



2020 Quality Program Evaluation Medicare

Allwell from Sunflower Health Plan - 2020

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Allwell Health Plan Quality Program Evaluation - 2020

Introduction

The purpose of this evaluation is to provide a systematic analysis of Allwell's performance of the Quality Improvement (QI) activities and to evaluate the overall effectiveness of the Quality Assessment and Performance Improvement (QAPI) Program. Allwell is the name of Sunflower Health Plan's Medicare product. The QI Department has established reporting QI activities as outlined in the QI Work Plan. This evaluation focuses on activities and interventions completed during the period of January 1 - December 31, 2020. The QAPI, QI Work Plan and QI Program Evaluation review and approval occur at least annually by the Quality Improvement Committee (QIC) and Sunflower Board of Directors (BOD). Allwell from Sunflower began operations providing services to members in Kansas on January 1, 2018. The purpose for Allwell is to "transform the health of the community, one person at a time". This is established through a local approach that strives to provide improved health status, successful outcomes, both member and provider satisfaction in an environment that focuses and promotes coordination of care.

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

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

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

Program Overview

Quality Program

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

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

maintain a comprehensive Quality program. The 2020 QI Work Plan defines the activities, the person(s) responsible for the activity, the date of expected task completion and the monitoring techniques that will be used to ensure completion within the established timeframe.

The QI Work Plan is presented to the QIC on an annual basis for approval, through the annual evaluation process and at regular intervals throughout the year. Additionally, the work plan is presented to the Board of Directors at least annually but more often as needed. The 2020 QI Work Plan is currently being updated and will be provided to the QIC for review and approval.

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

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Organizational Report / Changes in Organization in evaluation year

The QI department experienced significant reorganization in 2020. Three (3) Manager positions were eliminated. They were replaced with a director, supervisor, data analyst and coordinator positions. The department was aligned into like-functional areas to improve collaboration and bring scalability. QI gained a dedicated data analytics position and has repurposed a vacant FTE into a second data analyst for 2021. The goal is to drive more performance improvement with enhanced data analytics.

The QI Department has continued collaboration throughout the organization's departments to promote and facilitate continuous quality improvement by empowering all internal and external stakeholders through education, communication, data analysis and evaluation. This is accomplished through utilizing data from across Allwell including utilization of services, various surveys, grievances, appeals, and claims where representatives from various Allwell 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 Allwell, Do, Study, Act (PDSA) methodology. The collaboration is ongoing and may involve multiple teams simultaneously. Allwell 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.

Allwell has identified strengths and opportunities for improvement, which are outlined in more detail with action plans in the full annual evaluation report. Interventions included in Allwell for continuation in 2020 were reviewed and continued as appropriate for measures where continued improvement was warranted.

Strengths:

- Year over year improvements on Member satisfaction survey results, despite COVID related survey limitations
- Consistently higher than average member participation rates.
- Incorporates provider feedback into processes for continuous quality improvement
- Improvement in HEDIS scores year over year
- Access and Accessibility
- Integration of physical and behavioral health
- Utilizing innovation to drive Quality through Provider P4P arrangements, and collaboration with providers, health departments, schools and other organizations to improve the quality of care members receive

Opportunities for Improvement:

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

Because of this analysis, it has been identified that processes and operational systems are continuing to increase with regard to stabilization, which has allowed for innovation, producing positive results, and in some instances, our efforts reveal negative findings as Allwell matures and enforces guidelines. The findings from the analysis completed for 2020 did not indicate the need for major revisions to Allwell's QAPI, operations, or service delivery systems. Allwell will take the necessary steps to demonstrate continuous quality improvement on the areas identified as priorities for improvement in 2020. The aim is to improve the health and well-being of our membership and increase partnership approach with providers. Allwell continues with the purpose to transform the health of the communities we serve, one person at a time.

Scope of the Quality Program

The scope of the QAPI Program is comprehensive and addresses both the quality and safety of clinical care and quality of services provided to Allwell members including medical, radiology, behavioral health, dental and vision care. Allwell 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.

Allwell's QAPI Program monitors the following:

- Acute and chronic care management
- Behavioral health care
- Care Management
- Compliance with member confidentiality laws and regulation
- Compliance with preventive health guidelines and practice guidelines
- Continuity and coordination of care

- Data collection, analysis and reporting
- Delegated entity oversight
- Department performance and service
- Employee and provider cultural competency
- Fraud and abuse detection, prevention and reporting
- Home support service utilization for members, as appropriate
- Information Management
- Marketing practices
- Member enrollment and disenrollment
- Member Grievance System
- Member satisfaction
- Customer Services
- Network performance
- Organization Structure
- Patient safety
- Primary Care Provider changes
- Pharmacy
- Provider and Plan after-hours telephone accessibility
- Provider appointment availability
- Provider Complaint System
- Provider network adequacy and capacity
- Provider satisfaction
- Provider Services
- Selection and retention of providers (credentialing and re-credentialing)
- Utilization Management, including under and over utilization
- Policies to support the QAPI program

Goals

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

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

- A high level of health status and quality of life will be experienced by Allwell 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
- Allwell services will meet industry-accepted standards of performance
- Fragmentation and/or duplications of services will be minimized through integration of quality improvement activities across Allwell functional areas
- Member satisfaction will meet Allwell's established performance targets
- Preventive and clinical practice guideline compliance will meet established performance targets. This includes, but is not limited to, compliance with immunizations, prenatal care, diabetes, asthma and early detection of chronic kidney disease guidelines as these apply to the Allwell membership. Allwell will measure compliance with clinical practice guidelines until 90% or more of relevant network providers are consistently in compliance
- Compliance with all applicable state/federal regulatory requirements and accreditation standards

Compliance Program Description

Allwell's Compliance Department, in conjunction with Centene Corporation, is responsible for ongoing monitoring and investigation of potential waste, abuse and fraud related to providers, members, and internal staff. Allwell'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, Allwell from Sunflower underwent the Balanced Budget Act (BBA) state audit, and Kansas Department for Aging and Disability Services (KDADS) member quarterly files. Additionally, in 2020 Kansas Foundation for Medical Care (KFMC), our External Quality Review Organization (EQRO), performed validation of HEDIS measures and other measures included in the state Pay for Performance along with the following surveys: CAHPS, Provider Survey, and Mental Health Survey. Allwell from Sunflower anticipates the start of the 2020 Performance Measure Validation in June of 2020. Allwell from Sunflower complied with record requests for quarterly Home and Community Based Services (HCBS) documentation audit requests; Allwell from Sunflower is awaiting the final results of HCBS audits from the state.

Cultural Competency

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

Member Cultural Needs and Preferences (Medical Management, Customer Service, Quality) maintains and updates Member Demographic Information; at least annually, Medical Management performs a care management population assessment of the services utilized by the entire member population and any relevant subpopulations; Customer Service representatives and Care Managers receive Cultural Competency training as part of the new hire training plan and annually thereafter; the CCP plan is available to all members and providers via the Member Handbook and Allwell website; the CCP plan addresses member language needs beginning with the Welcome section of the Member Handbook.

Member materials are produced in English and Spanish and other language or format requests are accomplished through translation, interpreters, or appropriate accessible formats. The health plan contracts with Centene's language line vendor enabling Allwell 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 Culturally Competent Plan that addresses the cultural, linguistic, and disability access needs identified in the population assessment and the Chief Medical Director is responsible for oversight of the CCP, including annual approval of the CCP.

The CCP addresses, at a minimum, the Allwell's strategy for recruiting staff with backgrounds representative of Enrollees served; the availability of interpretive services; the availability of transportation services; Allwell's ongoing strategy to meet the unique needs of Enrollees who have developmental disabilities and cognitive disabilities and its operation; Allwell's ongoing strategy to provide services for home-bound Enrollees and the strategy's operation; Allwell's ongoing strategy to engage local organizations to collaborate on initiatives to increase and measure the effectiveness of culturally competent service delivery and its operation standards and performance requirements for the delivery of culturally and linguistically appropriate health care services.

In 2020 the health plan hired a Member Advocate in Customer Service who works closely with the LTSS Member Advocate and BH Member Advocate to assist members with needs related to housing, food, community resources, navigating the healthcare system and with any cultural or linguistic needs. Additionally, a Cultural Competency and Disability Awareness webinar training was offered to Network Providers on a quarterly basis instead of annually.

Delegation

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

Committee Structure

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

Board of Directors

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

The QIC is composed of Allwell’s CEO/President, Chief Medical Director, Medical Directors, and QI senior leadership, along with other Allwell executive staff representing Population Health Clinical Operations (including Utilization Management and Case Management), Network Development/Contracting, Customer Service, Compliance, and Pharmacy departments, with other ad hoc members as necessary. Additional QIC attendees include staff responsible for clinical appeals and Waste Abuse and Fraud. The committee meets on a quarterly basis, at a minimum. For 2020, QIC met a total of five (5) times including ad hoc meetings.

Credentialing Committee

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

2020 Credentialing Statistics As of 12/31/2020	
Total number of practitioners in network (includes delegated providers)	38,079*
Initial Credentialing (excludes delegated)	
Number initial practitioners credentialed	1760
Average Credentialing TAT from Complete Application to Committee (Days)	6 days
Re-credentialing	
Number of practitioners re-credentialed	1216
Number of practitioners re-credentialed within a 36 month timeline	1216
% re-credentialed timely	100%
Terminated/Rejected/Suspended/Denied	
Number with cause	2
Number denied	1

Pharmacy and Therapeutic Committee

The Pharmacy and Therapeutics (P&T) Committee is a standing subcommittee of the QIC and is responsible for administering the routine oversight and operating authority of the Pharmacy Program. The QIC is the vehicle through which communication of pharmacy monitoring and reporting activities occurs with the Board of Directors. The P&T Committee ensures Allwell provides a high quality, cost effective preferred drug list (PDL), an effective pharmacy program, and addresses quality and utilization issues related to pharmaceutical prescribing patterns, practices, and trends for Allwell. The P&T Committee is a multidisciplinary team composed of the Associate Medical Director, Pharmacy Director, network physicians, network pharmacist, and other executive staff. For 2020, P&T met two (2) times.

Utilization Management Committee

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

The UMC is composed of Allwell's Chief Medical Director, Medical Director(s), the Vice President of Population Health Clinical Operations (PHCO) and other operational staff, as needed. Network physicians also participate in this committee to provide input on process, policies and data. For 2020, the UM Committee met five (5) times, including an ad hoc meeting. Typically, the UM Committee meets quarterly.

Quality Measures Committee (previously HEDIS Steering Committee)

The Quality Measures Committee oversees Allwell'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 Allwell/Sunflower Senior Leadership. The Committee directs clinical, non-clinical, member and provider initiatives to improve selected HEDIS measure performance. The Quality Measures Committee oversees the implementation, progression and outcomes monitoring of initiatives specific to HEDIS, recommends resources necessary to support the on-going improvement of HEDIS scores, reviews/establishes benchmarks or performance goals for HEDIS and oversee delegated vendor roles in improving HEDIS scores. The Committee meets a minimum of quarterly and is facilitated by the QI Director. Membership includes the QI leadership, the CEO/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 Committee meets quarterly and met three (3) times in 2020.

Grievance and Appeals Committee

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

Directors, Pharmacy Director, QI leadership, Grievance Coordinators, Clinical Appeals Coordinators, Lead Clinical Appeals Nurse and representatives from Customer Service and Medical Management. The GAC provides summary reports to the QIC at regular intervals, but no less than quarterly. Meetings typically occur quarterly or more frequently as needed. The GAC met four (4) times in 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 Medical Director. This committee includes participation by both network physicians and Sunflower medical directors. The PRC members utilize their clinical judgment in assessing the appropriateness of clinical care and recommending a corrective action plan that will best suit the particular provider's situation. For 2020, PRC for Physical Health met ten (10) times to review cases and make recommendations as appropriate. The Behavioral Health PRC, committee was started as a stand-alone committee in 2020. The first meeting occurred in Q4 2020, led by the Behavioral Health Medical Director, with participation from internal and external Providers. External Providers included Practitioners with a Behavioral Health specialty.

Performance Improvement Committee

The 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 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 and Allwell. 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, with several subcommittee meetings of the PIC to address items such as the member experience survey, QRS and Stars initiatives. The PIC reports to the QIC committee. Multiple subcommittees report to the PIC.

CAHPS/Member Experience Workgroup

The focus of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Member Experience work group is to review the CAHPS and member satisfaction survey results. The group identifies opportunities for improvement, barriers and methods to mitigate the barriers. The goal of this committee is to improve the member experience and improve STARS, The committee meets monthly and more often as necessary. A Quality Specialist is designated by QI Leadership to facilitate 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 meets on a monthly basis and as needed may hold Ad Hoc meetings. In 2020, the work group met on twelve (12) occasions.

STAR Core Group Committee

The STAR Group Committee was initiated in January 2020 and meetings are held monthly. The committee's primary function is to coordinate efforts proactively and execute strategic actions to improve STAR measures. The STAR Core Group includes representation from each functional area that may impact STAR ratings. The committee reviews Part C, Part D, CAHPS and HOS scores and decides on initiatives to improve scores. The cross-functional team monitors interventions in order to achieve a 4 STAR rating by MY 2022. Responsibilities include:

- Facilitate monthly working sessions with measure owners in key departments
- Review measures for improvement initiatives. Identify risks & barriers and find solutions
- Track status & progress for activities impacting STAR measures

Allwell/Sunflower Vendor Delegated Joint Operations Committees

The Vendor Joint Operations Committees (JOCs) are active sub-committees of the QIC. The JOC's 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 suitability and quality of services provided on behalf of Allwell and Sunflower members. The Vendor JOCs includes representation from each of Allwell's 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. In addition to those listed below, Allwell/Sunflower is adding vendor JOC meetings for Turning Point in 2021.

Vendor	Number of Meetings in 2020
National Imaging Association	12
Envolve Pharmacy	4
ModivCare	12
EPC DM / NAL	12
Envolve Dental	4
Envolve Vision	4

Allwell/Sunflower Provider Joint Operations Committees (JOCs)

The Provider Joint Operations Committees (JOCs) are active provider committees that occur at least quarterly and report to QIC. These committees are with high volume providers whose primary function is to allow the providers to provide input on the following: Allwell 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, Allwell may engage providers to provide input on implementation of new policies, processes, and tools. In 2020, there were twenty four (24) Provider Joint Operations Committee meetings held.

Behavioral Health Advisory Committee

The Behavioral Health Advisory Committee was initiated in 2018 and is comprised of network Behavioral Health providers and its purpose is to allow for communication of Allwell's programs, policies and processes with the provider network allowing for opportunity to discuss and provide feedback to Allwell. Additionally, it allows for providers to make recommendations and identify key issues encountered by members and providers. The

committee chair is the Behavioral Health Medical Director or director level Allwell 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

Quality Leadership in 2020 **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 Allwell from Sunflower's 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

Program Overview

- Allwell's QAPI Program objectives include, but are not limited to, the following:
- To establish and maintain a health system that promotes continuous quality improvement;
- To adopt evidence-based clinical indicators and practice guidelines as a means for identifying and addressing variations in medical practice;
- To select areas of study based on demonstration of need and relevance to the population served;
- To develop standardized performance measures that are clearly defined, objective, measurable, and allow tracking over time;
- To utilize Management Information Systems (MIS) in data collection, integration, tracking, analysis and reporting of data that reflects performance on standardized measures of health outcomes;
- To allocate personnel and resources necessary to:
 - support the quality improvement program, including data analysis and reporting;
 - meet the educational needs of members, providers and staff relevant to quality improvement efforts
- To seek input and work with members, providers and community resources to improve quality of care provided to members
- To develop partnerships with new stakeholders and providers to establish services and relationships to support home and community based services and LTC residential option;
- 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

Quality Improvement Strengths

- Quality Improvement leadership was restructured to include a director and supervisor level, and includes four (4) nurses and a licensed behavioral health professional with Quality Improvement experience
- Quality Improvement reports up to the Chief Medical Director, who is directly involved in Quality initiatives as the SEQI

- Committee membership and structure continues to evaluate revised and functional support activities
- Network providers actively participating in various Quality committees to provide input and feedback to drive continuous Quality Improvement across the organization
- Quality improvement initiatives and focus studies identified, using data trends starting to take more shape with plan experience
- Successfully developing an expansive network, implementing case management, and refining operations in claims processing to meet the member and provider needs
- Year over year noted improvements in both the Member and Provider satisfaction surveys. Continued development of comprehensive plans for future improvement opportunities using multidisciplinary team approach
- Secured a dedicated data analyst to QI team to support STARS HEDIS, CAHPS, HOS and other performance improvement initiatives
- Continued use of skill and experience in HEDIS operations to allow for Allwell to increase year round abstractions/over-reads and also over-reads during hybrid season
- Continued efforts in place for optimization of data captured through member outreach to optimize collection of supplemental data, including records from in-home assessments and other opportunities for potential impact on HEDIS measures for MY2020
- Continued evaluation and updates to systems to incorporate state reporting criteria to reduce reporting errors and automate some reporting functions.
- Increased medical records provided to Allwell related to Provider Profiles sent out to engage providers on closing care gaps
- Ongoing evaluation, modification, and update of templates for trending of Grievances, Appeals, and Quality of Care issues data for more in depth analysis and display for team members and Committee, allowing improvement opportunities to be more easily identified
- Added an auditor to the Quality Improvement team to focus on contractual requirements for UM, appeals and grievances to include notices, manuals and process compliance.
- Continued collaboration with vendors to look through opportunities to improve efficiencies and satisfaction through education of providers, health plan staff and members
- Continued development and use of reports for monitoring and identification of cases at risk of not meeting turn-around time (TAT) for grievances and appeals before they are out of TAT.
- Utilize developed process in documentation system to route Adverse Incident Reporting System (AIRS) so all documentation remains in single entry/record and includes QOC nurse and CM in feedback
- Monitoring of reports to do surveillance of routine QOC issues on whole population, allowing focused review when there are findings and trending of certain types of at risk diagnosis patterns.
- Continued partnership with Allwell/Sunflower Data Analytics team to improve data integrity, revise provider profiles and accuracy related to member outcomes, strategic initiatives and to meet state reporting requirements.
- Implemented revisions to the Grievance Appeals Report (GAR) through collaboration with the Data Analytics team
- Monitoring Allwell Member grievance resolution TAT for 2020
- Monitoring Allwell Member standard appeal resolution TAT for 2020
- Monitored Care Management activities
- Participated in member outreach health fairs/community events
- Participated in provider conferences and seminars, presenting and providing information or as a conference participant

- Involve People Care's Disease Management demonstrated active health coaching
- The Allwell Customer Services/Provider Services call center provides education and referral services to members and providers. The call center received and responded to calls regarding benefit inquiries, concerns, complaints, and request for arranging service
- Continued to focus on expanded sources for supplemental data that allow better HEDIS data capture to reduce record request burden for providers, which included use of records received via the secure Provider Portal, in-home vendor assessments and utilization of KHIN.
- Continued to collaborate with providers and health departments with a goal to impact our members' health and well-being through preventative care for diabetes care, immunizations, dental care, and other preventive services
- Continued utilization of Provider Profiles/scorecards for monitoring of health plan rating scores that incorporate both CAHPS and HEDIS data as appropriate, allowing for current year trends to previous year and gap to meet thresholds and rating score
- Added Provider Profile Reminders as an 'end of year push' initiative
- Lab2U partnership to help close care gaps with in home testing option for Hemoglobin A1c testing
- Implemented and automated GAC based reporting including UM denial and AIRS (Adverse Incident Reporting)
- Continued member region specific data and implement member LOC data into internal weekly Grievance and Appeals reporting.
- Reporting Case Management HEDIS notes data from our TruCare system for any notes regarding medical records
- HEDIS A1c outreach campaign with Case Management without continuous enrollment requirements for all business lines to identify members early for opportunity to engage to close care gaps
- Implemented text messaging technology to engage members and assist in care gap closure

Quality Improvement Opportunities

- HEDIS rates continue to be an area of focus through member outreach, education and collaboration with various partners including providers, health departments, schools and organizations; Allwell continues to explore and evaluate resources and opportunities for education and incentives to improve rates with goal to meet or exceed the 75th Quality Compass Percentile. Focus measures for 2020 included CDC, MRP, and COA
- Allwell continues to work on HPRS interventions for 2021 to drive a 4 STAR performance
- Established interventions for at-home testing to ensure care needs were met due to COVID pandemic
- Continuously evaluating data and exploring new interventions to continuously improve Member and Provider satisfaction with Allwell services, care and operations based on survey results and other avenues of feedback including both member and provider appeals and grievances
- Continued efforts to develop and expand trending reports for data analysis and focused intervention to be used as a part of PDSA within all health plan departments
- Implement additional outreach to internal and external partners to share results of quality improvement activities and open doors for feedback
- 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

Population Characteristics

Member Demographics and Service Area

Allwell from Sunflower started providing services to members in Kansas on January 1, 2018 in Johnson and Wyandotte counties. As of 2020, Allwell expanded to 15 Counties. The following tables show age and gender breakdown for Allwell membership.

Age Group	2019	2020
18-64	39%	34%
65 - over	61%	66%

Gender	2018	2019	2020
Male	42%	41%	46%
Female	58%	59%	54%

Membership Characteristics

Allwell membership increased from 512 members in 2019 to 798 members in 2020. The age group of 61-70 continues to represent the highest number of Allwell members, with 66% of membership in this category. Female membership continues to be higher than male membership within Allwell.

An additional look at membership data evaluated the top diagnoses by physical and behavioral health. The top diagnoses were mainly related to cancer screenings, virus screenings, hypertension, immunization, chest pain and back pain.

Top Diagnosis

Physical Health

Top Physical Diagnosis Codes		
Service Date Range: January 1, 2020 - December 31, 2020		
Diagnosis Code	Diagnosis	# Unique Member
A419	SEPSIS UNSPECIFIED ORGANISM	11
U071	COVID-19	17
N186	END STAGE RENAL DISEASE	2
I110	HTN HEART DISEASE W/HEART FAIL	10

J9621	ACUTE CHRONIC RESP FAIL W/HYPOXIA	4
J441	COPD WITH ACUTE EXACERBATION	15
I4819	OTHER PERSISTENT ATRIAL FIBRILLATION	6
M4802	SPINAL STENOSIS CERVICAL REGION	3
Z4789	ENC FOR OTHER ORTHOPEDIC AFTERCARE	3
C9000	MX MYELOMA NOT ACHIEVED REMISSION	1
A4189	OTHER SPECIFIED SEPSIS	2
I2510	ASHD NATIVE CA W/O ANGINA PECTORIS	19
M4726	OTH SPONDYLS RADICULOPATHY LUMB RGN	1
J189	PNEUMONIA UNSPECIFIED ORGANISM	9
N179	ACUTE KIDNEY FAILURE UNSPECIFIED	4
I420	DILATED CARDIOMYOPATHY	3
F319	BIPOLAR DISORDER UNSPECIFIED	1
J869	PYOTHORAX WITHOUT FISTULA	1
T82110A	BREAKDOWN MECH CARD ELECTRODE INIT	1
M1611	UNI PRIM OSTEOARTHRITIS RT HIP	3
A4101	SEPSIS D/T METHICILLIN SUS STAPH	1
M1711	UNI PRIM OSTEOARTHRITIS RT KNEE	9
I6202	NONTRAUMAT SUBACUTE SUBDURAL HEMORR	1
C8590	NON-HODGKIN LYMPHOMA UNS UNS SITE	1
I130	HTN HRT CKD W/HF STAGE 1-4/UNS CKD	5
I214	NON-ST ELEVATION MYOCARDIAL INFARCT	2
G9341	METABOLIC ENCEPHALOPATHY	3
I483	TYPICAL ATRIAL FLUTTER	1
G92	TOXIC ENCEPHALOPATHY	1
R4182	ALTERED MENTAL STATUS UNSPECIFIED	5

Behavioral Health

Top Severe Mental Illness (SMI) Behavioral Health Diagnoses codes: Range: January 1, 2020-December 31, 2020		
Diagnosis Code	Diagnosis	# Unique Member
F411	GENERALIZED ANXIETY DISORDER	1
F320	MAJ DEPRESS D/O SINGLE EPIS MILD	1
F341	DYSTHYMIC DISORDER	1
F332	MAJ DEPRESS RECURR SEV W/O PSYCH	1
F321	MAJ DEPRESS D/O SINGLE EPIS MOD	1
F4310	POST-TRAUMATIC STRESS DISORDER UNS	1

Languages Spoken by Members

Allwell assesses members' linguistic needs based on the member reporting, requesting members of their primary language spoken. Allwell noted that English is reported as the primary language in 99% of the Allwell population. See table below:

Language	Member Count	% of population
English	796	99.8%
Spanish	1	.13%
	797	100%

Allwell reviews data to assess members' linguistic needs. While spoken language is not captured for MAPD enrollment, Allwell does track the usage of the language line. Allwell offers language assistance services for members that require translation services. Services are available in both telephonic and on-site interactions that can be arranged by Allwells' Customer Service department. Language services are also available for both Allwell staff and network providers. The table below represents all languages for which members have requested translation services based on unique interactions in 2020. Out of 122 calls, Spanish was the top language requested at 72.1%. Vietnamese was the second most requested language at 7.4%.

Language Service Line Requests

Allwell Language Line		
Spanish	88	72.1%
Arabic	10	8.2%
Vietnamese	9	7.4%
Russian	4	3.3%
Farsi (Persian)	1	0.8%
Gujarati	1	0.8%
Mandarin	3	2.5%
Brazilian Portuguese	1	0.8%
French	2	1.6%
Cantonese	2	1.6%
Hindi	1	0.8%
Total	122	100%

Race/Ethnicity

The 2020 Medicare Consumer Assessment of Healthcare Providers and Systems (MCAHPS) survey was administered to the Allwell population. Of the respondents, 74.4% reported being White, 24.6% as Black or African-American, and 6.9% of respondents reported as Hispanic or Latino descent. Since there was not enough responses to Asian, Native Hawaiian or other Pacific Islander, and American Indian or Alaska Native, those were all grouped into "other". The table below reflects member responses on race and ethnicity to the 2020 Survey. Allwell did not survey members in 2019.

Medicare Consumer Assessment of Healthcare Race/Ethnicity

White	74.4%
Black /African American	24.6%
Hispanic / Latino*	6.9%
Asian	NA
Hawaiian / Pacific Islander	NA
American Indian / Alaskan	NA
No race indicated	NA
Other	6.9%

Quality Performance Measures and Outcomes

NCQA Accreditation

Allwell continues NCQA Accreditation readiness practices, as applicable, for the Medicare line of business. Currently, Allwell is not seeking an accreditation status as directed by the corporate parent company, Centene Corporation.

Healthcare Effectiveness Data Information Set (HEDIS®)

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

HEDIS Indicators

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

Allwell has been collecting data since January 2018, and loading the information into its certified-HEDIS software. Allwell focuses efforts to improve on HEDIS measures by factoring in those that are required for NCQA accreditation, and those that have Star ratings. MY 2020 was impacted by the COVID emergency. Some interventions that included home visits did not occur due to a stay-at-home order, some preventative appointments were postponed for several months.

Comprehensive Diabetes Care

Allwell worked on this HEDIS measure and its sub measures in 2020, to help members have a better understanding of diabetes. This includes the importance of routine monitoring, proper diet, and exercise all aimed at helping to improve their management of diabetes. Some of the interventions were impacted by the COVID emergency. All of the items can help potentially lessen or avoid complications that result from diabetes. These efforts included continued partnership with Envolve Benefit Option for the Eye Exam sub measure.

Allwell partnered with USMM, to send in-home testing kits to Allwell members with diabetes. The project's goal was to impact those members who were still showing noncompliant with diabetes monitoring and to allow them to complete their test at home and submit to the lab.

Allwell also offered case management to help members find a provider, make appointments, arrange transportation, educate members on the importance to have these tests done annually, and even referred members as appropriate for the Disease Management services available to them via Nurtur.

Comprehensive Diabetes Care Interventions for 2020:

- Envolve Benefit Option HEDIS Outreach - Diabetic Retinopathy Exam sub-measure; monthly progress reports
- My Health Pays Program Incentives
- Medical Management performs outreach to non-compliant members and diabetic members in Care Management
- Customer Service and Medical Management training on measure to discuss care gaps with members on calls; reminders sent prior to care gap reports going out to members
- Use of KRAMES educational materials to educate members about diabetes care
- Provider profiling report based first on attribution then assignment were distributed to providers of non-compliant members
- Provider scorecards for Allwell providers
- HEDIS resource and training materials on provider website and included in provider trainings
- Continued partnerships with FQHCs to close member care gaps
- Proactive Outreach Management (POM) calls made to members with care gap for CDC.
- IVR messaging to support CDC outcomes
- In-home testing kits sent to non-compliant members

Allwell analyzed HEDIS data in 2020 to determine where opportunities exist to improve compliance with CDC measures. Member knowledge, understanding, and education continues to be a focus that Allwell continues to work on to address this barrier. In order to improve member engagement on these measures, the members have to have the knowledge and understanding of the significance for the testing. The knowledge and understanding will allow the appropriate treatment of their disease, which also promotes delaying progression of their diabetes and the complications that may result.

Allwell will continue to analyze the interventions implemented in 2020, as well as continue to explore options for expanding partnerships with providers.

The following table provided demonstrates results related to the Allwell Comprehensive Diabetes Care HEDIS measure. The denominator for the administrative data for MY 2020 was 443. It is important to note that the final HEDIS 2021 rate is not available at the time of this report.

Allwell HEDIS MEASURE	HEDIS 2019 (MY2018) Final	HEDIS 2020 (MY2019) Final	HEDIS 2021 (MY 2020) Admin*
CDC- Blood Pressure Control	0	54.26	37.02
CDC- Eye Care	52.94	62.02	59.14
CDC- HbA1c Testing	82.35	96.12	86.91
CDC- HbA1c Adequate Control (<8%)	5.88	60.47	30.93%
CDC- HbA1c Poor Control	88.24	31.78	64.79%
CDC- Monitoring for Nephropathy	100.00	96.90	92.33

*Awaiting HEDIS 2021 Final Hybrid Rates

Patient Safety

Quality of Care

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

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

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

Allwell reviews events both at an aggregate and provider/facility level for each individual plan. The following quantified information represent a breakdown of incidents, which met specified criteria for an internal review. The first graphic, labeled Category Summary, is a collected volume by event category. An event category is assigned by a Quality Improvement Coordinator based on

details of the referred incident. The graphic labeled Severity Summary, will reflect the ratio of assigned severity levels after a case has been studied by an Auditor and/or Medical Advisor, in which provided medical record or event documentation has been requested and reviewed.

Member Satisfaction

Allwell from Sunflower Health Plan conducted a member satisfaction surveys utilizing the Consumer Assessment of HealthCare Providers and Systems (CAHPS®) 5.0H Medicare Member Satisfaction Surveys to evaluate and compare health plan ratings by members. Allwell strives to understand the problems members face in order to implement actions to achieve better performance on specific opportunities for improvement identified by CAHPS. In addition, Allwell utilizes CAHPS results as a data source for other performance improvement initiatives throughout the year. 2020 was the first year Allwell conducted a Member Satisfaction survey.

The overall objective of the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) study is to capture accurate information about consumer-reported experiences with health care. The Centers for Medicare and Medicaid Services (CMS) uses this information to assign Star Ratings to health plans. However, in response to the COVID-19 pandemic, CMS is not using MA & PDP CAHPS results in the 2020 Star Ratings.

The survey was conducted according to the survey methodology outlined in the 2020 Healthcare Effectiveness Data and Information Set (HEDIS) Specifications for Survey Measures. All eligible members were included in the sample; Allwell does not exclude members with special needs from the sample. The Allwell annual Member Satisfaction survey for 2020 was a combined adult and child survey due to population size.

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

The following describes the methodology, results, and analysis for each data source, and actions initiated to improve member experience.

Survey Protocol

SPH Analytics utilized a mixed methodology of mail, phone, and internet processes to administer the surveys for Allwell. Sampling techniques utilized for Allwell are as defined by the HEDIS specifications.

Sample Size & Response Rates

For the Allwell Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, the sample size for MCAHPS 2020 consisted of 674 members, (mixed mail, telephone, and internet) with 211 completed valid surveys. After adjusting for ineligible members

(7 Allwell members were identified as ineligible), the Allwell CAHPS survey response rate for 2020 was 31.3%.

Allwell Response Rate

Survey Population	2019 Response Rate	2020 Response Rate
Allwell/ Medicare Mixed Population	N/A	31.3%

Allwell Medicare results were calculated in accordance with 2020 HEDIS specifications for survey measures. Results for the Allwell population were reported with no weighting, trending or case-mix adjustment was performed.

Composites and Key Questions

The 2020 Summary Rate Composite and Key Question scores for Allwell from Sunflower Health Plan are presented in Table 10 and compared to the 2019 CMS National Data. The 2019 CMS National Data is the mean summary rate from the Medicare plans that submitted data to CMS in 2019.

Table 10 displays Allwell’s current summary rate results for Composites and Key Questions for the CAHPS Medicare Survey compared to the 2019 CMS National Data. The 2019 Quality Compass All Plans Percentile was not available for comparison due to the COVID-19 pandemic.

Allwell Composite & Question Rating

Composite & Question Ratings	2019 Rate	2020 Rate	2019 CMS National Data	2019 Quality Compass All Plans Percentile
Getting Needed Care	NA	86.3%	83.7%	N/A
• Ease of getting care, tests, or treatment needed	NA	86.1%	84.6%	N/A
• Obtaining appointment with specialist as soon as needed	NA	86.4%	82.8%	N/A
Getting Care Quickly	NA	82.6%	78.2%	N/A
• Obtaining needed care right away	NA	93.2%	86.7%	N/A
• Obtaining care when needed, not when needed right away	NA	80.6%	84.6%	N/A
• Saw person came to see within 15 minutes of appointment time	NA	74.0%	63.3%	N/A
Doctors Who Communicate Well	NA	92.6%	91.7%	N/A
• Doctors explaining things in an understandable way	NA	94.5%	91.2%	N/A
• Doctors listening carefully to you	NA	92.7%	92.0%	N/A
• Doctors showing respect for what you had to say	NA	93.3%	93.7%	N/A
• Doctors spending enough time with you	NA	89.8%	89.8%	N/A
Health Plan Customer Service	NA	NR*	90.3%	N/A
• Getting information/help from customer service	NA	86.7%	82.6%	N/A

Allwell Composite & Question Rating

Composite & Question Ratings	2019 Rate	2020 Rate	2019 CMS National Data	2019 Quality Compass All Plans Percentile
• Treated with courtesy and respect by customer service	NA	NR*	93.6%	N/A
• Ease of Filling Out Forms	NA	94.0%	94.8%	N/A
Care Coordination	NA	NR*	86.0%	N/A
• Personal doctor's office followed up to give you test results	NA	91.3%	84.5%	N/A
• Got test results as soon as you needed	NA	89.9%	85.6%	N/A
Test Results	NA	94.2%	N/A	N/A
• Doctor had medical records or other information about your care	NA	94.0%	95.2%	N/A
• Doctor talked about prescription medicines	NA	83.9%	81.7%	N/A
• Got help managing care	NA	NR*	88.4%	N/A
• Doctor informed and up-to-date about specialty care	NA	86.2%	80.4%	N/A
Rating of Drug Plan	NA	77.1%	86.1%	N/A
• Ease of using health plan to get prescribed medicines	NA	91.1%	89.4%	N/A
• Ease of using health plan to fill prescriptions at local pharmacy	NA	96.8%	91.6%	N/A
• Ease of using health plan to fill prescriptions by mail	NA	NR*	89.1%	N/A
Ratings Items				
Rating of Health Care	NA	72.5%	86.6%	N/A
Rating of Personal Doctor	NA	85.5%	91.6%	N/A
Rating of Specialist	NA	NR*	90.0%	N/A
Rating of Health Plan	NA	77.2%	87.3%	N/A

* - Note: "NR" represents results that have cell sizes of 10 or less. These results have been suppressed according to CMS rules.

Analysis – Allwell Member Satisfaction Surveys

Allwell from Sunflower Health Plan's goal for the 2020 CAHPS surveys is to meet or exceed the NCQA Quality Compass 50th percentile for all Summary Rate Scores. Due to COVID-19, the CMS Quality Compass Percentiles were not available for plan comparison. Allwell identified rate summary scores more than 5 percent lower than the 2019 CMS National Data rate. Allwell from Sunflower Health Plan will focus those areas for improvements.

Allwell Survey – Allwell Composite and Questions Ratings identified for improvement:

- Rating of Drug Plan
- Rating of Health Care
- Rating of Personal Doctor
- Rating of Health Plan

Allwell Opportunities Analysis

To identify opportunities to improve performance, Allwell examines all sources of member experience data to identify common issues across the various data sources. The grievance and appeal data and CAHPS survey results, including the Key Driver analysis, were reviewed by representatives from Allwell departments, including Provider Relations, Medical Management, Quality Improvement (including the Grievance and Appeal Coordinator), Network & Contracting, Member Services, Compliance, Pharmacy, I/DD, and Behavioral Health. The Member Satisfaction workgroup met and discussed barriers, opportunities to address these barriers to increase member satisfaction, and potential interventions. Opportunities identified by the various data sources are listed below in Table 11.

Allwell Opportunities Identified Across Satisfaction Data Sources

Improvement Opportunity	Member Grievances	Member Appeals	CAHPS Satisfaction Survey
Rating of Drug Plan	0	0	“Rating of drug plan” rated 77.1%, below the 86.1% for CMS 2019 National Data.
Rating of Health Care	0	0	“Rating of Health Care” rated 72.5%, below the 86.6% for the CMS 2019 National Data.
Rating of Personal Doctor	#1 Grievance.	0	“Access – availability” highest grievance from Allwell members.
Rating of Health Plan	#3 Grievance	#1 Appeal	Prior authorization, availability and benefits all showed highest member dissatisfaction.
Customer Service	#2 Grievance	#2 Appeal	“Treated with Courtesy and Respect” listed as NR on composite scoring. Enrollment and disenrollment #2 highest appeal.

In review of the report, barriers that appear to still be applicable in 2020 include:

- Incomplete information received from providers with initial request to authorize services, particularly for prior authorization pharmacy requests. On pre-service member appeals for authorization of services where documentation is provided with the appeal request that allows for the appeals to be overturned, had that information been provided with the initial request it would have likely been approved. Allwell continues to educate providers as opportunities exist.
- Members unresponsive to health plan outreach via mail, phone, or text; this remains an issue and the health plan continues to look for new and innovative ways to reach our members.
- Members unaware of the process for scheduling transportation and that Allwell can provide assistance with scheduling. The plan continues education on transportation benefit and collaboration with the transportation vendor. Allwell continues to monitor for opportunities for improvement.
- Member lack of understanding of appointment standards continues to be a trend. Allwell is focusing on member education, as CAHPS data reflects this is an area for continued efforts for improvement based on member feedback. Allwell has assessed this trend and the times reported on getting appointments are consistent with standards.
- Inaccurate member demographic information being used for outreach maintains as a barrier. This is a common and continuous struggle as members often move or change contact information. Allwell persists in looking for opportunities to ensure member demographic information is current and up to date to ensure that members can be reached to facilitate services and assist members in a timely manner. Allwell ensures member demographic information is validated at each member contact by Customer Service, Care Management, and any other member facing touches.

2020 is the first year for reporting Allwell Member Satisfaction rating by members. Below are the barriers and opportunities identified by reporting and Allwell departments. As the barriers/ opportunities were identified, action were implemented for improving member experience for future years.

Allwell Barriers and Opportunities

Barrier	Opportunity	Selected for Improvement ?	Priority
Rating of drug plan rated low by members completing the CAHPS survey.	Educate members and providers on covered prescriptions and prior authorization process. Monthly outreach to members for prescription refills.	Yes	3
Provider access availability was the highest grievance from members.	Continue to work with Provider Relations on identifying areas with less than 80% providers available within a 25 mile radius.	Yes	1
Marketing was the highest member appeals.	Identify brokers/ sales individuals and provide training/ educational materials for communicating member benefits.	Yes	2
Customer Service was the 2 nd highest member grievance.	Allwell Call Center is regionally supported. The Quality Improvement Team attends monthly calls with Call Center management teams to analyze data and track improvements.	Yes	4

Allwell Actions/Planned Actions

Date Initiated	Action Implemented/ Planned	Barriers Addressed
Q1 2020 (Ongoing)	Quality Improvement attends monthly Call Center meetings to track improvement opportunities. The monthly calls highlight enrollment/ disenrollment, Call Center metrics and CTM submissions.	Allwell's Call Center is managed by a Regional team supporting many Centene plans.
Q1 2020 (Ongoing)	Quality Improvement provides quarterly training to internal staff on CAHPS results and impacts to scoring.	Provide Allwell team members' information on how every member impact reflects the members' experience.
Q1 2020 (Ongoing)	Update CAHPS results for quarterly provider trainings; update CAHPS handout with survey feedback.	Member perception related to member experience.
Q1 2020 (Ongoing)	Allwell Member information is sent to the Centene Corporate Enrollment team via the Ember ticketing system.	Inaccurate member demographic information used for mailing or outreach process.

Allwell Actions/Planned Actions

Date Initiated	Action Implemented/ Planned	Barriers Addressed
Q1 2020 (Ongoing)	<ol style="list-style-type: none"> 1. Include appointment standards in member handbook; possibly add to social media. 2. Include appointment standards in Member newsletter. 3. Include appointment standards in Provider newsletter. 4. Include appointment standards in Social media. 5. Include appointment standards on Website. 	Member lack of knowledge related to appointment standards to see specialist.
Q4 2021 (Ongoing)	Annual Cornerstone training for all Allwell employees to complete.	Health Plan staff lack of understanding of CAHPS survey.
Q3 2021 (Ongoing)	Empathy training for Allwell employees to watch on an annual basis.	Treat members with courtesy and respect.

Member Grievances

Allwell defines a grievance (i.e. complaint) as any expression of dissatisfaction, received either verbally or in writing, about any matter other than an action/adverse determination. A grievance does not include a matter of misunderstanding or misinformation that can be promptly resolved by providing accurate information to the member. Allwell maintains an internal system for the identification, acknowledgement and prompt resolution of oral and written member grievances. Upon receipt of a verbal or written grievance, each one is assigned a category code based upon the main issue in the grievance, such as access to care, quality of care, billing and financial, or attitude and service, as well as assigning a sub-category.

The Allwell Grievance & Appeal Committee and Quality Improvement Committee review grievance data on a quarterly basis. Analysis performed by the Quality Improvement Committee, which is composed of departmental leaders and network physicians, enables Allwell to initiate quality improvement efforts to improve member experience as needed. This data summarizes the results and analysis of member grievances for January 1, 2019 through December 31, 2019. Final data is pending for 2020.

The below tables display grievance data by category and represents all member grievances resolved. All grievances are reviewed and analyzed; no sampling is used. The population for the rate per 1000 members is calculated with the total number of members in a given quarter.

Allwell from Sunflower Health Plan Member Grievances

2019 Allwell Member Population

Timeframe	Population
Quarter 1	776
Quarter 2	981
Quarter 3	1,146
Quarter 4	1,116
Year	1,399

**Final data pending for 2020

The below tables display grievance data by category and represents all member grievances resolved. All grievances are reviewed and analyzed; no sampling is used. The population for the rate per 1000 members is calculated with the total number of members in a given year. Final data pending for 2020.

Allwell Member Grievances

Grievance Category	1/1/2019 - 12/31/2019	Per 1000
Access	56	40.03
Benefits	43	30.74
CMS Issues	2	1.43
Coverage Determination/ Redetermination	4	2.86
Customer Service	54	38.60
Enrollment/ Disenrollment	17	12.15
Marketing	37	26.45
Organization Determinations and Reconsideration Process	3	2.14
Pharmacy	9	6.43
Plan Benefits	19	13.58
Quality of Care	6	4.29
Other	18	12.87
Total	268	191.57

Allwell Access Grievances

Access Reason	Q1 2019	Per 1000	Q2 2019	Per 1000	Q3 2019	Per 1000	Q4 2019	Per 1000	Total	Per 1000
Availability	7	9.02	9	9.17	8	6.98	6	5.38	30	21.44
DME	1	1.29	1	1.02	4	3.49	1	0.90	7	5.00
Prior Authorization Delay	0	0.00	5	5.10	3	2.62	1	0.90	9	6.43
Referral Process	0	0.00	3	3.06	2	1.75	0	0.00	5	3.57
Other	1	1.29	3	3.06	1	0.87	0	0.00	5	3.57
Total	9	11.60	21	21.41	18	15.71	8	7.17	56	40.03

**Final data pending for 2020

The grievance category with the highest volume for this reporting period was *Access*, representing 20.8% (56/268) of all grievances. The grievance category with the second highest volume for this reporting period was *Customer Service*, representing 20.1% (54/268) of all grievances. The 2019 reporting period was our baseline year for this data with a grievance rate of 191.57/1000. Final data pending for 2020.

Member Appeals

Allwell from Sunflower Health Plan defines an appeal as a member's request for the health plan to review/reconsider an action/adverse determination, in cases where the member does not agree with Allwell's decision. Practitioners may appeal on behalf of the member as the member's authorized representative.

The Grievance and Appeal Committee and the Quality Improvement Committee also review appeal data on a quarterly basis. Analysis performed by the Quality Improvement Committee, which is composed of departmental leaders and network

physicians, enables Allwell to initiate quality improvement efforts to improve member satisfaction as needed.

The below table displays appeal data by category, and represents all member appeals resolved within the reporting period. All appeals are reviewed and analyzed; no sampling is used. The population for the rate per 1000 is calculated with the total number of members in a given quarter.

Allwell Member Appeals

Category	Q1 2019	Per 1000	Q2 2019	Per 1000	Q3 2019	Per 1000	Q4 2019	Per 1000	Total	Per 1000
Not Medically Necessary	0	0.00	0	0.00	2	1.75	1	0.90	3	2.14
Pharmacy Denial	4	5.15	7	7.14	7	6.11	3	2.69	21	15.01
Total	4	5.15	7	7.14	9	7.85	4	3.58	24	17.16

Table 6: Allwell Member Appeal Totals

Appeal Category	1/1/2018 – 12/31/2018	Per 1000	1/1/2019 – 12/31/2019	Per 1000
Not Medically Necessary	N/A	N/A	3	2.14
Pharmacy Denial	N/A	N/A	21	15.01
Total	N/A	N/A	24	17.16

**Final data pending for 2020

Analysis – Allwell Member Appeals

The appeal category with the highest volume of appeals is *Pharmacy Denial*, which includes all Part D appeals. *Pharmacy* appeals comprise 87.5% (21/24) of all appeals received in the reporting period. The 2019 reporting period was our baseline year for this data with an appeal rate of 17.16/1000.

Allwell also assigns a subcategory to each appeal received, as listed in Table 7, below. A further analysis was performed to detail the key issues driving appeals; analysis was completed for the Pharmacy Denial category. Results for the analysis are provided below.

Table 7: Allwell Pharmacy Denial Appeals

Marketing	Q1 2019	Per 1000	Q2 2019	Per 1000	Q3 2019	Per 1000	Q4 2019	Per 1000	Total	Per 1000
Drug Covered Under Medicare A/B	0	0.00	0	0.00	1	0.87	0	0.00	1	0.71
Not Enough Information Received	0	0.00	1	1.02	0	0.00	0	0.00	1	0.71
Pharmacy - Exclusion	1	1.29	0	0.00	0	0.00	0	0.00	1	0.71

Table 7: Allwell Pharmacy Denial Appeals

Marketing	Q1 2019	Per 1000	Q2 2019	Per 1000	Q3 2019	Per 1000	Q4 2019	Per 1000	Total	Per 1000
Pharmacy – Other – Does Not Meet Criteria	2	2.58	1	1.02	1	0.87	0	0.00	4	2.86
RX – Does Not Meet Exception Guidelines	0	0.00	2	2.04	1	0.87	2	1.79	5	3.57
RX – Does Not Meet Prior Auth Guidelines	1	1.29	1	1.02	3	2.62	0	0.00	5	3.57
RX – Non Form/No NF Benefit	0	0.00	0	0.00	0	0.00	1	0.90	1	0.71
RX – Quantity Limit	0	0.00	1	1.02	0	0.00	0	0.00	1	0.71
RX – Off Label Usage	0	0.00	1	1.02	0	0.00	0	0.00	1	0.71
Totals	1	1.29	4	4.08	1	0.87	2	1.79	21	15.01

**Final data pending for 2020

Pharmacy Denial appeals in the subcategories of RX – Does Not Meet Exception Guidelines and RX – Does Not Meet Prior Auth. Guidelines each had 5/21 appeals or 23.8%. Appeals related to Pharmacy – Other – Does Not Meet Criteria account for 19% (4/21) of total appeals and is the second highest subcategory of Pharmacy Denial appeals in this reporting period. Allwell will continue to monitor member appeals data to identify opportunities for improvement. The data captured for the current reporting time-frame reflects the 2019 calendar year, January 1, 2019 through December 31, 2019.

Allwell Out of Network Utilization

Allwell from Sunflower Health Plan began tracking out of network utilization data, for the purpose of monitoring and identifying potential issues that members may experience, regarding access to physical health and behavioral health services. The data was broken down based on grievances and appeals, for calendar year 2018 and 2019. The results for Allwell are below:

Allwell Out of Network Utilization

Category	Q1 2019	Per 1000	Q2 2019	Per 1000	Q3 2019	Per 1000	Q4 2019	Per 1000	Total	Per 1000
Access	0	0	0	0	0	0	0	0	0	0
Benefits	0	0	0	0	0	0	0	0	0	0
CMS Issues	0	0	0	0	0	0	0	0	0	0
Coverage Determination/Redetermination	0	0	0	0	0	0	0	0	0	0
Customer Service	0	0	0	0	0	0	0	0	0	0
Enrollment/Disenrollment	0	0	0	0	0	0	0	0	0	0
Marketing	0	0	0	0	0	0	0	0	0	0

Organization Determinations and Reconsideration Process	0	0	0	0	1	0.87	0	0	1	0.71
Pharmacy Access	0	0	0	0	0	0	0	0	0	0
Plan Benefits	0	0	0	0	0	0	0	0	0	0
Quality of Care	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	1	0.87	0	0	1	0.71

**Final data pending for 2020

Analysis – Out of Network Utilization

The 2019 reporting period was our baseline year for this data. The Allwell product line saw 1 grievance received regarding an out of network provider and no appeals. As more data is collected in subsequent years, we will analyze to see if trends can be identified and actions implemented to improve network adequacy and member satisfaction.

Provider Satisfaction

Provider Appeals

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

In 2020, Allwell received 51 provider appeals. The top category by volume was Claim Payment Dispute – Hospital- Other followed by Claim Payment Dispute- Outpatient Procedure.

Reason	Count of Reason
Claim Issues - Claim Dispute	2
Claim Payment Dispute - Consultation - Internal Medicine	1
Claim Payment Dispute - Diagnostic - Test	1
Claim Payment Dispute - DME - Other	1
Claim Payment Dispute - DME - Oxygen Supplies	2
Claim Payment Dispute - Hospital - Other	9
Claim Payment Dispute - Office Visit - Routine Phys Exam	1
Claim Payment Dispute - Other - Mental Health Service	1
Claim Payment Dispute - Outpatient - Procedure	7
Claim Payment Dispute - Transportation - Ambulance	1
Non Authorized Service - DME - Medical and Surgical Supplies	1
Non Authorized Service - Hospital - Other	20

Non Authorized Service - Outpatient - Procedure	1
Timely Filing - ER - X-Ray/Lab Charges	1
Timely Filing - Late Filing of Appeal	1
Timely Filing - Transportation - Ambulance	1
TOTAL:	51

Provider Satisfaction Survey

SPH Analytics (SPH), a National Committee for Quality Assurance (NCQA) Certified Survey Vendor, was selected by Allwell/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 November to December 2020. 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.

The methodology demonstrating the response rates for mail, internet and phone survey responses is depicted below as well as shows how the ineligible provider responses are addressed.

Mail/Internet Component

$$91 \text{ (mail)} + 26 \text{ (Internet)} / 2,000 - 143 \text{ (ineligible)} = 6.3\%$$

Phone Component

$$1035 \text{ (phone)} / 2000 - 222 \text{ (ineligible)} = 28.4\%$$

Overall Satisfaction with Plan

2019 Provider Satisfaction Composite Scores	2019 Summary Rate	2020 Rate
Overall Satisfaction	63.80%	66%
Comparative Rating of Allwell compared with all other contracted health plans	32.90%	32%
Finance Issues	33.40%	32%
Utilization & Quality Management	32.20%	31%
Network/Coordination of Care	28.0%	25%
Pharmacy	21.0%	23%
Health Plan Call Center Service Staff	32.90%	32%
Provider Relations	35.20%	29%
Recommended to Other Physicians Practices	54.00%	55%

Year over year trending shows an overall increase in Overall Provider Satisfaction by 2.2% and 2% increase in Pharmacy.

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

Access and Availability

Cultural and Linguistic Capabilities

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

Network Adequacy

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

Accessibility of Primary Care Services

Allwell monitors primary care provider appointment accessibility against its standards, identifies opportunities for improvement and initiates actions as needed to improve results. Allwell incorporates practitioner office surveys, member complaints/grievances, and customer service telephone triage access on a regular basis and actions are initiated, when needed, to improve performance. This section describes the monitoring methodology, results, analysis, and action for each measure. The tables on the following pages denote the standards and performance.

Appointment Access Definitions - Standards and Methodology

Allwell defines urgent care appointments as within 48 hours from the time of the request for all practitioner types. Routine appointment accessibility for PCPs are not to exceed three weeks from the date of member requests. Access to a specialty care appointment within 30 days of request is the standard. For Behavioral Health, the access to care standard is 48 hours for urgent care, 10 days for routine care, and 6 hours for non-life threatening emergent care. Allwell 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.

Allwell surveyed a sample of participating (in network) credentialed practitioners, both PCPs and specialists (includes OB/GYN), and behavioral health, in 2020. No practitioners were excluded from the sample. Practitioner data was pulled from Allwell's provider management system, Portico. Data is collected by standardized survey. Allwell's appointment availability surveys request confirmation that the practitioner can accommodate members' appointment needs based on current practitioner availability for routine and urgent appointments.

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

Appointment Type	Standard and Performance Goal	Measurement Method	Measurement Frequency
Primary care urgent appointments within 48 hours	90% of surveyed PCPs report availability of urgent appointment within defined timeframe	Survey sample of all PCP offices	Annually
Primary care routine appointments not to exceed three weeks from date of member request	90% of surveyed PCPs report availability of urgent and appointment within defined timeframes	Survey sample of all PCP offices	Annually
Specialist urgent care appointments within 48 hours	90% of surveyed specialists report availability of urgent appointment within defined timeframe	Survey sample of all specialist offices	Annually
Specialist routine appointments not to exceed 30 days from the date of member request	90% of surveyed specialists report availability routine appointment within defined timeframes	Survey sample of all specialist offices	Annually
Behavioral Health routine appointments not to exceed 10 days from the date of the members request	90% of surveyed Behavioral Health providers	Survey sample of Behavioral Health providers	Annually
Behavioral Health Non-Life Threatening Emergent Care within 6 hours	90% of surveyed Behavioral Health Prescribers within defined timeframe	Survey sample of Behavioral Health providers	Annually
Wait time not to exceed 45 minutes	90% of surveyed PCPs 90% of surveyed specialists	Survey sample of PCP offices and specialists offices	Annually

Appointment Accessibility Results

The tables below demonstrates the results from 2020 assessment of Plan providers by types to include primary care, oncologists, OB/GYN providers and behavioral health providers. For the primary care providers (PCP), 142 completed the survey. Allwell met the goal for PCP first available routine appointment for both new and established. However, Allwell failed to meet the goals for Well Child EPSDT and primary care urgent appointments within 48 hours. The survey for the Allwell high impact specialists' yielded 17 oncology practitioners. The goal was met for high-impact specialists for first available appointment for new and established patients, for adults and children. The goal was not met for Urgent Care for new patients. For high-volume specialists, there were 19 OB/GYN who completed the survey. The results demonstrated failure to meet the goal for high-volume OB/GYN for initial visit, first trimester visit and urgent appointments within 48 hours. The results show that the goal was met for second and third trimester appointments for new patients, but not for established patients. For Behavioral health, there were 21 prescribers and 57 non-prescribers completing the survey. For BH providers, the only goals that were met were Routine Substance Use and Pregnant with IV Drug Use treatment for established patients, both at 90% for non-prescribers. Allwell directs members with non-life-threatening emergencies to the ER. In all categories, regardless of patient status.

Allwell considers the third available appointment to be the best overall indicator of appointment availability, as the first and second available appointments may actually reflect

available urgent appointment or appointments available due to cancellations for a given day, which may not represent average accessibility.

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

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

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, Allwell/Allwell 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 Allwell/Sunflower. Allwell/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 Allwell are distributed as MD (e.g. psychiatrists) and Non-MD behavioral health therapist.

For the 2020 Practitioner Availability Analysis, Allwell/Sunflower identified high-volume specialists as Obstetrics/Gynecology and high-impact specialists as Hematology/Oncology. For this report, Allwell/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).

Allwell/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 minutes.	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 40 minutes	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 minutes	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
	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
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

Practitioner Type	Standard	Measurement Method	Results	Goal Met?
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 Allwell/Sunflower’s standards for members residing in urban areas.

Two standards were not met for Allwell/Sunflower 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. Allwell/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 Allwell/Sunflower: 1:2000 for each type of PCPs.

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%.

Allwell/Sunflower analyzed behavioral health access for 2019, as behavioral health integrated at Allwell. 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. . Allwell/Sunflower is researching available psychiatrists in rural counties where we are not meeting access, which are Jewell, Smith, and Wallace.

Allwell/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).

Allwell/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. Allwell is contracted with all available hospitals in the rural and frontier areas.

Allwell/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 Allwell/Sunflower network to identify providers who are non-par for recruitment/contracting
- Identifying potential providers through other sources such as competitor websites, 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 Allwell/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, Allwell/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?”

2020 After-Hours Care Provider 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*

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 Allwell/Sunflower as the behavioral health component was incorporated into Allwell/Sunflower in 2019. Allwell/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 Allwell/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.

Disease Management Programs

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

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

Clinical Practice Guidelines

Allwell utilized the following clinical and preventive health practice guidelines in review of policy. Allwell made providers aware of the guidelines and their expected use through the provider newsletters, inclusion in the provider manual, and on the Allwell 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
- Immunizations
- 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 2020 related to practice guidelines were to continue and expand provider profiles in 2020 to a larger provider group to help increase knowledge, awareness and compliance.

Efforts Undertaken in 2020:

Allwell continues to complete annual review of CPGs and PHGs, review and update as appropriate based on the policy and procedure requirements. Goal was met in 2018 and Allwell will continue efforts in 2020:

- Continue to notify practitioners about the guidelines via newsletter and website announcements. Goal met in 2019 and continued in 2020
- Continue member and provider outreach and education-based initiatives regarding all guidelines. Goal is related to provider profiles
- Continue to meet applicable NCQA Standards throughout 2019 and continued in 2020 to meet standards

Allwell maintains preventive care guidelines as a reference on the Allwell 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

Numerous studies have demonstrated a deficiency in providing continuity in care across the healthcare system. Allwell from Sunflower Health Plan acknowledges this poverty of care delivery,

which may lead to patient safety concerns and poorer health outcomes for members. Allwell recognizes that a lack of communication and adequate care coordination can contribute to an increase in potential errors and a decrease in member satisfaction. Allwell is committed to monitoring aspects of continuity and coordination of medical care throughout the delivery system, and initiates actions to continually improve.

Allwell's annual continuity and coordination of medical care review, for reporting year 2020 (calendar year 2019), continues to monitor the following areas and initiate actions for improvement in the delivery of continuity and coordination of medical care. At the time of this report, the 2020 measurement year data was not complete:

- **Monitor 1:** The total number of members 18 years of age and older who have multiple high-risk chronic conditions and who had a follow-up service within 7 days of an ED visit.
- **Monitor 2:** The total number of inpatient discharges resulting in a follow-up visit with an outpatient provider within 30 days.
- **Monitor 3:** Number of members 18 years of age and older who discharge from an inpatient facility and who have medication reconciliation on the date of discharge through 30 days after (31 total days)
- **Monitor 4:** Practitioner satisfaction with the communication between primary care providers and specialists.

Monitor 1

The total number of members 18 years of age and older who have multiple high-risk chronic conditions and who had a follow-up service within 7 days of an ED visit.

In 2020, Allwell identified this as a new monitor and utilized HEDIS metric Follow-up after Emergency Department Visit for People with High-Risk Multiple Chronic conditions (FMC) to serve as the baseline measurement for Monitor 1.

- The population from which the measure is drawn is the total number members with emergency department visits for the calendar year.
- The denominator is the total number of members with emergency room visits who have multiple high-risk chronic conditions per HEDIS specifications.
- The numerator is the total number of members from the denominator who had a follow-up service within 7 days of the ED visit.
- Ambetter's performance goal will be to increase the FMC rate by 5 percent each measurement period.

Measurement Period	Numerator	Denominator	Rate	Goal	Goal Met?
MY 2019	14	27	51.85%	Baseline	NA

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Analysis – Monitor 1

Allwell offers clinical programs including an Emergency Department (ED) Avoidance Program as well as a Condition Management/Health Coaching Program to help members manage these conditions and avoid unnecessary ED utilization. The ED Avoidance program includes mailing an education packet that includes a flyer regarding the importance of seeing a PCP, using the Nurse Advice Line, and information regarding urgent care centers. Member are also referred to disease management or case management as indicated. Allwell has dedicated a workgroup to evaluate the ED Avoidance program, identify areas to enhance the identification of high-risk members for outreach, and develop a more robust intervention for the identified members. The members in the Condition Management/Health Coaching program are stratified by risk level and interventions are implemented dependent upon the risk level. Interventions may include self-management tools and education via an online portal, self-management guides, and behavior change coaching and education materials as agreed upon between the member and the health coach. All members that engage with a health coach are assessed for social determinants of health, co-morbidities, and depression.

Allwell established a performance goal to increase ED 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. The baseline rate for MY 2019 is 51.85%.

Allwell 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.

Priority	Barriers	Opportunity	Select for Improvement?	Actions/Interventions	Date Initiated
1	Lack of ED facility notifying or sharing medical records with PCP/ specialists	Educate ED facilities and other providers on ways to improve sharing of information post ED visit	Yes	Hired a dedicated provider communications and training specialist	Q2 2020
				Increase provider knowledge and use of provider portal	Q1 2019
2	Lack of systematic approach to coordination between ED facilities and PCP or specialist	Develop systematic approach for coordination	Yes	Implement medical home approach (OneCare Kansas)	Q2 2020

3	Members over-utilize ED and not managing chronic conditions	Educate members on managing chronic conditions and appropriate use of ED	Yes	ED Diversion program and Condition Management/Health Coaching program	Ongoing Best practice
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Monitor 2

The total number of inpatient discharges that resulted in a follow-up visit with an outpatient practitioner within 30 days.

Allwell continues to monitor the total number of inpatient discharges that resulted in a follow-up visit within 30 days and generated an administrative claim and encounter report for calendar year 2020. Allwell'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 Allwell 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.
- Allwell's performance goal is to increase follow-up visits with outpatient practitioners by 5 percentage points over the previous year results.

Monitor 2 Results: Inpatient Discharge Follow-Up

Measurement Period	Numerator	Denominator	Rate	Goal	Goal Met?
1/1/2019 – 12/31/2019	223	283	78.80%	Baseline	NA

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Analysis- Monitor 2

In an effort to ensure a comprehensive discharge plan is developed and in place prior to discharge, Allwell conducts multidisciplinary inpatient rounds weekly to discuss newly admitted inpatient members to address discharge planning; the team includes Medical Directors, Concurrent Review Nurses, Physical Health Care Managers, Behavioral Health Care

Managers, and leadership from each team. The discharge planning discussion includes any possible barriers to discharge, scheduled follow-up visits with a primary care or specialty provider, and other needed services. The Concurrent Review Nurse engages the hospital staff and the member's Care Manager, as applicable, to ensure appropriate discharge planning, assist with coordinating the discharge plan, and assesses for additional member needs. The discharge plan discussion includes the need for scheduled follow-up appointments, to occur within seven (7) days of discharge, organized post-discharge services, such as home care services, after-treatment services and/or therapy services, and information on what to do if a problem arises following discharge including primary care physician and the Care Manager contact information.

The discharge planning process was revamped in Q2 2020 to include outreach to members and discharge planners prior to discharge to enhance engagement. The CM team now also assesses Social Determinates of Health (SDOH) needs during this outreach. Once discharged to home, Allwell's post-discharge outreach to members on the per the Readmissions 2.0 protocol. Designated staff make attempts to contact all identified members within 3 days post-discharge and complete a transition of care (TOC) assessment. The goal of this outreach is coordination and continuity of care as members move from the acute care setting to ensure members have appropriate access to needed follow up care, home care services and medication with the goal of preventing secondary health conditions or complications, re-institutionalization, re-hospitalization or unnecessary emergency room use. If after initial discussion, the member is determined by Allwell to be at high risk for readmission and not already enrolled in care management, they are referred for Allwell care management services.

The rate for the baseline year 2019 was 78.80% of members that had a follow-up visit with an outpatient provider within 30 days of the inpatient discharge during the measurement period.

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 <i>Ongoing best practice</i>
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 of care	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 <i>Annually</i>
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Monitor 3

Number of members 18 years of age and older who discharge from an inpatient facility and who have medication reconciliation on the date of discharge through 30 days after (31 total days).

For Monitor 3, Allwell utilized the HEDIS metric TRC sub-measure Medication Reconciliation Post-Discharge.

- The population from which the measure was drawn is total number of members who discharged from an inpatient facility during the calendar year.
- The denominator is the number of members who discharged from an inpatient facility based on claims.
- The numerator is the number of members in the denominator who had a claim that indicated medication reconciliation from the date of discharge through 30 days after discharge.
- The goal is to improve by 5% year over year.

Monitor 3 Results: Transition of Care Sub-Measure Medication Reconciliation Post-Discharge (TRC)

Measurement Period	Numerator	Denominator	Rate	Goal	Goal Met?
HEDIS 2020 (MY 2019)	32	242	13.22%	Baseline	NA

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Analysis- Monitor 3

Allwell's goal is to improve care coordination post-discharge, including medication reconciliation. In order for medication reconciliation to occur, the member must first make it to their follow-up appointment. Allwell employs a discharge planning process, described in Monitor 2, to assist members with scheduling and keeping these appointments. Transportation can sometimes be a barrier to these follow-up appointments, so Allwell reminds members of non-emergent transportation benefits.

While this metric monitors that the medication reconciliation occurred, it does not assess the quality of the reconciliation. Quality medication reconciliation can be impacted by provider's lack of knowledge of historical medications prior to the discharge and incomplete records post-discharge. Allwell encourages utilization of the provider portal so providers can access this information.

Barriers/Interventions- Monitor 3

Priority	Barriers	Opportunity	Select for Improvement?	Actions/Interventions	Date Initiated
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3	Lack of transportation to appointments	Educate members/providers on NEMT benefit	Yes	Educational information available in Member Handbook/ Provider Manual and on website	Ongoing best practice
				CM's will reinforce follow-up care with members during post-discharge follow up calls and assist with scheduling of an appointment as needed.	
1	Members do not schedule/keep visits	Assist members with scheduling visits, remind members of appointments	Yes	Discharge Planning process (which includes assistance with scheduling/ keeping visits) revised, enhance outreach efforts, pilot new process to make improvements and retrain	Q2 2020
2	Providers lack of knowledge of historical medications	Provide tools to providers to gain knowledge of historical medications	Yes	Provide training on provider portal	Q1 2019
				Hired a dedicated provider communications and training specialist	Q2 2020

Monitor 4

Practitioner satisfaction with the communication between primary care providers and specialists.

The Allwell Provider Satisfaction Survey includes the evaluation of satisfaction with communication between primary care practitioners and specialty practitioners. Survey results allow Allwell to assess the level of satisfaction regarding communication among treating providers to assure appropriate coordination of medical care is occurring. Allwell 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.

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

$$\frac{231 (\text{phone})}{2000 (\text{sample}) - 143 (\text{ineligible})} = 28.4\%$$

The table below shows the response rates for the 2018 and 2019 Allwell Provider Satisfaction Survey.

Year of Survey	Component	Completed Surveys	Response Rate
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. Allwell'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=195)	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

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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.

Composite/ Attribute	2017 Responses	2018 Responses	2019
4C - The timeliness of feedback/ reports from specialists in	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%

this health plan's provider network.	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

Allwell’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. Allwell 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, Allwell 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, Allwell 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.

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 Relations and are presented in the table below. Many of the same barriers and opportunities identified from previous year’s analysis remain relevant.

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 Relations and are presented in the table below. Many of the same barriers and opportunities identified from previous year’s analysis remain relevant.

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	Yes	Information posted to Allwell website and include information on need to coordinate care between providers.	Q4 2016 <i>Ongoing best practice</i>
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 Allwell for assistance needed in identifying specialty providers member is receiving treatment.	Q4 2016 <i>Ongoing best practice</i>
				Increase provider knowledge and use of provider portal	Q1 2019 <i>Ongoing</i>
				Hired a dedicated provider communications and training specialist	Q2 2020

Priority	Barriers	Opportunity	Select for Improvement?	Actions/Interventions	Date Initiated
		Provide member education about the importance of informing their	Yes	Care managers and Customer service to educate members on the importance of telling PCP who they are seeing for specialty care.	Q1 2017 <i>Ongoing best practice</i>
			Yes	Person Centered Planning approach implemented during face-to-face visits to aid in identifying member barriers and goals.	Q4 2017 <i>Ongoing</i>
			Yes	CM to provide face-to-face Care Gap visits and assessments with members to address collaboration with providers.	Q4 2016 <i>Ongoing</i>

		PCP of specialists they are seeing.	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 Allwell staff to provide assistance with communication between practitioners.	Inform providers of the results of the Provider Satisfaction Survey.	Yes	Annual provider newsletter article regarding the survey results, and how Allwell can assist with issues related to communication between practitioners.	Q2 2017 <i>Ongoing best practice</i>

Continuity and Coordination of care between Medical and Behavioral Healthcare

Allwell from Sunflower Health Plan monitors and analyzes continuity and coordination of care between medical and behavioral healthcare on an annual basis. This report describes the methodology, results, analysis, and identifies opportunities for improvement for each monitor, for 2020 reporting year (calendar year 2019). At the time of this eval, the 2020 calendar year information was not complete. Allwell 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	DDE sub-measure Dementia and Antipsychotics (DDE)
Monitor 4	Screening and Management of Coexisting Disorders	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications (SSD) HEDIS measure
Monitor 5	Preventive Behavioral Program	Risk of Continued Opioid Use (COU)
Monitor 6	Special Needs of Members with Serious and Persistent Mental Illness	Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) HEDIS Measure

Monitor 1- Exchange of Information.

Allwell 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. Allwell 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. Allwell’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

$$91 \text{ (mail)} + 26 \text{ (Internet)} / 2,000 \text{ (sample)} - 143 \text{ (ineligible)} = 6.3\%$$

Phone Component

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

The table below shows the response rates for the Allwell 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 Rates

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%

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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:

Table 3- Satisfaction Rate

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 providers?	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%)

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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, Allwell met the goal of having a 5% increase. Allwell's goal for the 2020 provider satisfaction survey will again be to increase the satisfaction rating by 5 percent. Allwell 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/report	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%

s from the behavioral health providers?		(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%
		(n=122)	(n=97)	(n=97)

**Final Data Pending for 2020

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.

Allwell 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 Allwell's approach.

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

Table 5- 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
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Most of the actions previously in place have continued. As identified last year, Allwell from 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, Allwell identified a couple of additional action plans to address several of the opportunities. In Q2 2020, Allwell hired a dedicated provider communications and training specialist. Also in Q2, Allwell participated in the implementation of the OneCare Kansas medical home program.

Monitor 2- Appropriate Diagnosis, Treatment and Referral of Behavioral Disorders Commonly Seen in Primary Care.

Allwell 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. Allwell 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).

Table 6 AMM

Antidepressant Medication Management (AMM)			
AMM Indicator	HEDIS 2019	HEDIS 2020	Goal*
Effective Acute Phase Treatment	70.75% (75/106)	76.19% (288/378)	71.65%
Effective Continuation Phase Treatment	59.43% (63/106)	61.64% (233/378)	55.00%

*Quality Compass 50th Percentile HEDIS 2020

Allwell’s HEDIS 2020 rate for the *Effective Acute Phase Treatment* was 76.19%. This was a 5.44 percentage point increase over the benchmark year. Notably, the denominator also more than tripled as this line of business population grew since the baseline year. This metric exceeded the goal of the Quality Compass 50th percentile, which was 71.65% for HEDIS 2020. The rate for the *Effective Continuation Phase Treatment* was 61.64%, also an increase from the previous year of 59.43%. This metric also exceeded the benchmark goal.

Allwell mails education materials to members in the HEDIS AMM measure. The mailers were sent in the months of March and May. In Q4 2018, Allwell began mailing letters to members who were non-compliant with their depression medication each month, and this has continued in 2020. 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. Allwell's contact information is provided in the materials. Provider Profiles are sent to prescribing providers which will include their AMM adherence metrics.

Q1 and Q2 2019 Health Departments were sent lists of their non-compliant members for outreach. In Q4 2019, Provider Profiles will be sent to prescribing providers which will include their AMM adherence metrics. The table below states the barriers and opportunities Allwell has identified for the appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in the primary care setting.

The table below states the barriers and opportunities Allwell has identified for the appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in the primary care setting.

Table 7 Barrier and Opportunity

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 depression.	Yes	4
Treating providers not familiar with the depression clinical practice guideline	Educate providers about Allwell'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.

Allwell Health Plan monitors the use of antipsychotic medications for Allwell members with dementia. Allwell identified the use the HEDIS measure Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) sub-measure Dementia and Antipsychotics for this monitor.

Appropriate Use of Psychotropic Medications – Barrier Analysis

Allwell assessed the barriers and found no new barriers for the measurement year. Allwell continues to improve year over year and is meeting the goal, so the same interventions have been maintained.

Table 8 - DDE

Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) Sub-measure Dementia and Antipsychotics		
DDE Indicator	HEDIS 2020	Goal
Rate	33.33% (1/3)	Baseline

DDE is an inverted rate, meaning a lower rate is considered to be a better rate. The intent is to reduce the membership that falls into the numerator. The denominator for this metric was extremely small at only three members. One of those members fell into the numerator for potentially harmful antipsychotic use. With such a small numerator, member-specific outreach to the provider is an option for action.

In August 2020, Allwell held an ECHO provider training on implications of the use of Antipsychotics with the elderly population. Additionally, Allwell has a performance improvement plan (PIP) for the Medicaid line of business for the reduction of use of antipsychotics in the nursing facilities. That PIP may indirectly benefit the Medicare line of business, since the providers are the same.

Appropriate Use of Psychotropic Medications – Barrier Analysis

Allwell from Allwell assessed the barriers and found no new barriers for the measurement year. Allwell continues to improve year over year and is meeting the goal, so the same interventions have been maintained.

Table 9 - Monitor 3 Barrier and Opportunity Table

Barrier	Opportunity	Selected for Improvement?	Priority
Overuse of antipsychotics in Nursing Facilities	Coordinate with NF to identify patients who receive antipsychotics without an appropriate diagnosis	Yes	2

Prescribers limited understanding of effectiveness and implications of antipsychotic use in geriatric population or limited understanding of proper alternatives to treat symptoms	Educate providers on effectiveness and implications of antipsychotic use in geriatric population, as well as alternatives to address undesirable symptoms	Yes	1
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Monitor 4- Management of Treatment Access and Follow-up for Members with Coexisting Medical and Behavioral Disorders

Allwell monitors the coordination of care of members with serious and persistent illness. Specifically examining the barriers surrounding coordination and continuity of care for members who meet the criteria for the HEDIS *Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications (SSD)* measure. Through the collection of data, the SSD measure evaluates the percentage of members 18-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. Ensuring that members with high acuity special healthcare needs are receiving the proper monitoring and service coordination for both their behavioral and physical health conditions.

Allwell identified this metric for HEDIS 2020 to monitor for improvement opportunities. The below table demonstrates the baseline performance.

Table 10 – DM Screening/SSD

Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications (SSD)			
Year	Goal	Rate	Goal Met?
HEDIS 2020	Baseline	73.91% (17/23)	NA

The HEDIS 2020 rate for SSD was 73.91%. There were 23 members in the denominator, and of those, 17 members completed the necessary screening. There is no Quality Compass data available, so the goal in the future is to improve 5% year over year.

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

The development of a shared care plan has resulted in increased communication and a more collaborative approach. This approach allows both medical and behavioral health team members to employ and update a shared plan of member-driven goals.

Additionally, this model also allows the case management teams to provide cohesive education and resources to members for their medical and behavioral health needs.

Monitor 4– Barrier Analysis

Table 11 - Monitor 4 Barrier and Opportunity Table

Barrier	Opportunity	Selected for Improvement?	Priority
Members not understanding the importance of having regular diabetic screenings while on antipsychotic medications	Member education about importance of regular screenings	Yes	1
Staff knowledge regarding correlation between diabetes and the use of antipsychotic medications	Staff education/training regarding diabetes and the use of antipsychotic medications	Yes	3
Members not communicating to PCP that they are seeing a BH provider	Educate members regarding importance of notifying providers of services they receive from other providers	Yes	2

Monitor 5- Primary or Secondary Preventive Behavioral Healthcare Program

Allwell 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. Allwell hopes to see increased utilization of this more robust program starting Q4 2020.

Allwell 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, Allwell’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 Allwell will monitor the progression and assess the potential to leverage this pilot.

Table 12 - COU

Risk of Continue Opioid Use-15+ and 31+		
COU Indicator	HEDIS 2020	Goal
Total 15	17.07% (7/41)	Baseline

Total 31	14.63% (6/41)	Baseline
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The following barriers and opportunities were identified regarding management of members with coexisting medical and behavioral health disorders.

Table 13- 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 4- Management of Treatment Access and Follow-up for Members with Coexisting Medical and Behavioral Disorders.

Allwell monitors the coordination of care of members with serious and persistent illness. Specifically examining the barriers surrounding coordination and continuity of care for members who meet the criteria for the HEDIS *Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications (SSD)* measure. Through the collection of data, the SSD measure evaluates the percentage of members 18-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. Ensuring that members with high acuity special healthcare needs are receiving the proper monitoring and service coordination for both their behavioral and physical health conditions.

Table 10 - SSD

Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications (SSD)			
Year	Goal*	Rate	Goal Met?
HEDIS 2019	Baseline	77.4% (82/106)	NA
HEDIS 2020	81.27%	73.76% (104/141)	No

*5% increase Y over Y (no Quality Compass available for Marketplace for this metric)

Allwell launched the Allwell product in January 2018. The table above represents our baseline data for the Allwell SSD measure HEDIS year 2019 and the HEDIS 2020 data. The data shows there were 141 members identified in the denominator and 104 members identified in the numerator. The rate decreased from 77.4% to 73.76%, which did not meet the goal to increase 5 percent year over year. The management of treatment access and follow-up for members with coexisting medical and behavioral disorders requires overcoming the following barriers and opportunities.

Allwell practices integration between medical and behavioral health, case management departments. A primary case manager is assigned to a member, who can be a behavioral health or physical health case manager. The member's needs are assessed to determine who the primary case owner will be. A secondary case manager/owner may be assigned if the

member has both physical and behavioral health needs. The secondary case owner consults with the primary case owner and provides outreach services to the member as needed. Integrated rounds also increases communication regarding shared members.

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

Monitor 5- 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. Allwell 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. Allwell’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.

Allwell 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. Allwell hopes to see increased utilization of this more robust program starting Q4 2020.

Allwell 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, Allwell’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 Allwell will monitor the progression and assess the potential to leverage this pilot.

The table below demonstrates Allwell’s baseline performance on COU metric for HEDIS 2020.

Table 12 – Continued Opioid Use

Risk of Continue Opioid Use-15+ and 31+		
COU Indicator	HEDIS 2020	Goal
Total 15	3.69% (54/1463)	Baseline

Total 31	1.23% (18/1463)	Baseline
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The following barriers and opportunities were identified regarding management of members with Medical and Behavioral Healthcare Analysis.

Table 13- Barrier and Opportunity

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.

Allwell collects and analyzes data related to the coordination of special needs for members with serious and persistent mental illnesses for Allwell members through the use of the Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) HEDIS measure. This measure monitors the percentage of members 18-64 years of age with schizophrenia and diabetes who had both the LDL-C test and the HbA1c test during the measurement year. The table below shows Allwell performance for this measure for HEDIS 2019. This is a benchmark year for this Allwell report.

Table 14 – Diabetes/ SMD

Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)			
SMD Indicator	HEDIS 2019	HEDIS 2020	Goal
Rate	75.0% (3/4)	42.86% (3/7)	78.75%

The population size for this measure is extremely small, only ten members total who fell into the denominator. Of those, eight completed the tests required to meet the measure. There is no available Quality Compass benchmark for Medicare MY2019 due to COVID-19. The future goal is to improve the rate by 5% year over year.

Allwell case management staff review all cases referred to them for care alerts within Allwell's medical records system. Allwell's Impact Pro and Interpretata 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 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.

Additionally, Allwell's Medicaid LOB developed a performance improvement plan (PIP) in 2020 to address SMD. Allwell will monitor the effectiveness of those interventions to determine if they may be viable for Allwell. Those include:

- Warm outreach calls to members. Allwell Case Management Staff will make outreach calls to members who have not completed an LDL-C test and an 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.
- Allwell will provide CMHCs and PCPs with reports that include the member's compliance status with the SMD measure.
- Co-branded letters. Allwell will partner with willing PCP/CMHC offices to offer co-branded member facing letters to encourage members to complete their recommended follow up.

Table 15- Barrier and Opportunity

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

Table 16- Comprehensive Table

Monitor	Barrier Addressed	Action	Date Initiated
Appropriate Use of Psychotropic Medications	Prescribers limited understanding of effectiveness and implications of antipsychotic use in geriatric population or limited understanding of proper alternatives to treat symptoms	ECHO training for providers covering the effectiveness and implications of antipsychotic use in geriatric population, as well as other alternatives to address undesirable behaviors	Q3 2020
	Overuse of antipsychotics in Nursing Facilities	Leverage potential benefit of action from Medicaid P4P actions: Educational letters to	Q1 2020

Management of Treatment Access and Follow-up for Members with Coexisting Medical and Behavioral Disorders	Members not understanding the importance of having regular diabetic screenings while on antipsychotic	Refer identified members to the CM team for education on regular diabetic screenings	Q1 2019 (Ongoing)
	Staff knowledge regarding correlation between diabetes and the use of antipsychotic	Case management training on diabetes and antipsychotic medication	Q2 2019 (Ongoing)
	Members not communicating to PCP that they are seeing a BH	Develop member brochure to explain the importance of sharing information between providers	Q4 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	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 2019 (Ongoing)
		CM outreach and education to the member regarding regular antipsychotic medication	Q1 2019
	Prescribers not aware of status of diabetic testing	Enhanced education of providers regarding using the portal to determine care gaps	Q1 2019

UM Program Overview

Purpose

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

Utilization Improvement Program/ Integration

Allwell 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. Allwell BOD delegates the daily oversight and operating authority of the utilization management (UM) activities to Allwell'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 Allwell's QIC, which reports to the BOD. The UM Program is reviewed and approved by Allwell's BOD, through the QIC, on an annual basis.

Allwell Medical Directors have operational responsibility for and provide support to Allwell's UM Program. The Medical Directors, Vice President of Population Health Clinical Operations (VPPHCO) and/or any designee, as assigned by Allwell 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 Allwell's QIC and ultimately to Allwell 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 Allwell's QIC.

UM Committee Scope

- Oversee the UM activities of Allwell in regard to compliance with contractual requirements, federal and state statutes and regulations, and requirements of accrediting bodies such as NCQA and/or URAC
- Annually review and approve the UM program description, guidelines, and procedures
- Annually review and approve the criteria for determination of medical appropriateness to be used for nurse review
- Adapt criteria for determination of medical appropriateness to work within the delivery system
- Review provider specific reports for trends or patterns in utilization
- Review reports specific to facility or geographic areas for trends or patterns
- Formulate recommendations for specific providers for further study
- Monitor the adequacy of the network to meet the needs of the patient population
- Examines results of annual member and practitioner experience surveys to determine overall satisfaction with the UM program and identify areas for performance improvement
- Examine reports of the appropriateness of care for trends or patterns of under or over utilization and refer them to the proper provider group for performance improvement or corrective action
- Examine results of annual surveys of members and providers regarding satisfaction with the UM program

- Include a feedback mechanism for communicating findings and recommendations, and contain a plan for implementing corrective actions
- Report findings to the QIC
- Liaison with the QIC for ongoing review of indicators of clinical quality

UM Committee Members

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

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 Allwell 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 Allwell's QI department. As care managers perform the functions of utilization management, member quality of care measures (indicators prescribed by Allwell 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 Allwell 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 Allwell for review and resolution as needed. The Chief Medical Director or Medical Director determines if the information warrants additional review by Allwell 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, Allwell coordinates utilization/care management and education activities with local community providers for activities that include, but are not limited to:

- State protective and regulatory services
- Substance Abuse Screenings
- Services provided by the local community mental health centers and substance abuse providers
- Services provided by local public health departments

Delegation

Allwell will delegate various UM activities to entities that demonstrate the ability to meet Allwell's UM standards and standards for delegation, as outlined in the UM plan and policies and procedures. Allwell 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 Allwell. 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 Allwell's UM standards; including timeframes outlined in Allwell's policy and procedure Timeliness of UM Decisions and Notifications.
- The delegated group is responsible for providing Allwell with a written UM Program Description/Plan for annual review and approval by Allwell's QIC
- The delegated group is responsible for submitting utilization reports, to include monthly utilization summaries, high cost days, and quality assurance/improvement issues.
- Allwell 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, Allwell 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 Allwell must evaluate the compatibility of the delegate's UM Program with Allwell's UM Program. Once delegation is approved, Allwell will require that the delegate provide the appropriate reports as determined by Allwell to monitor the delegate's continued compliance with the needs of Allwell. Allwell will annually review the delegate's ongoing accreditation status.

Allwell 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, Allwell 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 Allwell 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.

Allwell 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 Allwell 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, Allwell 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. Allwell uses InterQual's Level of Care and Care Planning Criteria for Pediatric Acute, Adult Acute, Home Care, Durable Medical Equipment and Procedures to determine medical necessity and appropriateness of care. Allwell may also use the Sub acute/Skilled Nursing guidelines to assist in determining medical necessity for sub-acute or skilled nursing care for members with catastrophic conditions or special health care needs. Allwell utilizes InterQual Criteria for

behavioral health inpatient, residential/PRTF, partial hospitalization, intensive outpatient and outpatient therapy services. Allwell may also use ASAM criteria for substance abuse. For determination of the community based services for behavioral health, Allwell 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 Allwell 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 Allwell 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 Allwell 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.

Allwell makes determinations for standard, non-urgent, pre-service prior authorization requests within 14 calendar days of receipt of the request. A determination for urgent preservice care (expedited prior authorization) will be issued within 72 hours of receiving the request for service. Allwell 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 Allwell. 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 from receipt of request.

Allwell met the goals for TAT. The compliance rate for Part C expedited was 100%, and standard was 99%. Part D (pharmacy) expedited rate was 100% and standard was 99.1%

TAT	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Year
Part C pre-service - expedited	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100%	100.0%	100.0%
Part C pre-service - standard	96.0%	100.0%	100.0%	100.0%	100.0%	96.0%	100.0%	100.0%	100.0%	100.0%	96%	100.0%	99.0%
Part D - expedited <24 hours							100.0%	100.0%	100.0%	100.0%	100%	100.0%	100.0%
Part D - standard <72 hours							100.0%	100.0%	100.0%	97.50%	100%	97.1%	99.1%

Denials

Denials	Inpatient	Outpatient	Pharmacy (bio-pharm)
Denied	44	255	5
% Denied	2.50%	13.21%	3.73%
Approved	1,714	1,676	129
% Approved	97.50%	86.79%	96.27%
Total	1,758	1,931	134

The greatest denial rate was outpatient at 13.21%, followed by pharmacy at 3.73% and lastly inpatient at 2.50%. Allwell monitors denial rates for outlier data to determine the need for process improvement or internal or external education. The denial rates for 2020 were within typical ranges.

Appeals

Appeals	Pharmacy	Other
Upheld	22	2
% Upheld	40.74%	18.18%
Overtured	32	9
% Overtured	59.26%	81.82%
Total	54	11

*Note, there are more appeals than report denials because the appeal include those completed by Envolve Pharmacy, while the denials only included those completed within the health plan.

The total number of appeals is small at 54 for pharmacy and 11 for other decisions. The majority are overturned. Most appeals are overturned because more information is provided upon appeal than upon request for services.

Pharmacy	Urgent	Standard
In TAT	144	565
% in TAT	96.00%	97.08%
Out of TAT	6	17
% Out of TAT	4.00%	2.92%
Total	150	582

Allwell met the TAT goals of 98% for 2020 for all inpatient authorizations, with 98.05% compliance with Medical and 98.36% with BH 3 calendar day TAT. Allwell met the BH 14 calendar day TAT goal at 98.50%; however, the Medical 14 calendar day TAT was 96.18%. Allwell pharmacy manages the bio-pharmacy at Allwell, whereas other pharmacy is managed by the vendor Envolve Pharmacy Solutions. Allwell did not meet the 98% TAT for urgent (96.00%) or standard (97.08%) pharmacy authorizations. Allwell experienced a staffing challenge during the year that contributed to this performance. As a result, Allwell is reviewing prior authorizations to determine if there are any authorization requirements that could be eliminated. Allwell 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. Allwell uses two delegated vendors, NIA for PT/OT/ST and Turning Point for musculoskeletal services. Allwell continues to monitor and assess the potential benefits or costs of vendors for impact on overall performance.

Denials

	Inpatient*	Outpatient*	Pharmacy
Denied	229	744	64
% Denied	6.42%	13.54%	8.74%
Approved	3,336	4,749	668
% Approved	93.58%	86.46%	91.26%
Total	3,565	5,493	732

*Note: There is some variance in totals compared to the TAT metrics based on received date versus decision date.

Appeals

Appealed Authorizations		
	Pharmacy	Other
Upheld	22	2
% Upheld	40.74%	18.18%
Overtured	32	9
% Overtured	59.26%	81.82%
Total	54	11

*Note, there are more appeals than report denials because the appeal include those completed by Envolve Pharmacy, while the denials only included those completed within the health plan.

The total number of appeals is small at 54 for pharmacy and 11 for other decisions. The majority are overturned. Most appeals are overturned because more information is provided upon appeal than upon request for services.

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 Allwell 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 Allwell. 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.

Allwell, in coordination with Centene corporate technology partners, is exploring automation and bots to improve efficiencies of health plan activities by eliminating the manual transfer of information from the input source to the output. Such efficiencies will allow staff to focus time on the critical responsibilities that require higher skill sets.

Member and Practitioner Satisfaction with UM

Member Grievances related to UM

Grievances received by Allwell 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	5	<5:100	Yes
% UM Member Grievances / Total Member Grievances	2.14:100		
Total Member Grievances	234		

Allwell met the goal of less 5 of 100 grievances related to UM at the rate of 2.14:100. Allwell continues to educate members on how to file a grievance.

Member Experience with UM

Allwell 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 Marketplace CAHPS Survey Results for 2020:

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 Allwell’s Marketplace 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, Allwell 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.
- Educate members on how to access information about the health plan.
- 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 needing.
- 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

Allwell 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.
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Provider satisfaction rates are seen in the following table, and are inclusive of all products. Detailed analysis is available in the 2020 Member and Provider Satisfaction with UM Report.

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 Allwell 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

Allwell from 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 Allwell covers and encourages preventive care and wellness, is significantly lower in 2020 at 33% compared to 44.1% in 2019.

Allwell 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 provider education on covered benefits.
- Enhance training of UM staff for interrater reliability.

Provider Grievances related to UM

Grievances received by Allwell 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 Allwell’s Marketplace Utilization Management. Allwell 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	0	<25/100	Yes
% UM Provider Grievances / Total Provider Grievances	0.00%		
Total Provider Grievances	24		

The goal for provider grievances related to UM is less than 25 of every 100 grievances. None of the grievances filed from Allwell providers in 2020 were related to UM. There were only 24 provider grievances filed in total. Allwell continues to educate providers on how to file grievances.

ER Utilization

Allwell 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. Allwell 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.

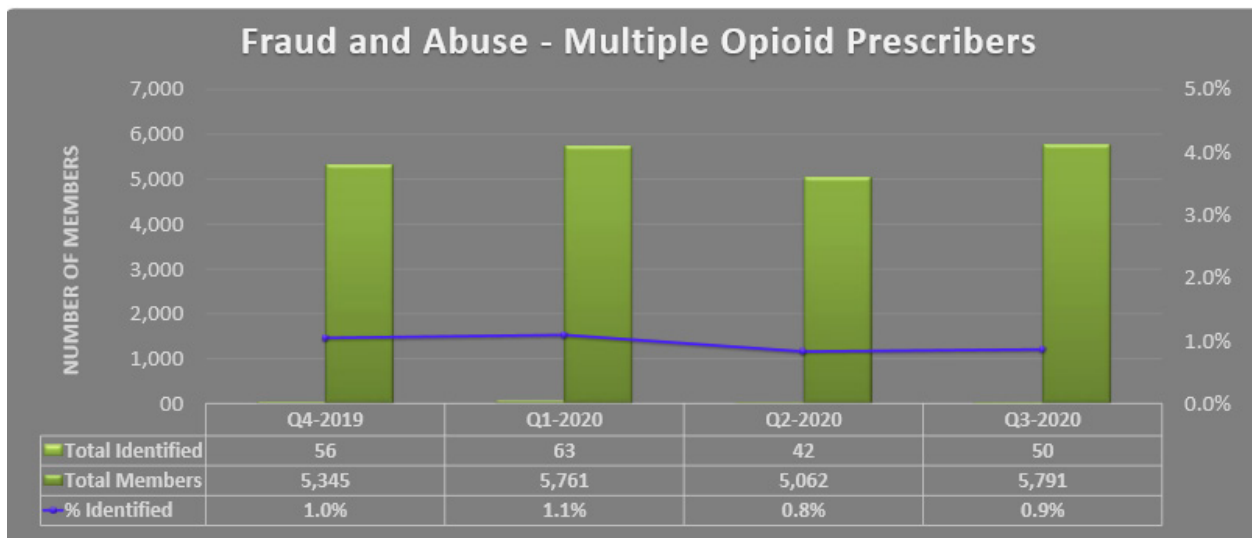
Allwell's strategies including review of monthly reports of member using the ED, triaging that list for referrals to Disease Management or Case Management, and sending education flyers to members.

ED Utilization Ages: 18 +	2019	2020	Goal
Observed ED Visits	2,142	1,494	4% reduction
Members	8,946	9,476	
Observed ED Visits per 1,000 Members	239.44	157.66	

Allwell experienced a dramatic decrease in ED utilization from 239.44 per 1000 in 2019 to 157.66 in 1000 in 2020. That is a 24% decrease, far exceeding the goal of 4% reduction.

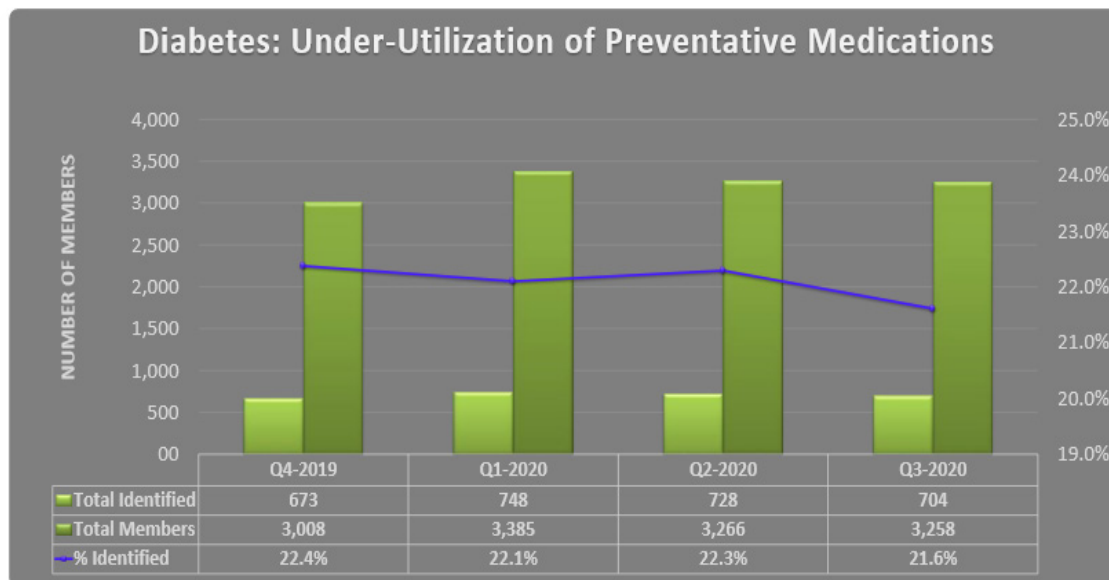
Pharmaceutical Management

Allwell 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/out-patient 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. Allwell’s goal is for 100% of Allwell’s UM and Appeals staff to pass all applicable IRR tests with a score of 90% or higher. At least annually, the Allwell Medical Management Training Department 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. Allwell 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 Allwell 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 Allwell 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.

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 Allwell from Allwell's 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 provider in the UM program

Allwell 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 Allwell’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. Allwell will continue to work to maintain and improve on the gains achieved in 2019, and will take the necessary steps to improve on the areas noted with priority opportunities for improvement in 2021.

Review and Approval

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



Submitted By: Susan Beaman, VP of Quality

Date of QIC: 3.29.2021



QIC Chair Approval: Scott Latimer, MD

Date of QIC: 3.29.2021



Board Chair Approval: Michael R. Stephens

Date: 5.20.2021