network, and claims payment data.

2. Envolve Pharmacy Solutions (EPS) – Sunflower's pharmacy benefits manager. EPS provide information for prior authorizations, utilization management, verification of active licenses for all participating pharmacies, and claims payment data.
3. Envolve People Care (EPC) Sunflower's after-hours call center and nurse advice line.. The after-hours call center and nurse advice line provides bilingual care with registered nurses, which complete health screenings, and after hours nurse advice.
4. Envolve Dental – Sunflower's dental benefit manager. They provide prior authorizations, utilization management, network development and maintenance and claim payment information.
5. National Imaging Associates (NIA) – Sunflower's high-tech radiological imaging manager. NIA provides prior authorizations, credentialing of their network and first level appeals. NIA also is the vendor for pre-service utilization review of speech, physical and occupational therapies.
6. ModivCare – Sunflower's non-emergent transportation vendor.
7. TurningPoint –Sunflower's musculoskeletal utilization management program.

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

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. Therefore Sunflower monitors the performance of the delegated entity through annual approval of the delegated programs (Credentialing, UM, QI, etc.), routine reporting of key performance metrics and annual or more frequent evaluation to determine whether the delegated activities are being carried out according to the contract, accreditation standards and program requirements. The Plan retains the right to reclaim the responsibility for performance of delegated functions, at any time, if the delegate is not performing adequately.

## Review and Approval

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

**Approval**

The Quality and Utilization Program Evaluation for 2020 has been reviewed and approved as follows:

Submitted By: Susan Beaman, RN Date of QIC: 3.29.2021

QIC Chair Approval: Scott Latimer, MD Date of QIC: 3.29.2021

UM Committee Chair Approval: N/A Date of UM: _____

Board Chair Approval: Michael R. Stephens Date: 5/20/2021