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

January 1 - December 31, 2015

*Data as available by 4/18/16

Introduction

The purpose of this evaluation is to provide a systematic analysis of Sunflower Health Plan's (Sunflower) performance of the Quality Improvement (QI) activities and to evaluate the overall effectiveness of the Quality Assessment and Performance Improvement (QAPI) Program. The QI Department has established reporting QI activities as outlined in the QI Work Plan. This evaluation is focused on activities and interventions completed during the period of January 1 - December 31, 2015. The QAPI, QI Work Plan and QI Program Evaluation are reviewed and approved at least annually by the Quality Improvement Committee (QIC) and the Sunflower Health Plan's Board of Directors (BOD).

Mission

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

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

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

Purpose

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

Member Demographics and Service Area

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

Assessment of Sunflower's membership population has been completed annually from 2013 through 2015. A systematic review was undertaken to determine if there have been material changes in the population that would require the case management program to be substantially revised.

Membership Characteristics

Sunflower is in its third year of operations and has demonstrated below, TANF and CHIP members consistently make up the majority of the Sunflower membership. The children aged 0-10 also consistently comprise nearly half of the membership each year. Males and females are fairly equally distributed. Sunflower's membership by month data demonstrates there has been little change by product line and overall the Sunflower membership by product line has remained stable.

The Sunflower membership characteristics for 2013 through 2015 are shown in the tables below:

Product	2013	2014	2015
CHIP	15%	14%	14%
Foster Care	4%	4%	4%
LTC Dual	6%	6%	3%
LTC Non-Dual	3%	3%	6%
SSI Dual	5%	4%	1%
SSI Non-Dual	8%	7%	10%
TANF	60%	62%	61%
Total	100%	100%	100%

Age Group	2013	2014	2015
0-10	47%	48%	47%
11-20	26%	25%	26%
21-30	7%	7%	7%
31-40	5%	5%	5%
41-50	4%	3%	4%
51-60	4%	4%	4%
61-70	3%	2%	3%
71-80	2%	2%	2%
81-90	2%	1.70%	2%
91+	0	0	1%

Gender	2013	2014	2015
M	54%	46%	54%
F	46%	54%	46%

The table below reflects the 2015 membership for each product periodically throughout the year demonstrating relative consistency.

	CHIP	Foster Care	LTC Dual	LTC Non-Dual	SSI Dual	SSI Non-Dual	TANF	Total
2/2015	19,639	5,309	9,091	3,920	6,473	10,625	90,498	145,555
4/2015	20,172	5,396	9,013	3,881	6,416	10,529	90,949	146,356
7/2015	20,240	5,442	8,937	3,893	2,381	14,259	88,018	143,170
10/2015	20,043	5,415	8,897	3,956	2,322	14,232	86,996	141,861
12/2015	19,948	5,453	8,796	4,009	2,252	14,153	88,561	143,172
% of Membership	13.93%	3.81%	6.14%	2.80%	1.57%	9.89%	61.85%	100.00%

Below are Sunflower's 2015 year-end information and percentage of change from 2014 to 2015.

	CHIP	Foster Care	LTC Dual	LTC Non-Dual	SSI Dual	SSI Non-Dual	TANF	Total
2014	19,868	5,330	8,922	3,994	6,400	10,638	89,609	144,761
2015	19,948	5,453	8,796	4,009	2,252	14,153	88,561	143,172
Percentage of change	0.40%	2.30%	-1.41%	0.38%	-64.81%	33.04%	-1.17%	-1.10

The following are the percent of the total membership that each of Sunflower's products comprised, 2014 compared to 2015.

Percentage of membership	CHIP	Foster Care	LTC Dual	LTC Non-Dual	SSI Dual	SSI Non-Dual	TANF	Total
2014	13.7%	3.7%	6.2%	2.8%	4.4%	7.3%	61.9%	100.0%
2015	13.9%	3.8%	6.1%	2.8%	1.6%	9.9%	61.9%	100.0%

When comparing the year-end information Sunflower's total membership decreased from 144,761 in 2014 to 143,172 in 2015, a decrease of 1.10%. In 2015, Sunflower's largest membership group was Temporary Assistance for Needy Families (TANF), making up 62% of the population which has remained consistent over the last two years. Followed by Children's Health Insurance Program (CHIP) as second highest population served by Sunflower. It has been noted that year over year the membership of SSI Duals has decreased while the SSI Non-Duals has increased. Little movement was seen overall by product in 2015 for Sunflower.

For 2015, Sunflower's membership remained stable as there were no changes with regard to expansion of Medicaid in Kansas. Members have an annual open enrollment period to change MCO's. As most members do not act upon making change, Sunflower does not expect much member movement to be reflected in 2016.

Languages Spoken by Sunflower Members

Language Line July 14 – June 15	Number of calls	Percentage of Total
Spanish	**9799**	**94.07%**
Burmese	**159**	**1.53%**
Russian	**133**	**1.28%**
Vietnamese	**82**	**.79%**
Somali	**45**	**.43%**
All other languages	**199**	**1.9%**
Total	**10417**	**100%**

Sunflower assesses members' linguistic needs based on the state eligibility files which query members on their primary language spoken, 72.85% of Sunflower members speak English, 23.07% did not report a primary language, and 3.14% speak Spanish. A detailed

breakdown of other less common languages are below. Sunflower membership mix of Spanish speaking members is less than 2013 US Census Bureau data which reports a Spanish speaking rate of 7.2%, which was also considered.

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Sunflower offers language assistance services to members who require translation services. Services are available for both telephonic and on-site interactions and can be arranged by Sunflower case management or Customer Service staff for member interactions with both Sunflower staff and network providers. The table above represents the top five languages for which members have requested translation services by unique interactions. Sunflower also has two Spanish-speaking and one Russian-speaking Customer Services Representatives on staff. One Customer Service Supervisor and Quality Specialist I from the Customer Service team are also Spanish speaking to ensure that our Spanish speaking members are well served.

Race/Ethnicity

The table below reflects race and ethnicity and is based on members who responded to the 2015 CAHPS survey and responded to provide designated race/ethnicity on the survey. This data provided allows for comparison to the designated race/ethnicity provided on the 2014 CAHPS surveys as well.

Race / Ethnicity Category	2014 Child CAHPS	2015 Child CAHPS
White	81.3%	79.5%
Black /African American	20.4%	15.0%
Hispanic / Latino**	23.7%	30.5%
Asian	4.8%	3.6%
Hawaiian / Pacific Islander	2.4%	1.4%
American Indian / Alaskan	6.1%	6.3%
Other	11.1%	13.2%

Race / Ethnicity Category	2014 Adult CAHPS	2015 Adult CAHPS
White	75.8%	80.1%
Black /African American	16.8%	15.4%
Hispanic / Latino**	12.9%	11.1%
Asian	3.9%	2.2%
Hawaiian / Pacific Islander	0.2%	0.6%
American Indian / Alaskan	7.4%	8.0%
Other	8.0%	7.2%

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

Results from the 2015 CAHPS surveys for both adult and child populations indicate that there was consistency with respect to the race/ethnicity of the Sunflower membership in comparison from 2014 to 2015. The majority of Sunflower membership is white followed by Black/African Americans and then by the Hispanic/Latino membership. This remains consistent with results demonstrated on both the adult and child 2014 CAHPS surveys as well.

Program Overview

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

Scope

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

Sunflower's QAPI Program monitors the following:

- Acute and chronic care management
- Behavioral health care
- Care Management
- Compliance with member confidentiality laws and regulation
- Compliance with preventive health guidelines and practice guidelines
- Continuity and coordination of care
- Data collection, analysis and reporting
- Delegated entity oversight
- Department performance and service
- Employee and provider cultural competency
- Fraud and abuse detection, prevention and reporting
- Home support service utilization for LTSS services
- Information Management
- Marketing practices
- Member enrollment and disenrollment
- Member Grievance System
- Member satisfaction
- Customer Services
- Network performance
- Organization Structure
- Patient safety
- Primary Care Provider changes
- Pharmacy
- Provider and Plan after-hours telephone accessibility
- Provider appointment availability
- Provider Complaint System
- Provider network adequacy and capacity

- Provider satisfaction
- Provider Services
- Selection and retention of providers (credentialing and re-credentialing)
- Utilization Management, including under and over utilization
- Policies to support the QAPI program

Goals

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

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

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

Objectives

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

- To establish and maintain a health system that promotes continuous quality improvement;
- To adopt evidence-based clinical indicators and practice guidelines as a means for identifying and addressing variations in medical practice;
- To select areas of study based on demonstration of need and relevance to the population served;
- To develop standardized performance measures that are clearly defined, objective, measurable, and allow tracking over time;
- To utilize Management Information Systems (MIS) in data collection, integration, tracking, analysis and reporting of data that reflects performance on standardized measures of health outcomes;
- To allocate personnel and resources necessary to:

    - support the quality improvement program, including data analysis and reporting;
    - meet the educational needs of members, providers and staff relevant to quality improvement efforts;
- To seek input and work with members, providers and community resources to improve quality of care provided to members;
- To develop partnerships with new stakeholders and providers to establish services and relationships to support home and community based services and LTC residential options;
- To oversee peer review procedures that will address deviations in medical management and health care practices and devise action plans to improve services;
- To establish a system to provide frequent, periodic quality improvement information to participating providers in order to support them in their efforts to provide high quality health care;
- To recommend and institute "focused" quality studies in clinical and non-clinical areas, where appropriate.

Committee Structure

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

Board of Directors

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

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

The Board delegates the operating authority of the QAPI Program to the Quality Improvement Committee (QIC), with operational oversight by the SEQI. Sunflower senior management staff, clinical staff, and network providers, who may include primary,

specialty, behavioral, dental and vision health care providers are involved in the implementation, monitoring and directing of the relative aspects of the quality improvement program through the QIC, which is directly accountable to the BOD.

Quality Improvement Committee (QIC)

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

The QIC is composed of Sunflower's CEO/President, Chief Medical Director, Associate Medical Director, and QI senior leadership, along with other Sunflower executive staff representing Medical Management (including Utilization Management and Case Management), Network Development/Contracting, Customer Service, Compliance, and Pharmacy departments, with other ad hoc members as necessary. Additional QIC attendees include staff responsible for clinical appeals and Waste Abuse and Fraud. The first QIC meeting was held December 19, 2012, prior to implementation of KanCare, and met four times in 2014. The QIC met at minimum quarterly in 2015.

Credentialing Committee

The Credentialing Committee is a standing subcommittee of the QIC and is responsible for administering the daily oversight and operating authority of the Credentialing Program. The QIC is the vehicle through which credentialing activities are communicated to the Board of Directors. The Credentialing Committee is responsible for the credentialing and re-credentialing of physicians, non-physician practitioners, facilities, long-term care providers, and other practitioners in Sunflower's network, and to oversee the credentialing process to ensure compliance with regulatory and accreditation requirements. The Credentialing Committee is facilitated through Centene's corporate office and is composed of Sunflower's Chief Medical Director and Associate Medical Director, Centene's Corporate Credentialing Director, network physicians, and other Sunflower QI staff. The Credentialing Committee met 11 times in 2015. Typically the Credentialing Committee meets monthly and on an ad-hoc basis.

The Credentialing Department is responsible for ensuring all practitioners are appropriately licensed and experienced in their field. This is accomplished through applying rigorous standards that verifies practitioner's license, education, training, experience, certification, malpractice history, work history, and quality of care attributes. To become a participating provider in the Sunflower network, each practitioner must meet the minimum qualifications as outlined by the State of Kansas and the National Committee for Quality Assurance (NCQA). The Credentialing Department is housed at Centene's corporate offices. The table below reflects the 2015 Credentialing report for Sunflower.

Sunflower's number of practitioners in network for 2015 was 15,884 which was up from 14,369 in 2014. In 2015, Sunflower practitioners started through the process of being re-

credentialed which numbered 987. 100% of those were successfully re-credentialed timely. These details are depicted in the table that follows.

2015 Credentialing Statistics	
Total number of practitioners in network (includes delegated providers) as of 12/31/2015	15,884
Initial Credentialing (excludes delegated)	
Number initial practitioners credentialed	907
Average Credentialing TAT From Complete Application to Committee (Days)	12.41
Recredentialing	
Number practitioners re-credentialed	987
Number practitioners re-credentialed within 36 month timeline	987
% re-credentialed timely	100%
Terminated/Rejected/Suspended/Denied	
Number with cause	0
Number denied	0

Pharmacy and Therapeutic Committee

The Pharmacy and Therapeutics (P&T) Committee is a standing subcommittee of the QIC and is responsible for administering the daily oversight and operating authority of the Pharmacy Program. The QIC is the vehicle through which pharmacy monitoring and reporting activities is communicated to the Board of Directors. The P&T Committee ensures Sunflower provides a high quality, cost effective preferred drug list (PDL), an effective pharmacy program, and addresses quality and utilization issues related to pharmaceutical prescribing patterns, practices, and trends. The P&T Committee is a multidisciplinary team composed of Sunflower's Chief Medical Director, Associate Medical Director, Pharmacy Director, network physicians, and other executive staff. For 2015, P&T met three times. Typically, the P&T Committee meets quarterly.

Utilization Management Committee

Daily oversight and operating authority of utilization management activities is delegated to the Utilization Management Committee (UMC) which reports to the QIC and ultimately to the Sunflower Board of Directors. The UMC is responsible for the review and appropriate approval of medical necessity criteria and 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 and appropriate use of services and resources as well as member and practitioner satisfaction with the UM process. The UMC is composed of Sunflower's Chief Medical Director, Associate Medical Director, Sunflower's Vice Presidents of Medical Management, and other operational staff as needed. For 2015, UM Committee met. Typically, the UM Committee meets quarterly.

HEDIS Steering Committee

The HEDIS Steering Committee oversees Sunflower's HEDIS process and performance measures. The Committee reports directly to the QIC and reviews monthly HEDIS rate trending, identifies data concerns, and communicates both plan and corporate initiatives to

Sunflower Senior Leadership. The Committee directs clinical, non-clinical, member and provider initiatives to improve selected HEDIS scores. The HEDIS Steering Committee oversees the implementation, progression and outcomes monitoring of initiatives specific to HEDIS, recommends resources necessary to support the on-going improvement of HEDIS scores, reviews/establishes benchmarks or performance goals for HEDIS and oversee delegated vendor roles in improving HEDIS scores. The Committee meets a minimum of quarterly and is facilitated by the HEDIS Coordinator. Membership includes the senior leadership of QI, the CEO/President, Chief Medical Director, Associate Medical Director, and Vice Presidents of Medical Management, with representation from Contracting/Network Management, Member/Provider Services, and Pharmacy. The HEDIS Steering Committee meets quarterly and met four times in 2015.

Peer Review Committee

The Peer Review Committee (PRC) is an ad-hoc committee of the QIC and is responsible for reviewing inappropriate or aberrant service by a provider including alleged quality of care concerns, adverse events, and sentinel events where initial investigation indicates a significant potential or a significant, severe adverse outcome has occurred, or other cases as deemed appropriate by the Chief Medical Director. The PRC is expected to use their clinical judgment in assessing the appropriateness of clinical care and recommending a corrective action plan that will best suit the particular provider's situation. For 2015, PRC met on five occasions to review cases and make recommendations as appropriate.

Performance Improvement Team

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

The PIT meets monthly and includes representation from each functional area within Sunflower. Membership includes staff that conducts or directly supervises the day-to-day activities of the departments, i.e. Case Management, Compliance, Member Connections, Contracting, Customer Services, Network Development, Prior Authorization, Provider Relations/Services, Quality Improvement or other members as determined by the topic under discussion. The PIT met eleven times in 2015, with several subcommittee meetings of the PIT to address items such as the CAHPS survey results and Pay for Performance (P4P) activities. The PIT typically meets monthly.

Three subcommittees report to the PIT, as described below:

Member and Community Advisory Committee (MCAC)

The goal of the Member and Community Advisory Committee (MCAC) is to solicit member input into the Quality Improvement Program, operations, and services that are provided to members. The purpose of the MCAC is to act as a focus group to facilitate member and community perspective on the quality of care and services offered by Sunflower Health Plan and to offer recommendations for improvement to Customer Services and community

engagement, assisting the plan to remain member centric and provide services and activities that improve member quality of care and satisfaction. The MCAC met three times in 2015.

Joint Operations Committees

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

Vendor	Number of meetings in 2015
National Imaging Association	9
US Scripts	4
Logisticare	13
NurseWise	4
/Dental Health and Wellness	5
Nurtur	4
OptiCare	4
Cenpatico Behavioral Health (CBH)	4
Cenpatico Physical, Occupational, Speech Therapy (STRS)	4

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 and timeliness of resolution, performing barrier and root cause analysis, and making recommendations regarding corrective actions as indicated. The GAC is composed of Sunflower's Chief Medical Director, Pharmacy Director, QI leadership, Grievance Coordinator, Clinical Appeals Coordinator, QI Nurse and representatives from Customer Service. The GAC provides summary reports to the QIC at regular intervals, but no less than quarterly. The GAC met four times in 2015. Meetings typically are held quarterly or more frequently as needed.

Quality Improvement Department Structure and Resources

The QI resources were evaluated, and it was determined additional resources were needed to meet the needs of the QAPI Program during 2014. The QI department is now composed of the following members:

- Chief Medical Director, serving as the Senior Executive for Quality Initiatives (SEQI) (member by position and role)
- Medical Director of Utilization Management (member by position and role, not formal reporting structure)
- Vice President, Quality Improvement (Nurse)
- Director, QI (Nurse)
- Quality Improvement Coordinator (Nurse) - 2 total
- EPSDT Coordinator
- HEDIS Coordinator
- Grievance Coordinator
- Appeals Coordinator
- NCQA Coordinator

- P4P Coordinator
- Clinical Appeals Coordinator (Nurse) - 2 total, 1 promoted to Lead
- QI Analyst
- QI Project Manager
- Centene Corporate support.

Quality Leadership in 2015

Following the transition in the QI leadership for Sunflower that occurred in 2014, the leadership in Quality remained consistent throughout 2015. The Vice President of Quality Improvement remained in position who reported directly to the COO. The plan Medical Director left the plan early in 2015. However, that same Medical Director returned to Sunflower late in 2015. During the interim, there was coverage by another plan Medical Director that allowed for leadership and coverage without any lapse in physician leadership. This allowed the plan Medical Director to easily step back in as the SEQI and easily provide continued leadership and oversight of QI. There was turnover of two staff persons in 2015 in the QI Department, with one member joining another team at the plan and one leaving the organization. Routine assessments of work volume and progress with respect to plan priorities allow for reallocation of staff resources to address needs encountered in work volume spikes and also to address priority areas that are in need.

In 2015, the employment positions at Sunflower have remained relatively consistent as the plan membership had minimal change and product lines remained unchanged following the addition of case managers to adequately handle the addition on February 1, 2014, when Sunflower assumed responsibility for approximately 4,000 members in the I/DD waiver program. Staffing needs continue to be assessed on an ongoing basis to ensure the plan is able to accommodate member needs, improve quality, and to adequately address the volume of routine audits and reporting uniquely required by the state contract.

Compliance Program

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

In 2015, Sunflower underwent two on site reviews of the Health Homes program to ensure that contract compliance, member and provider needs were being met. The data reviewed included Health Assessment Plan data, HEDIS data unique to the Health Home population, and processes specifically aimed at ensuring appeals, grievances and quality of care concerns were being addressed appropriately. Sunflower also had an onsite audit related to the state contract. Additionally, in 2015 KFMC our EQRO performed validation of the following surveys: Provider Survey, Mental Health Survey, CAHPS to include both adult and child surveys. The results all included minimal recommendations with none noted at the level of immediate need for mitigation or action plan. Sunflower also underwent Performance Measure Validation survey in early 2015 and the opportunities identified on the survey were addressed. Sunflower complied with record requests for quarterly HCBS documentation audit requests (over 500 records per quarter) for the first 3 quarters of 2015 and have not received any reports of the findings from those audits. Sunflower participated in an Information Systems Capability Assessment ICSA audit in

2015 and was determined to have an infrastructure that enables collection, analysis and reporting of data to support quality assessment and improvement activities. Additionally, the system provides capability of tracking enrollees should they change programs allowing for continual assessment of continuity of enrollees. The system also provides ability to restrict reports to KanCare data and stratification by product line for report submission to State up to CMS. Sunflower anticipates further discussion and identification of areas for improvement from these data audits in 2016.

Health Insurance Portability and Accountability Act (HIPAA) of 1996 Compliance and Confidential Information

Sunflower is required to establish policies and procedures which address privacy and confidentiality of member information. Specific policies detail Magnolia's safeguards, collection, use and disclosure of protected health information (PHI) and how PHI is shared with the members based upon HIPAA. In accordance with Sunflower's policy, the following tasks are undertaken to ensure the protection of member information:

- Quarterly Desk Audits.
- Annual compliance training for all personnel.
- New Hire Compliance and HIPAA Training.
- Member complaints regarding management of health information are monitored.
- All member information will be maintained in secure systems and hard copies will be kept in locked locations.

All employee desk and work areas were audited to make sure that member PHI was secured, laptops were locked and PHI was disposed of properly. The Compliance Department conducted four desk audits in 2015 and the results revealed 30 infractions out of 434 desks/workspaces audited This resulted in a 93% compliance rate with securing PHI.

QAPI Program Effectiveness

Throughout 2015, the QI Department continued its collaboration with all organizational departments to facilitate continuous improvement in performance by empowering all stakeholders through education, communication, and evaluation. Sunflower has continued to improve the quality of care and services provided to the membership through continuous assessment of patterns, trends and identification of barriers to desired outcomes.

Sunflower continues to strive to include network physicians in the program through committee participation. Sunflower believes physician involvement ensures influencing network-wide safe clinical practices and improving care provided to membership.

Quality Improvement Work Plan

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

The 2015 QI Work Plan defines the activities, the person(s) responsible for the activity, the date of expected task completion and the monitoring techniques that will be used to ensure completion within the established timeframe. The QI Work Plan is presented to the

QIC on an annual basis for approval, through the annual evaluation process and at regular intervals throughout the year. The 2016 QI Work plan is currently being updated and will be provided to the QIC for review and approval.

Quality Improvement Program Integration

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

Strengths and Accomplishments:

- Quality Improvement continued to have two nurse leaders with Quality Improvement experience.
- Medical Director directly involved in Quality initiatives
- Committee membership and structure revised and functional to support activities.
- Quality improvement initiatives and focus studies identified, using trend of data starting to take more shape with plan experience.
- Successfully continued support for HCBS services, developing an expansive network, implementing case management, and refining operations in claims processing to meet the member and provider needs.
- Continued refinement around P4P metrics and development of tracking tools, supporting reports, comprehensive intervention plans, and reporting tools.
- Noted improvements in both the Member and Provider satisfaction surveys. Development of comprehensive plans for future improvement opportunities using multidisciplinary team.
- Continued use of skill in HEDIS operations to allow for the plan to do over-reads during hybrid season, optimization of data captured through state immunization registry and collection of supplemental data for potential impact on HEDIS measures in 2015.
- Continued to evaluate and update systems to incorporate state reporting criteria to reduce reporting errors and automate some reporting functions.
- Continued use of templates for trending of Grievances and Appeals and Quality of Care issues data for more in depth analysis and display for team members and Committee, allowing improvement opportunities to be more easily identified.
- Continue to review all Sunflower and vendor grievance and appeals documentation, revising and creating more consistency to reduce member confusion.
- Continued used of developed reports to identify cases at risk of not meeting turn-around time (TAT) for grievances and appeals before they are out of TAT.
- Utilize developed process in documentation system to route 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.
- Continue to evaluate and refine processes for State Fair Hearings, including documentation storage, and increasing reliability and quality of work product to Office of Administrative Hearings (OAH).

- TAT for timely resolution was met for CY 2015 for both Grievances and Appeals.
- Case Management worked with 12,869 members in 2015.
- NurseWise responded to 11,490 calls from Sunflower members.
- Participated in approximately 115 member outreach health fairs/community events.
- Participated in approximately 72 provider conferences and seminars, presenting and providing information or as a conference participant.
- Partnered with Nurtur to provide disease management services for Sunflower members. Nurtur enrolled 2992 members in active health coaching and 1806 in education programs in 2015.
- Answered 178,474 calls in the call center in 2015 with a 94.79% service level. The average speed to answer was 11 seconds.
- The Sunflower Customer Services/Provider Services call center provides education and referral services to members and providers. The call center received and responded to an average of 3,432 calls weekly regarding benefit inquiries, concerns, complaints, and request for arranging services.
- Expanded sources for supplemental data that allow better HEDIS data capture to reduce provider record request burden.
- Utilized WebIZ, state immunization registry to improve capture of immunization data for HEDIS
- Provided $2.7M in value added services to our membership and $780,259 for in-lieu of services.
- Achieved an overall claims payment average TAT of 6.54 days on over 325,000 claims a month.

Opportunities for Improvements:

- HEDIS rates are a focus of improvement; Sunflower continues to evaluate resources and opportunities for education and incentives to improve rates.
- Sunflower continues to work on P4P interventions for 2016.
- Sunflower will implement interventions to continuously improve Member and Provider satisfaction with Sunflower services and operations.
- Sunflower will continue to develop and expand trending reports for data analysis and focused intervention.
- Developed and implemented new MCO collaborative HPV PIP in 2015.
- Closed the Pre-Diabetes PIP after all members completed programs.
- Implement additional outreach to internal and external partners to share results of quality improvement activities.
- Continue to work with the other Kansas Medicaid MCOs on issues to improve care to Medicaid beneficiaries as necessary.

QUALITY PERFORMANCE MEASURES AND OUTCOMES

Performance Improvement Projects

Sunflower is required by state contract to have at least two Performance Improvement Projects (PIPs) annually. Additionally it is required that one of those is related to behavioral health. Sunflower started out 2015 with two PIPs that were related to Pre-Diabetes Management and Initiation and Engagement for Alcohol and Other Drugs. Late in 2015, Sunflower worked with fellow MCOs to close out the Prediabetes Management PIP and implemented a new PIP that focused on improving the compliance with HPV vaccination rates for adolescent females.

Pre-Diabetes Management

The Pre-Diabetes PIP program was initiated in 2015 with members participating in the program choices provided to members identified as being at risk for diabetes. The PIP program offers choices to members in Southeast Kansas, Wichita and Kansas City area to allow the members to choose an opportunity to participate in a program that allows them to increase their knowledge, activity and decrease the likelihood of developing diabetes through implementing changes in their diet and daily activities. The members have the option of participating in multiple programs, including the Diabetes Prevention Program (DPP) offered at the YMCA's located in the Wichita and Kansas City areas.

There was a second option developed by the MCO's called the KanBeWell program that includes educational materials that are specific to healthy eating, increasing activity and monitoring their diet/activity on a log provided to the members. For the members located in Southeast Kansas they had the option to participate in KanBeWell program due to limitations of the DPP program's availability in that area of the state. The overall goals for the members who choose to participate in one of these programs is to help them determine their risk for developing diabetes, learn about healthy eating, increasing activity and allow them to modify the factors in their lifestyle that decrease their risk for developing diabetes. Results from the members' participation will be determined.

Sunflower made outreach attempts to the 225 eligible members with 15 of them who were willing to enroll in one of the programs offered. Sunflower had two member who completed the programs offered with one completing the KBW and one completing the DPP program. Sunflower noted multiple barriers on the responses back from members who did not wish to participate initially or decided to discontinue participation in their program of choice. Due to the lack of participation and statistical significance from this PIP, the three MCOs proposed closing the PIP out after the members that were in a program successfully completed to allow them to benefit from the programs. The state accepted the proposal to close this PIP out and the last member completed the program in the fourth quarter of 2015.

Human Papilloma Virus (HPV) Vaccination

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

Each of the MCOs had a separate goal for 2015 performance that was based of their HEDIS 2015 final rate for the measure. Sunflower's baseline was the HEDIS 2015 rate was 21.67% for measurement year 2014. This rate exceeded the 2014 Quality Compass 50th percentile of 19.21%. Therefore, the goal for 2015 performance was established to be 22.03% which if met will continue to demonstrate exceeding the 5oth percentile according to the 2015 Quality Compass which has been noted to be 21.9%.

The three MCOs started with provider profiles to raise provider awareness and enlist their assistance with member compliance. Letters were also sent to the parents/guardians of the members who were non-compliant to provide educational material to help increase awareness and understanding related to the importance of the vaccination with the intended outcome of increasing the vaccination rate. Additionally, efforts were initiated with multiple clinics to offer extended hours to provide well child visits and vaccinations that were not limited to just the HPV vaccination. Outreach to members by phone was implemented to assist in scheduling appointments and arranging transportation to promote attendance with appointments. Educational materials were provided on the plan website as resources specifically aimed to assist providers with having conversations related to HPV vaccinations with parents of adolescents. These resources included a webinar that offered CME credits through February of 2016.

Initiation and Engagement for Alcohol and Other Drugs

Sunflower selected this PIP topic after meeting with the State and obtaining approval. The PIP is administered and monitored by Cenpatico, Sunflower's Behavioral Health affiliate, with oversight provided by Sunflower. Sunflower and Cenpatico provide quarterly and ad hoc updates to the State regarding progress and barriers. In 2015, initiated additional steps to help identify members earlier with regard to ER admissions and secondary diagnoses. Started utilizing a new application called ACHESS with two providers to keep members actively engaged in their treatment. Also, utilizes MyStrength program to support members.

Initiation Phase – Member: Upon initiation of treatment, Sunflower begins care coordination to improve initiation of substance use disorder treatment. In follow-up, Cenpatico care coordinators/case managers reach out to the member to help them with:

- Transportation Assistance.
- How to contact a mental health case manager/care coordinator.
- Overview of behavioral health care coordination/disease management programs.
- Substance Use Disorder (SUD) fact sheet.
- Early detection of members through ER admission
- Use of secondary diagnoses to identify members earlier

In the event SUD is identified during an inpatient event, care coordination is triggered for the purpose of guiding the member towards engagement into treatment. This intervention is then documented in the clinical care management system, TruCare.

Engagement Phase – Member: At weeks two and three of member SUD treatment, the Sunflower care management teams conduct outreach and follow up calls with members in SUD treatment for members receiving Case Management services. The calls will be documented in the case management note section in TruCare. The calls are designed to:

- Engage members in continued treatment.
- Ensure members are scheduled for their continued SUD follow up services and schedule the service if needed.
- Assess for treatment compliance barriers and identify resources for the members to improve access.

- ACHESS application aims at assisting those with alcoholism abstain in their recovery
- MyStrength program is an online resource to assist with management of depression and/or anxiety for use at home that includes personalized daily articles, videos, quotes and utilizes evidence based learning modules with goals, weekly action plans and tools to help be successful.

Initiation – Providers: Sunflower continuously provides technical assistance and training to its SUD providers. Sunflower distributes the Sunflower behavioral health provider newsletter biannually, which contains:

- Names, contact numbers and overview of all Sunflower behavioral health/co-occurring programs.
- Information to access transportation assistance.
- Training for MCO/Provider staff on motivational interviewing is available for all Sunflower behavioral health providers through our E-learning module. Sunflower tracks provider participation in trainings completed through E-Learning, and is exploring additional provider incentives for their staff to participate in ongoing professional development.

Cenpatico care coordinators and case managers also work with the Providers to insure engagement with treatment and ask about any barriers the providers may see to prevent the member from successfully completing treatment.

Continuation – Providers:

- Deliver member access and provider performance reports each quarter to all SUD providers.
- Establish provider mental health access line that connects providers with Sunflower behavioral health clinicians for assistance with SUD screening and treatment referral.

The interventions identified above were selected to support member and provider education regarding available resources for improved access to SUD services; serve to support member engagement in the critical pathway measured by the HEDIS indicators; support member adherence to SUD treatment protocols; and support clinician adherence to best practices in SUD treatment.

Technical assistance and provider trainings are expanded as needed based on analysis of interim monitoring and annual measurement findings. All intervention data is collected at the point of delivery of the intervention; documented member outreach efforts are included in the Sunflower electronic care management system, TruCare. Intervention data is analyzed and presented in conjunction with interim monitoring study indicator data at the following frequencies: quarterly and annually. Statistical testing for impact/correlation of effectiveness of interventions to the study indicators is conducted at least annually to support barrier analyses and identification of additional intervention opportunities. All interventions are culturally and linguistically appropriate.

The analysis was performed according to the data analysis plan. The results and findings present numerical data in a way that provides accurate, clear and easily understood information. The analysis identifies initial and repeated measurements, statistical

significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity. The analysis includes an interpretation of the extent to which the PIP was successful and follow-up activities.

Sunflower and Cenpatico Behavioral Health continued to encounter challenges in 2015 related to reporting. There have been insufficiencies noted with the state systems allowing for early identification of pregnant women who are using and also the IV drug users. The 2014 report was finalized at the end of 2015.This also resulted in the delay of the 2015 report.

There were success noted for 2015. All members who are identified as needing SUD treatment are referred to a care coordinator or case manager. Trainings continued in 2015 with the Providers around Motivational Interviewing and ASAM criteria. There is a pilot project in development to determine the efficacy of the ACHESS mobile application which supports members through their recovery process. Two providers have been identified to participate in the pilot project. Meetings have been held monthly with providers to address any issues that may arise regarding initiation and engagement of members.

NCQA Accreditation

Sunflower received accredited status with the National Committee for Quality Assurance (NCQA) effective May 21, 2014. As a result, Sunflower is preparing for the NCQA accreditation renewal through the remainder of 2016. The next NCQA survey is anticipated for end of February, 2017. In preparation for the review, Sunflower continues to review all plan and quality improvement processes to be consistent with NCQA standards. During 2014 and 2015, additional refinements were made to hardwire accreditation compliance into processes including revision of member letters with auto attachments that include appeal information, development of a process for policy review, and training of new staff on documentation requirements. In 2015 readiness reviews/audits, and ongoing health plan NCQA education and reminders. Additionally in 2014 an individual was hired to lead NCQA efforts to ensure the plan had a focus on continued readiness. Sunflower continued its efforts to prepare for NCQA accreditation by sending Quality team leadership and staff member to NCQA conference in 2015 and worked very closely with corporate resources on NCQA compliance.

Healthcare Effectiveness Data Information Set (HEDIS®)

HEDIS is one of the most widely used data sets used in performance measurement in the United States. The measures include performance measures pertaining to effectiveness of care, access/availability of care, satisfaction with the experience of care, cost of care, health plan descriptive information, health plan stability, use of services, and informed health care services. Sunflower uses HEDIS criteria for all applicable clinical studies as part of the NCQA accreditation process. Preliminary reports are provided by Centene’s corporate office for monthly review.

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. In 2014 and 2015, Sunflower submitted HEDIS data in accordance with the performance measure specifications. Sunflower also continued to design and implement key interventions to increase the Plan's HEDIS rates reported each calendar year.

Sunflower has been collecting HEDIS data since plan inception January 2013 and loading the information into its certified-HEDIS software. Sunflower focuses efforts to improve on HEDIS measures by factoring in those that are required for NCQA accreditation and those that are included in the yearly state Pay for Performance (P4P) measures. Sunflower has tracked progress on these measures on a monthly basis throughout 2015 while actively working interventions and continues to track these measures on a monthly basis for our performance in 2015. Unfortunately due to the timing of the due date of this report, a determination as to whether the measure goals will be met will not be able to be provided until the final HEDIS 2016 results are available, which will likely be after July 2016. As an area for improvement, for 2016 the HEDIS work-plan will focus on the NCQA and state recognized P4P measures.

Well Child Visits in the First 15 Months of Life

Sunflower focused on the measure Well Child Visits in the First 15 Months of Life in 2015. One of the Kansas Pay for Performance Measures included a HEDIS-like or custom measure to look at the number of visits for newborns. This resulted in some overlap between the HEDIS measure and the P4P measure. The focus of the pay for performance measure on four or more well child visits within the first 7 months of life for the members who were born January to May of the measurement year aligns with the Well Child Visits in the First 15 Months of Life measure.

Below, you will see the interventions that we used along with the results of our efforts. Keep in mind that there is no established NCQA benchmark for the custom measure Well Child 7.

- Member Connection outreach and visits to newborns and mothers
- Monthly letters sent out to children having birthdays to promote Well Child Checks and Immunizations
- Monthly post cards sent for newborns born previous month to promote Well Child Checks and Immunizations
- SHP sponsored baby showers to educate expectant mothers to be on Well Child Checks and Immunization
- Birthday card mailings month prior to birthday reminding of well-child visits
- Start Smart for Your Baby Program – Packets given to expectant mothers with Periodicity schedule
- POM calls made to parents/guardians of newborns to remind them of schedule for well-child visits.
- Developed EPSDT Provider Resource Kit on Well Child Checks, immunizations, billing, and other resources to assist providers and their office staff
- Training offered to both Medical Management, Provider Relations and Customer Service pertaining to the HEDIS measure and the importance of this to the member
- Developed magnet to write appointments on for inclusion in Smart Start for Your Baby Packets and also to be handed out by plan staff

The table provided below demonstrates results related to HEDIS measure. It is important to note that the final HEDIS 2016 rate is not available at the time of this report, therefore an administrative rate is provided.

HEDIS MEASURE	HEDIS 2015 (CY2014) Admin.	HEDIS 2016 * (CY2015) Admin.	NCQA 2015 HEDIS 50th Percentile
Well Child Visits 15 month (Four visits)	13.25	*10.03	9.58
Well Child Visits 15 month (Five visits)	19.27	*15.21	17.82
Well Child Visits 15 month (Six or more visits)	44.33	*55.20	59.76
Well Child Visits 7 month (Four or more visits)	68.49	*68.18	N/A

** Awaiting final administrative run*

Childhood Immunizations

Much of Sunflower Health Plan's immunization data comes from the Kansas State Immunization Registry or WebIZ as supplemental data. This data has been collected for our non-compliant members since 2013. One of the barriers we have encountered is that the data comes to us with different codes assigned, dependent on what the provider has used. This past year, the plan implemented the use of the auditor approved CDC mapping table for the CVX immunization codes, in order to map them over from WebIZ to allow for translation to the CPT codes that are accepted in our HEDIS software. A significant improvement was observed in most of our immunizations, and this can be attributed to our interventions, listed below.

- Alerts for Customer Service Representatives to indicate members who have care gaps and can remind them of the need for an appointment and assist with making one, if needed
- Birthday card mailings the month prior to the member's birthday, as a reminder of Well Child Checks and Immunizations
- Monthly post cards sent for newborns born previous month with Periodicity schedule
- Baby showers given for parents of newborns, providing educational information concerning child wellness issues
- Start Smart for Your Baby Program – outreach to parents of newborns to educate on Periodicity schedule
- POM calls made to parents/guardians of newborns to remind them of schedule for well-child visits, including immunizations
- Wyandotte County Back-to-School Fair – distributed Health Check Schedules and other information regarding health issues
- Corporate "Healthy Reminders" mailer sent out bi-monthly to remind members of immunizations completed and due
- HEDIS Quick Reference Guide distribution to new providers and annual updates to existing providers with ICD-10 updates
- Gap analysis for high volume providers currently available on the Provider Portal
- Provider newsletter article completed in Summer 2015 issue with an article pertaining to supporting HEDIS scores
- Provider EPSDT Reference Kit developed and distributed to high volume providers
- Obtaining KDHE Immunization Registry data, beginning with a list of non-compliant members from July QSI run, and then on another 3 subsequent runs, to enter as Supplemental Data

The table provided below demonstrates results related to HEDIS measure. It is important to note that the final HEDIS 2016 rate is not available at the time of this report, therefore an administrative rate is provided.

HEDIS MEASURE	HEDIS 2015 (CY2014) Hybrid	HEDIS 2016 * (CY2015) Admin.	NCQA 2015 HEDIS 50th Percentile
DTaP Immunizations	75.00	*85.21	79.52
OPV/IPV Immunizations	90.00	*90.18	91.22
Measles, Mumps and Rubella Immunizations	89.29	*87.33	90.93
H Influenza Type B Immunizations	85.95	*88.66	91.00
Hepatitis B Immunizations	90.24	*89.21	91.48
Rotavirus Immunizations	68.57	*78.16	69.91
Influenza Immunizations	46.67	*42.64	51.34

** Awaiting final HEDIS 2016 hybrid rates*

Comprehensive Diabetes Care

Sunflower continued to work on this HEDIS measure, with the assistance of OptiCare for the Eye Exam submeasure. There was an increase of 26.4% on the final rates from 2013 to 2014. The current administrative rates for 2015 are 8.95 % above the previous year, and the final hybrid rates are expected to exceed the previous year's rate. Additionally, in fourth quarter of 2015 Sunflower ventured into project to impact those members who were still showing non-compliance with their diabetes monitoring with Quest/ExamOne to allow members the option to have their lab draws, blood pressure, height and weight measurements taken in their own home. This resulted in approximately 700 members who were willing to participate and getting these tests and measurements completed to allow for proper monitoring and treatment as needed based on the results with their provider.

Interventions: Comprehensive Diabetes Care

- Corporate "Healthy Reminders" mailed September of 2015, highlighting the sub-measures completed and those that still needing compliance
- OptiCare's HEDIS Outreach - Diabetic Retinopathy Exam sub-measure; monthly progress reports starting in July of 2015
- CentAccount Program Incentives
- New member outreach within 90 days of plan enrollment; receive "Welcome to Sunflower" letter with new member packet and card
- Script provided to Medical Management for contacts with non-compliant members and diabetic members in Case Management
- Member mailer postcards and letter with measure/test dates and reminders
- Customer service training on measure to discuss care gaps with members on calls; reminders sent prior to care gap reports going out to members
- Use of KanBeWell program materials as well as KRAMES educational materials to educate members about diabetes care
- Member Newsletter containing detailed information on the importance of screenings, and proper diabetes care

- Quest Diagnostics providing outreach to non-compliant members and offering member lab draws in the member's home, as well as BMI and BP measurements
- Provider profiling report distributed to top-volume providers of non-compliant members and visits to providers as appropriate
- Provider newsletter articles related to plan performance and goals
- Include P4P measure review/discussion in DVO meetings with vendors who have the ability to assist members

The table provided below demonstrates results related to HEDIS measure. It is important to note that the final HEDIS 2016 rate is not available at the time of this report, therefore an administrative rate is provided.

HEDIS MEASURE	HEDIS 2014 (CY2013) Hybrid	HEDIS 2015 (CY2014) Hybrid	HEDIS 2016 * (CY2015) Admin.	NCQA 2015 HEDIS 50th Percentile
Comprehensive Diabetes Care - Eye Care	48.59	61.42	*59.55	54.74
Comprehensive Diabetes Care - HbA1c Testing	83.42	84.48	*79.35	86.20

* *Awaiting final HEDIS 2016 hybrid rates*

Two additional measures that Sunflower focused on in 2015 were Breast Cancer Screenings and Cervical for the entire population served with anticipation of improvement for those waivers that these measures were a focus as a part of the state P4P measures. Those measures and their interventions are noted below.

Breast Cancer Screening (BCS) Interventions:

- Mailer to female members
- Mammogram post cards and "Healthy Reminders" mailing from Corporate office
- Provider Profile mailer
- Member education

Cervical Cancer Screening (CCS) Interventions:

- Mailer to female members
- "Healthy Reminders" mailing from Corporate office
- Care Gap Reports available on Provider Portal
- Member education

Behavioral Health HEDIS Measures

Two of the behavioral health measures that were the plan's focus this year were Follow-Up after Hospitalization for Mental Health and Initiation and Engagement of AOD Treatment. Since most of the measures listed below hover around the Quality Compass 75th percentile, the last column identifies the NCQA benchmark for this percentile, rather than the 50th percentile, as used in the above tables.

Interventions for Follow-Up after Hospitalization for Mental Health:

- CM involvement during Hospital Discharge Planning, including assistance with appointments; referral is received by CM as soon as the authorization is received by the health plan

- CMHCs to develop process to identify & follow members who are hospitalized; due to the change in the state processes, notifications will have to now be re-directed for hospitalizations; discussion in progress
- Education of CMHCs and Inpatient Hospital Administrators and Chief of Medical Staff as to the importance of this indicator and the elevation of awareness of the need to collaborate with the health plan's CM to ensure follow-up appointments are scheduled
- Provider Newsletter article
- Staff training on measure and bridge appointments
- Work with major hospitals to make sure bridge appointments are being billed
- Analyses of data to determine what facilities are not billing these visits
- Provider mailers/reminders to bill 513 visits
- Provider profiling given to providers detailing their rates during annual visits
- Include P4P measure review/discussion in DVO meetings
- Non-compliant list distributed to CBH for review as requested
- Hiring of BH HEDIS Coordinator to manage clinical team interventions and track progress

Interventions for Antidepressant Medication Management:

- Monthly mailer sent out by Corporate, Healthy Reminder. Targets members with a depression diagnosis and a recently prescribed/filled antidepressant, or a new Rx script. Member must also have a negative 90-day Rx history with AMM medications. Member receives an informational brochure and personalized letter to encourage prescription compliance and provide general education regarding the prescription

The Initiation and Engagement of Alcohol and Other Drug Dependence Treatment measure also had a Performance Improvement Project by SHP. The State of Kansas modified the HEDIS measure by adjusting the age group from the HEDIS standards. So both the HEDIS measure and the HEDIS-like modified measure were followed during the year. The table below only includes the actual HEDIS measure.

Interventions for Initiation and Engagement of AOD Treatment:

- Daily outreach and engagement of SUD members into Care Coordination to improve treatment compliance
- Interventions will then be generalized to all eligible study members
- Targeted SUD provider education; regular meetings scheduled throughout the year with providers; train on measures & review the HEDIS specifications
- Include P4P measure review/discussion in DVO meetings with affected vendors
- Data collected on an on-going basis and collected weekly, monthly, quarterly and analyzed annually for volume & impact on measures

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The table provided below demonstrates results for the HEDIS measures. It is important to note that the final HEDIS 2016 rates are not available at the time of this report, therefore an administrative rate is provided.

HEDIS MEASURE	HEDIS 2014 (CY2013) Hybrid	HEDIS 2015 (CY2014) Hybrid	HEDIS 2016 * (CY2015) Admin.	NCQA 2015 HEDIS **75th** Percentile
Follow-up after Hospitalization for Mental Illness - 7 day	65.13	59.54	67.34	56.78
Follow-up after Hospitalization for Mental Illness - 30 day	82.17	72.60	78.14	75.28
ADHD Medication Follow-up (Initiation Phase)	N/A	55.84	54.07	49.07
ADHD Medication Follow-up (Continuation & Maintenance Phase)	N/A	64.74	66.09	58.36
Antidepressant Medication Management (Effect. Acute Phase)	57.14	49.09	50.03	56.15
Antidepressant Medication Management (Effect. Continuation Phase)	37.44	33.78	34.46	40.48
Initiation and Engagement of AOD Treatment: Initiation	42.62	44.22	39.25	42.17
Initiation and Engagement of AOD Treatment: Engagement	14.66	15.47	11.17	14.96

* *HEDIS 2016 - Awaiting final administrative rates*

Pharmacy HEDIS Measures

During 2015, Annual Monitoring for Patients on Persistent Medications was one of our Pay for Performance measures for the State of Kansas. Since this was also the case in 2014, the plan had initiated the interventions listed below that allowed a 6.8% improvement from 2013 to 2014. Based on administrative data that is available pending final rates for HEDIS 2016, it is anticipated that Sunflower will again achieve 75th percentile on this particular measure.

Interventions for Annual Monitoring for Patients on Persistent Medications:

- Reminder faxes sent to providers throughout the year of members who need testing, with detail on specific members and the importance of this procedure; if records are received, they are given to Quality Department to enter into QSI as supplemental data
- In late 3rd quarter, member outreach begins by medical management to members who have not had testing since the beginning of the year; calls are made to prescribers to supplement the faxes for non-adherent Digoxin members; after that, the same process will be done for prescribers of ACE/ARB & Diuretics
- During November, pharmacy will refer members to case management from the non-compliant list who may need assistance in scheduling appointments with a provider or lab
- During November, pharmacy will refer members to case management from the non-compliant list
- Provider mailers sent to top providers detailing members who need lab tests completed, using a provider profile process.
- Direct contact with providers having non-compliant members, during the 3rd quarter

The table provided below demonstrates results related to HEDIS measure. It is important to note that the final HEDIS 2016 rate is not available at the time of this report, therefore an administrative rate is provided that has not yet been determined to be final.

HEDIS MEASURE	HEDIS 2014 (CY2013)	HEDIS 2015 (CY2014)	HEDIS 2016 * (CY2015)	NCQA 2015 HEDIS **75th** Percentile
Annual Monitoring for Persistence Medications - Combined Rate	84.18	89.88	89.70	89.17

PATIENT SAFETY

Quality of Care and Adverse Events

Sunflower monitors the safety of its members through identification of potential and/or actual quality of care (QOC) events and adverse incidents (AI). Sunflower's Quality Improvement Department monitors member and provider issues related to quality of care and adverse incidents on an ongoing basis. A QOC Severity Level table is used to classify issues into the four levels (Low, Medium, High and Critical) based on the potential or actual serious effects. These issues are tracked and trended for patterns and any applicable corrective action plans put into place when issues warrant further action. All cases are entered into a database and reviewed quarterly. Practitioners or providers with multiple potential quality of care issue referrals per quarter may be subject to additional review/investigation. Providers will be reported to the Credentialing Committee at the discretion of the Peer Review Committee. Reports are provided to the QIC and Credentialing departments for consideration at the time of re-credentialing.

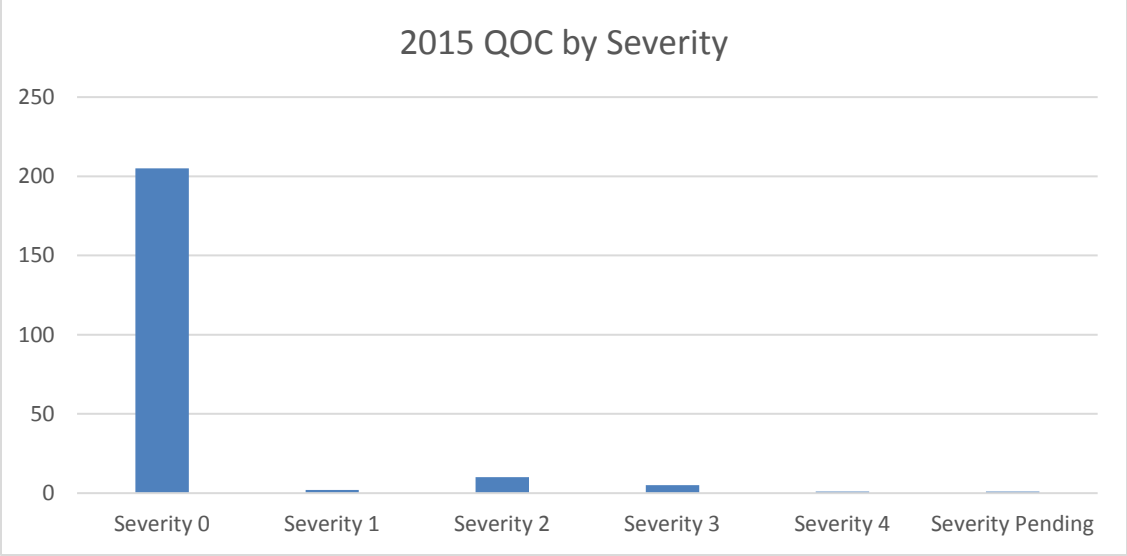
Potential quality of care issues are defined as any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care, or that signals a potential sentinel event.

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

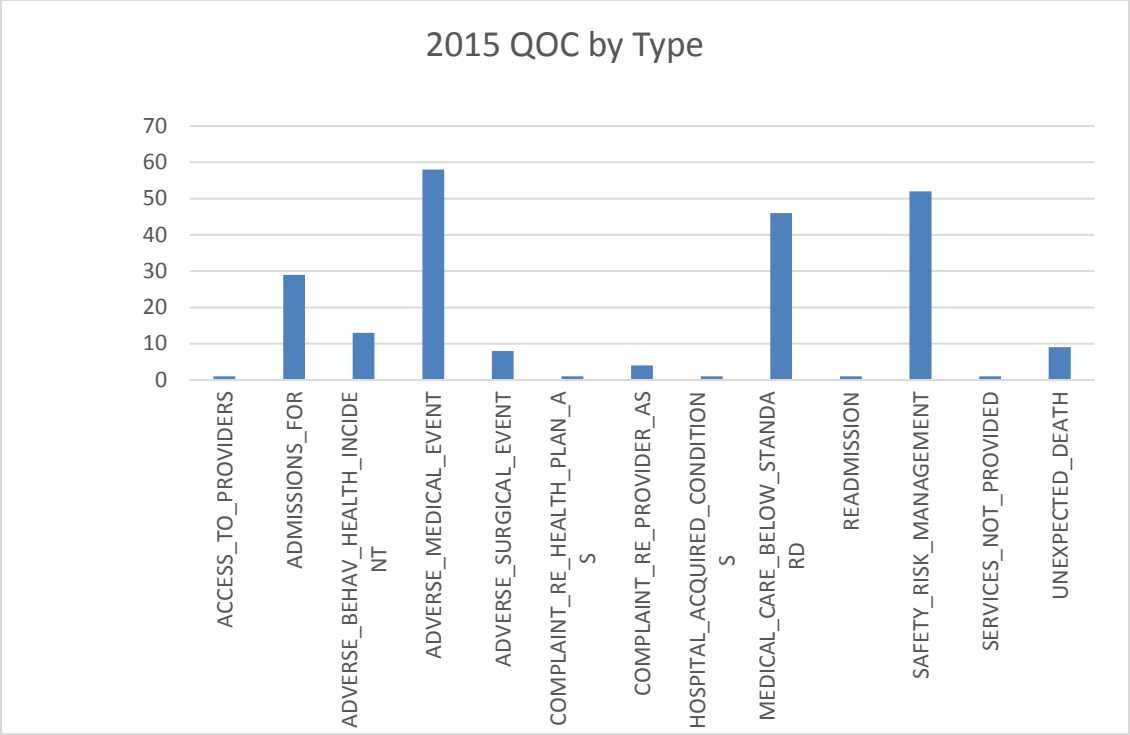
- Admit following outpatient surgery
- Altercations requiring medical intervention
- CMS Never Events
- Decubitus Ulcers in LTC
- Enrollee elopement/escape from facility
- Enrollee Injury or Illness during BH Admission
- Enrollee suicide attempt
- Falls/Trauma
- Fetal Demise
- Hospital Acquired Infections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

- Unplanned return to operating room
- Urinary Tract Infection in LTC facility

Sunflower reviews events both at an aggregate and provider/facilty level. The below graphics show the type and severity of QOCs reviewed by Sunflower in 2015. Sunflower's data on QOCs demonstrates that the majority of the cases referred for review as potential QOC are determined to not meet the criteria for a QOC or received the lowest severity level of zero accounted for 205 cases in 2015. There was only 1 case noted to be given the highest severity level 4, with 5 cases receiving severity level of 3, 10 cases with severity level of 2 and 2 that were noted to have a severity level of 1. Sunflower provides a monthly report to the state advising of cases with high severity levels determined through the QOC process utilized internally at Sunflower and by the appropriate delegated vendors. The table below depicts the severity levels that resulted in the cases refered as potential QOC cases and their severity level based on review of records provided to Sunflower to allow for review to determine if there was a QOC concern and allow for severity level to be assigned accordingly.



Sunflower also looks at QOC data to determine the most common types of QOC cases. Adverse Medical event was noted to be the highest type of QOC referral received in 2015. The next category was noted to be Safety Risk Management issues. The third highest typ of QOC case was Medical Care Below Standard. Sunflower utilizes the Peer Review Committee to review cases and make recommendations related to the next steps which can include requesting documentation from providers to demonstrate their actions that have already been implemented to prevent further occurences and may make recommendations for education to occur with staff responsible for specified care to members to help avoid future occurences that present risk to members served.



In review of the QOC issues by Providers for trends with more than 1 QOC for 2015, it was noted that there were 4 providers noted to meet that criteria. However, of the cases referred on these providers there were 8 actual referrals for these four providers. Upon review, 11 of these were noted to not be QOC concern. One provider was identified for tracking/trending of future potential QOCs due to the review of two referrals assigned low severity levels. Based on review of one of the potential QOCs, the member was referred as potential candidate to the lock-in program. There was a provider with multiple QOC referrals which at the time these cases were in the proces of review, Sunflower recieved request by the provider's attorney discontinue the appeal process related to his previous request for records for QOC review that was initiated in 2014 that overlapped into 2015 with the production of records by the provider to allow Sunflower to review the cases.

The State of Kansas has defined, and developed a system of provider reporting for events considered "Adverse Incidents". Selected providers are able to report the defined events into a state developed portal and these reports are named Adverse Incident Report(s) or AIRS. Adverse incidents are defined by the state to providers for the purpose of this self-reporting as an event over which health care personnel could exercise control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred.

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

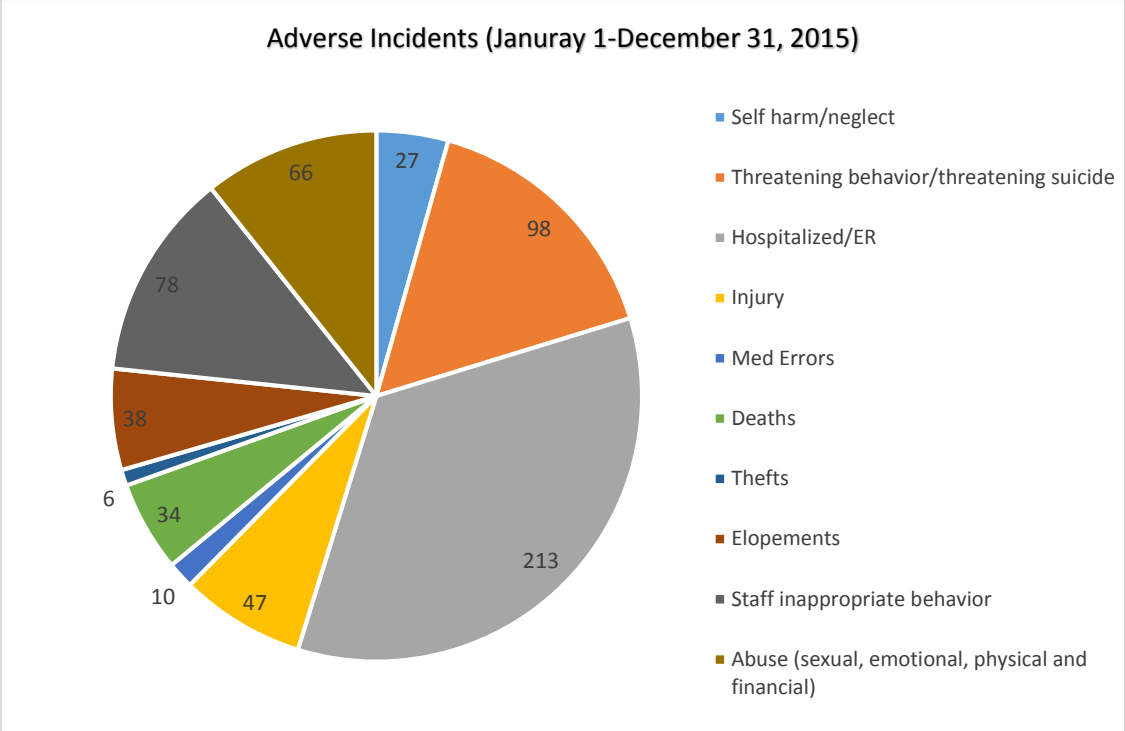
1. Preventable death- Any death that occurs as a direct result of the actions (or lack thereof) of any CSP provider that can be reasonably confirmed by the providers or upon medical examination.
2. Physical abuse - Any allegation of intentionally or recklessly causing physical harm to a consumer by any other person, while receiving a CSP service.

3. Inappropriate sexual contact - Any allegation of intentional touching of a sexual nature, of any consumer, who does not give consent or is incapable of resisting or declining consent due to mental deficiency, or disease, or fear of retribution or hardship. In addition:
    a. Consumers receiving services in any KDADS CSP licensed or certified program who are under the age of 18 years of age cannot give consent
    b. Any allegation of intentional touching of a sexual nature, by a provider, towards a consumer is inappropriate sexual contact
4. Misuse of medications - The incorrect administration or mismanagement of medication, by someone providing a CSP service which result in or could result in serious injury or illness to a consumer.
5. Psychological abuse - A threat or menacing conduct directed toward an individual that result in or might reasonably be expected to cause emotional distress, mental distress or fear to an individual.
6. Neglect - The failure or omission by one's self, caretaker or another person with a duty to supply or to provide goods or services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.
7. Suicide - Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.
8. Suicide attempt - A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.
9. Serious injury – An unexpected occurrence involving the significant impairment of the physical condition of a consumer. Serious injury specifically includes loss of limb or function.
10. Elopement – The unplanned departure from an inpatient unit or facility where a consumer leaves without prior notification or permission or staff escort.
11. High profile event - Any situation which is likely to result in negative media coverage or involvement of the Kansas Legislators or complaints to the Governor's office.
12. Natural disaster – Any closure or evacuation of a facility due to fire, storm damage or mechanical system failure that may result in major expenditures or work stoppage or any significant event affecting consumers.

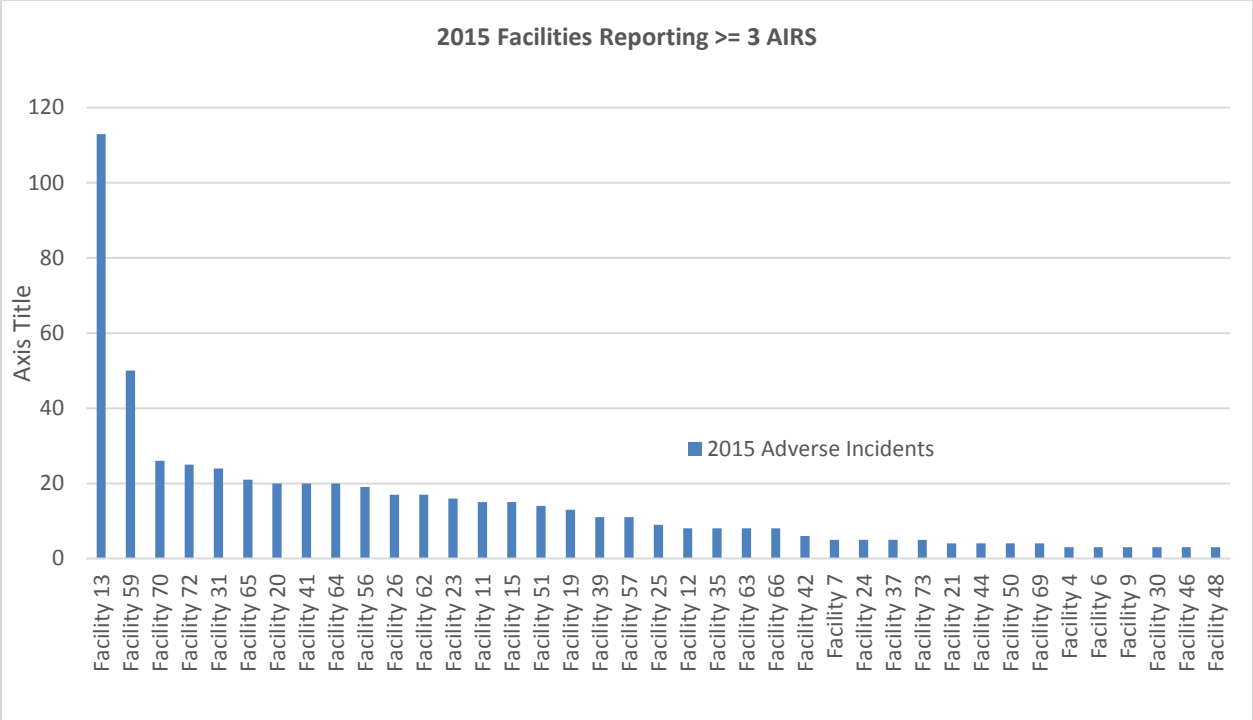
These Adverse Incidents are included in the routine QOC reviews completed at the Plan. As stated previously, the State of Kansas has developed parallel reporting mechanisms for providers to report Adverse Events to the state and MCOs through an "Adverse Incident Reporting System (AIRS)". As a result,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

In 2014, Sunflower's Quality Improvement team worked on making the process for documenting and tracking AIR's more automated within the clinical documentation system utilized by both Quality and the Medical Management teams. This process was refined in early 2015 and continues to be utilized to allow the two teams continue to work collaboratively to address needs or issues for the members as a result of the AIR reports received. The process for AIR is demonstrated in the diagram provided. This process also depicts how an AIR can be addressed related to being a potential QOC issue.

In 2015, Sunflower was forwarded 617 individual AIRs from 38 unique providers. Each AIR reported was reviewed and processed as discussed previously. The following graphic demonstrates the categorization type of 2015 AIR reports. Hospitalized/ER visits represent the highest category, with 213 AIRS related to them. Historical practice in KS has been to report any time a vulnerable member visits the ED or is hosptialized, any unexplained abrasion, or otherwise noteworthy behavior for these vulnerable populations which could contribute to this being the most commonly received type of AIR.Threatening behavior/threatening suicide was the second highest report AIR with 98 followed by staff inappropriate behavior at 78. These details are noted in the table below.



The AIR data are also trended by provider to ensure that there are not provider trends in member reported AIRs as depicted in the graph provided below. At this time, due to the low number of events that come in as AIR and are converted to true QOCs, no specific trends of providers have been noted. However, it continues to be suspected that some agencies are more diligent reporters of events making the frequency of events skewed which is something Sunflower noted in 2014 and continued to see in 2015. All events that meet mandatory reporting requirements and trends of concerns are also reported to the appropriate state and/or local agency or personnel.



Recommendations for 2015 related to the quality of care and adverse incident reporting include continuing to evaluate for provider trending, developing more objective follow-up documentation to allow for trending of findings and provider follow up on AIR reporting.

Practice Guidelines (CPG)

Sunflower utilized the following clinical and preventive health practice guidelines in 2015. Sunflower made providers aware of the guidelines and their expected use through the provider newsletters, inclusion in the provider manual, and on the Sunflower website. Performance on CPGs is monitored through performance on applicable HEDIS measures.

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

All Clinical Practice Guidelines (CPGs) and Preventive Health Guidelines (PHGs) are reviewed annually and updated accordingly. Opportunities in 2015 related to practice

guidelines were to continue and expand provider profiles in 2015 to a larger provider group to help increase knowledge, awareness and compliance.

Efforts Undertaken in 2015:

- Continue annual review of CPGs and PHGs, review and update as appropriate based on the policy and procedure requirements.-Goal met in 2015, continue in 2016.
- Continue to notify practitioners about the guidelines via newsletter and website announcements. Goal met in 2015, continue in 2016.
- Continue member and provider outreach and education-based initiatives regarding all guidelines. Goal partially met in 2015 due to three sets of provider profiles. Continue efforts in 2016.
- Continue to meet applicable NCQA Standards throughout 2015. -Goal met in 2015, continue in 2016.

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

Member Satisfaction

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

- Member grievances
- Member appeals
- Member satisfaction survey data

Member Grievances

The Sunflower Grievance & Appeal Committee and Quality Improvement Committee review grievance and appeal data on a quarterly basis. Analysis performed by the Quality Improvement Committee, which is composed of departmental leaders and network physicians, enables Sunflower to initiate quality improvement efforts to improve member satisfaction as needed. The following is a summary of the results and analysis for January 1, 2015 through December 31, 2015, compared to calendar year 2014.

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The table below displays grievance data by category and represents all member grievances resolved. All grievances are reviewed and analyzed; no sampling is used.

Grievance Category	Jan 1 -Dec 31, 2014	Per 1000	Jan 1- Dec 31, 2015	Per 1000
Access to care & Services	N/A	N/A	N/A	N/A
Accessibility of Office	15	0.10	7	0.05
Attitude/Service of Staff	133	0.93	151	1.10
Availability	183	1.28	167	1.22
Billing and Financial Issues	48	0.34	59	0.43
Criteria Not Met - DME	6	0.04	5	0.04
Criteria Not Met - IP	N/A	N/A	3	0.02
Criteria Not Met - MP	4	0.03	8	0.06
HCBS	3	0.02	3	0.02
Lack of Information from Provider	9	0.06	10	0.07
Level of Care Dispute	12	0.08	15	0.11
Other	60	0.42	55	0.40
Overpayments	1	0.01		0.00
Pharmacy	8	0.06	18	0.13
Prior or Post Authorization	10	0.07	16	0.12
Quality of care	16	0.11	24	0.18
Quality of office, building	N/A	N/A	1	0.01
Sleep Studies	1	0.01	1	0.01
Sterilization	N/A	N/A	3	0.02
Timeliness	124	0.87	99	0.72
(blank)	N/A	N/A	N/A	N/A
Grand Total	633	4.43	645	4.72

The grievance category denoting the highest volume in 2015 was Availability with 26% or 167 grievances out of 645 total for the year. Grievances secondary to Attitude/Service of staff accounted for 23% or 151 for 2015. These grievances include those related to providers, their office staff and health plan staff as well. Timeliness grievances came in next at 15% with 99. The grievances related to timeliness were primarily related to transportation issues. Sunflower has established a goal to have less than 5.00/1000 members annually. Sunflower successfully achieved that goal with 4.72/1000 for all grievances resolved in 2015. For 2016, Sunflower's goal is to achieve 4.5/1000 members.

Additionally, Sunflower drills down grievances by subcategory to allow further analysis of grievances to assist in identifying opportunities for improvement. Sunflower placed priority on improving transportation related grievances in 2015 due to the volume that had been experienced in 2014. This drill down allowed Sunflower to work closely with the transportation vendor on trends with transportation vendors to help alleviate situations that would result in grievances. As a result of the collaboration with the transportation vendor, Sunflower noted a 9% decline in transportation related grievances in 2015 as compared to 2014.

The transportation sub-category drill down grievance detail is noted below.

Transportation Provider Grievances by NCQA Sub-Category	Jan 1- Dec 31, 2015	Percentage of total grievances
Access - Other	3	0.47%
After-hours access	1	0.16%
Billing - other	1	0.16%
Claims payment	7	1.09%
Distance to provider	1	0.16%
Eligibility issues	2	0.31%
Failure to respect Member's rights	1	0.16%
Health plan service - other	1	0.16%
Provider service - other	6	0.93%
Quality of Care - other	2	0.31%
Rude/unprofessional health plan staff	1	0.16%
Rude/unprofessional office staff	33	5.12%
Rude/unprofessional provider or clinical staff	2	0.31%
Service/benefit limitations or exclusions	4	0.62%
Transportation issue	231	35.81%
Transportation vendor issue	4	0.62%
Total	300	46.51%

Member Appeals

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

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

The table below reflects member appeals by category for 2015 as they compared to 2014.

Appeals Category	Jan 1 -Dec 31, 2014	Per 1000	Jan 1- Dec 31, 2015	Per 1000
Availability	1	0.01	N/A	N/A
Quality of care	3	0.02	N/A	N/A
Pharmacy	87	0.61	137	1.00
Criteria Not Met - Medical Procedure	96	0.67	84	0.61
HCBS	81	0.57	78	0.57
Criteria Not Met - Durable Medical Equipment	47	0.33	73	0.53
Level of Care Dispute	53	0.37	56	0.41
Prior or Post Authorization	91	0.64	48	0.35
Lack of Information from Provider	7	0.05	30	0.22
Criteria Not Met - Inpatient Admissions	80	0.56	23	0.17
Other	5	0.03	4	0.03
Sleep Studies	N/A	N/A	1	0.01

For 2015, Pharmacy appeals were noted to be of highest incidence. This was attributed to changes with criteria on specific medications and once additional documentation was provided on appeal the majority of these were able to be overturned through the appeal process. Pharmacy appeals were followed by Criteria Not Met – Medical procedures and then by HCBS appeals. Education occurred throughout 2015 with medication criteria to providers to assist them with an understanding of what is required as a result of the changes. Sunflower set a goal of 3.5 appeals per 1000 members for 2015. Sunflower failed to meet that goal with 3.9 per 1000 members in 2015. For 2016, Sunflower's goal will remain 3.5 appeals per 1000 members.

Sunflower noted an increase in the number of appeals that were overturned on appeal secondary to documentation that was made available for inclusion in the appeal review process that was not provided with the initial request for the service throughout 2015. As a result, Sunflower has implemented education to providers and encouraged providers to submit items necessary with the initial request for services/authorizations that will help in making these decisions in a more timely fashion versus through proceeding to an appeal where these documents are then provided to allow for approval. This trend is noted in the table on the following page.

Member Appeals by Category

Member Appeal Category	2015 Upheld	2015 Overturned
Criteria Not Met - Inpatient Admissions	13	10
Criteria Not Met - Durable Medical Equipment	24	49
Criteria Not Met - Medical Procedure	41	43
HCBS	52	26
Lack of Information from Provider	14	16
Level of Care Dispute	35	21
Other	4	
Pharmacy	21	116
Prior or Post Authorization	24	24
Sleep Studies	0	1
Total	228	306

Sunflower continues to review appeal data to determine if there are any trends with opportunities for improvement. These reviews include looking at denials by initial reviewers, appeal reviewing physician and appeal type. In 2016, Sunflower will continue to work with providers to share information related to criteria changes and to promote inclusion of documentation with initial service requests or authorizations to help make the approval process more efficient and avoid appeals potentially.

Provider Appeals

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

Sunflower established a goal of a 5% reduction in provider appeals for 2015. Sunflower noted a decrease in provider appeals from 1210 for 2014 to 1040 in 2015. This reduction resulted in 14% decrease in provider appeals allowing Sunflower to meet the goal of reducing provider appeals by 5%. Sunflower's goal for 2016 will be to decrease provider appeals by 5%.

The table below depicts the provider appeals by category. Claims/billing issues were by far the highest category with 675, accounting for 65% of provider appeals in 2015. The second highest provider appeal category was authorizations with 149 or 14%. Claims/billing and authorizations are key components that work together in allowing for claims to be processed. Sunflower reviews provider grievances for trends that warrant

processes to be evaluated for improvement opportunities as well as works with providers when opportunities exist as well with relation to authorization requests or claims submission processes that are noted to be a trend.

Provider Appeals Category	Jan 1- Dec 31, 2015	Per 1000
Authorizations	149	1.090345
Claims/Billing Issue	675	4.939482
Credentialing/Contracting	N/A	N/A
Provider Relations	4	0.029271
Formulary	N/A	N/A
Customer Service	N/A	N/A
Health Plan Administration	4	0.029271
Clinical/Utilization Management	54	0.395159
Quality of Service or Care	76	0.556149
Other	84	0.614691

Member Satisfaction Survey

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

The 2015 Summary Rate Composite and Key Question scores for Sunflower are presented in CAHPS Adult and Child survey results provided below. These tables also demonstrate comparison of the survey results for 2015 against results for 2014 along with comparison to the Quality Compass® All Plans means and percentiles. The 2014 Quality Compass® All Plans is the mean summary rate from the Medicaid adult health plans that submitted data to NCQA in 2014. The Medicaid Child CAHPS is compared to the 2014 Quality Compass® All Plans benchmark; this benchmark includes approximately 132 samples of Medicaid child plans that submitted to NCQA.

Sunflower's summary rate results for 2015 Composites and Key Questions for the CAHPS Medicaid Adult Survey compared to the 2014 Quality Compass All Plans means and percentiles. Results for 2015 demonstrated improvement in How Well Doctors Communicate, Customer Service and Shared Decision Making.

Medicaid Adult CAHPS Survey Results

Composite & Question Ratings	2014 Rate	2015 Rate	2014 Quality Compass All Plans Rate	2014 Quality Compass All Plans Percentile
Getting Needed Care	**86.2%**	**84.1%**	**80.5%**	**73rd**
• Ease of getting care, tests, or treatment needed	87.7%	86.9%	82.5%	82nd
• Obtaining appointment with specialist as soon as needed	84.7%	81.3%	78.7%	63rd
Getting Care Quickly	**87.0%**	**83.9%**	**81.0%**	**75th**
• Obtaining needed care right away	89.3%	88.6%	82.7%	95th
• Obtaining appointment for care as soon as needed	84.7%	79.2%	79.3%	44th
How Well Doctors Communicate	**89.4%**	**90.6%**	**89.5%**	**67th**
• Doctors explaining things in an understandable way	90.8%	89.7%	89.9%	42nd
• Doctors listening carefully to you	88.9%	91.2%	89.9%	65th
• Doctors showing respect for what you had to say	89.8%	92.4%	91.4%	67th
• Doctors spending enough time with you	88.2%	89.1%	86.8%	77th
Customer Service	**90.1%**	**92.2%**	**86.5%**	**97th**
• Getting information/help from customer service	84.6%	86.6%	80.3%	92nd
• Treated with courtesy and respect by customer service	95.6%	97.8%	92.7%	99th
Shared Decision Making	**50.9%**	**82.2%**	NA	NA
• Doctor/health provider talked about reasons you might want to take a medicine	49.5%	93.2%	NA	NA
• Doctor/health provider talked about reasons you might not want to take a medicine	26.4%	71.7%	NA	NA
• Doctor/health provider asked you what you thought was best when talking about starting or stopping a prescription medicine	76.6%	81.8%	76.4%	90th
• **Health Promotion and Education**	68.4%	67.8%	71.6%	13th
• **Coordination of Care**	82.1%	83.3%	79.2%	81st
• **Providing Needed Information**	69.3%	70.5%	66.7%	77th
• **Ease of Filling Out Forms**	93.7%	93.0%	94.2%	23rd
Ratings Items				
Rating of Health Care	73.8%	74.5%	71.3%	78th
Rating of Personal Doctor	78.9%	81.5%	78.8%	79th
Rating of Specialist	78.5%	79.1%	80.4%	27th
Rating of Health Plan	71.7%	73.5%	74.7%	37th

Sunflower's 2015 summary rate results for Composites and Key Questions for the CAHPS Medicaid Child Survey compared to the 2014 Quality Compass All Plans. In 2015, Getting Needed Care, Customer Services and How Well Doctors Communicate all demonstrated improvement over the results for 2014 for the child survey.

Medicaid Child CAHPS Survey Results

Child Composite & Question Ratings	2014 Rate Title 19	2014 Rate Title 21	2015 Rate Title 19 & 21 Combined	2014 Quality Compass All Plans Rate (mean)	2014 Quality Compass Plan Approximate Ranking
Getting Needed Care	**88.3%**	**86.0%**	**89.6%**	**85%**	**84th**
• Ease of getting care, tests, or treatment child needed	92.2%	93.0%	92.4%	89.5%	75th
• Obtaining child's appointment with specialist as soon as needed	84.5%	78.9%	86.7%	81.9%	87th
Getting Care Quickly	**92.5%**	**92.3%**	**91.1%**	**89.5%**	**57th**
• Obtaining needed care right away	93.5%	92.6%	92.6%	90.7%	63rd
• Obtaining appointment for care as soon as needed	91.5%	92.0%	89.6%	88.4%	53rd
How Well Doctors Communicate	**93.5%**	**95.6%**	**94.1%**	**93%**	**57th**
• Doctors explaining things in an understandable way	95.2%	95.9%	95.4%	93.5%	69th
• Doctors listening carefully to you	95.1%	96.0%	95.1%	94.5%	55th
• Doctors showing respect for what you had to say	95.6%	97.3%	95.8%	95.6%	48th
• Doctors spending enough time with your child	87.9%	93.3%	89.9%	88.3%	63rd
Customer Service	**89.9%**	**91.1%**	**89.7%**	**87.9%**	**68th**
• Getting information/help from customer service	84.7%	86.4%	85.6%	82.6%	79th
• Treated with courtesy and respect by customer service staff	95.1%	95.8%	93.7%	93.2%	53rd
Shared Decision Making	**56.4%**	**57.2%**	**80.1%**	**N/A**	**N/A**
• Doctor/health provider talked about reasons you might want your child to take a medicine	62.2%	61.4%	95%	N/A	N/A
• Doctor/health provider talked about reasons you might not want your child to take a medicine	30.5%	28.1%	67.8%	N/A	N/A

Child Composite & Question Ratings	2014 Rate Title 19	2014 Rate Title 21	2015 Rate Title 19 & 21 Combined	2014 Quality Compass All Plans Rate (mean)	2014 Quality Compass Plan Approximate Ranking
• Doctor/health provider asked you what you thought was best for your child when starting or stopping a prescription medicine	76.7%	82.2%	77.4%	77.2%	52nd
Health Promotion and Education	74.1%	61.2%	66.5%	71.7%	<10th
Coordination of Care	83.7%	79.7%	82.4%	81%	57th
Ease of Filling Out Forms	95.9%	96.0%	94.8%	95.5%	31st
Rating Items					
Rating of Health Care	86.0%	86.9%	87%	84.7%	80th
Rating of Personal Doctor	87.9%	87.9%	89%	87.6%	68th
Rating of Specialist seen most often	85.7%	82.8%	72%	85%	71st
Rating of Health Plan	86.5%	84.9%	71.9%	84.5%	71st

Sunflower's goal for the 2015 CAHPS surveys is to meet or exceed the NCQA Quality Compass 50th percentile for both the Adult and Child surveys. Sunflower reached the 50th percentile on most measures and exceeded the 75th and the 90th percentile on several questions. Sunflower met the goal for most areas on the 2015 Adult and on the Child surveys. The areas not meeting Sunflower's goal of meeting the 50th percentile or above are the areas Sunflower is focusing improvement efforts on.

Medicaid Adult Survey – Sunflower's responses less than the 50th percentile:

- "Health Promotion and Education" and "Ease of Filling out Forms" were less than the 25th percentile.
- "Obtaining Appointment for Care as Soon as Needed" and "Doctors Explained Things in an Understandable Way" were less than the 50th percentile.
- "Rating of Specialist" and "Rating of Health Plan" were also below the 50th percentile.

Medicaid Child Survey – Sunflower's responses less than the 50th percentile:

- "Health Promotion and Education" was less than the 25th percentile.
- "Ease of Filling out Forms" was less than the 50th percentile.

Some composites impact the members' responses to the rating questions more than others and are considered Key Drivers. SPH Analytics ran multiple linear regression analyses on the results to identify which composites were Key Drivers for both the Adult and Child Surveys.

The analysis of key drivers allows Sunflower to drive actions based on plan strengths (summary rates at or above 75th percentile), opportunities (summary rates below 50th percentile) and areas to monitor (summary rates between 50th and 75th percentile). The 2015 Key Drivers for the Medicaid Adult Survey identified as areas of opportunity or areas to monitor are identified in tables that follow.

Medicaid Adult Survey Opportunity Analysis

Key Driver of Health Plan Rating	**2014 Opportunity Analysis**	**2015 Opportunity Analysis**
Customer Service	89th, Strength	98th, Strength
Getting Needed Care	93rd, Strength	71st, Monitor
Key Driver of Health Care Rating	**2014 Opportunity Analysis**	**2015 Opportunity Analysis**
Customer Service	N/A	N/A
Getting Needed Care	93rd, Strength	71st, Monitor
How Well Doctors Communicate	46th, Opportunity	48th, Opportunity
Getting Care Quickly	99th, Strength	82nd, Strength
Key Driver of Personal Doctor Rating	**2014 Opportunity Analysis**	**2015 Opportunity Analysis**
How Well Doctors Communicate	46th, Opportunity	48th, Opportunity
Coordination of Care	76th, Strength	66th, Monitor

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

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

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

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

- Increase member understanding of Medicaid benefits.
- Educate providers on documents and information needed for PA request.

- Increase member engagement in provided materials.
- Increase reliability of member demographic information.
- Member education regarding transportation benefit via the member newsletter.
- Increase member knowledge of standard/expected timeframes to obtain an appointment.

ACCESS & AVAILABILITY

Customer Service Call Statistics

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

The Customer Service Department has state contractual requirements to meet telephone access standards. In 2015, the Customer Service Department met Sunflower's performance goals in 2015 for member and provider inbound calls. Sunflower's Customer Service department had a total call volume of 178,474 for 2015. The average speed to answer was 11 seconds in 2015 and Sunflower successfully met the goal of 95% answered within 60 seconds or less. The 2015 abandonment rate was 0.97% which demonstrates meeting the goal of less than 4%. As a result of the performance goals having been met, there are no opportunities to improve Sunflower's telephone access at this time. Sunflower will continue monitoring and reporting telephone access on a monthly basis to allow for tracking, trending and identifying any opportunities.

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

Accessibility of Primary Care Services

Sunflower Health Plan (Sunflower) monitors primary care provider appointment accessibility against its standards, identifies opportunities for improvement and initiates actions as needed to improve results. Sunflower incorporates data and results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys, practitioner office surveys, member complaints/grievances, and customer service telephone triage access on a regular basis and actions are initiated when needed to improve performance. This report describes the monitoring methodology, results, analysis, and action for each measure. Access to behavioral healthcare practitioner and behavioral healthcare telephone access is monitored on a regular basis and actions are initiated when needed to improve performance by Cenpatico, Sunflower's NCQA-accredited behavioral healthcare vendor.

Below is a table showing the standards, performance goal, measurement, and frequency for each area of assessment of accessibility.

Accessibility Type	Standard and Performance Goal	Measurement Method	Measurement Frequency
Primary care: Routine, Non-Symptomatic	90% within 21 calendar days of request	Phone Survey	Annually
Primary care: Urgent, Symptomatic	90% within 48 hours of request	Phone Survey	Annually
Primary care: Emergent	90% within 24 hours of request	Phone Survey	Annually
OB: First Trimester	90% within 14 calendar days of request	Phone Survey	Annually
OB: Second Trimester	90% within 7 calendar days of request	Phone Survey	Annually
OB: Third Trimester	90% within 3 calendar days of request	Phone Survey	Annually
OB: High Risk Pregnancy	90% within 3 calendar days of request	Phone Survey	Annually
Wait Time in Office	Patients seen in less than 45 min. of appointment time	Phone Survey	Annually
After-hours Care	90% have acceptable after-hours coverage	Phone Survey	Annually
Q4 Adult Survey: Percent of members who responded always or usually to “Obtaining needed care right away”	Quality Compass 50th percentile	CAHPS Survey	Annually
Q6 Adult Survey: Percent of members who responded always or usually to “Obtaining appointment for care as soon as needed”	Quality Compass 50th percentile	CAHPS Survey	Annually
Q4 Child Survey: Percent of members who responded always or usually to “Child obtaining needed care right away”	Quality Compass 50th percentile	CAHPS Survey	Annually
Q6 Child Survey: Percent of members who responded always or usually to “Child obtaining appointment for care as soon as needed”	Quality Compass 50th percentile	CAHPS Survey	Annually
Supplemental Adult and Child (in 2015 survey): In the last 12 months, when you phoned after regular office hours, how often did you get the help or advice you needed?	NA-Will compare against other health plans in book of business for vendor and across Centene Corporation	CAHPS Survey	Annually

Accessibility Type	Standard and Performance Goal	Measurement Method	Measurement Frequency
Member Grievances related to Appointment Access	< 5.0/1000 members	Grievance Database	Annually

Appointment Access Definitions - Standards and Methodology

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

Sunflower surveyed a sample of participating (in network) credentialed practitioners, both PCPs and specialists (includes OB/GYN), with Sunflower Health Plan as of July 17, 2015. No practitioners were excluded from the sample. Practitioner data was pulled from Sunflower's provider management system, Portico. Data is collected by standardized survey; a total of 1074 practitioners were included for the 2015 analysis. Sunflower Health Plan's appointment availability surveys request confirmation that the practitioner can accommodate members' appointment needs based on current practitioner availability for routine and urgent appointments.

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

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

Practitioner Type	Standard	2015 Results	Goal Met? (Yes/No)
Primary care urgent care appointments within 48 hours	90% of surveyed PCPs report availability of urgent appointment within defined timeframe	91.33%	Yes

Practitioner Type	Standard	2015 Results	Goal Met? (Yes/No)
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	87.86%	**No**
Specialist urgent care appointments within 48 hours	90% of surveyed specialists report availability of urgent appointment within defined timeframe	68.58%	**No**
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	70%	**No**
Wait time not to exceed 45 minutes	90% of surveyed PCPs 90% of surveyed specialists	87.86% 96%	**No** Yes

The survey of a sample of PCPs for accessibility of routine and urgent care appointments found that the Sunflower goal of 90% compliance with appointment standards was met for urgent appointments (91.33%) but fell slightly short for routine care appointments (87.86%).

The survey of specialists for accessibility of routine and urgent care appointments found that the Sunflower goal of 90% compliance with appointment standards was not met for both urgent (68.58%) and routine (70%) appointments. The audit sample for wait time not to exceed 45 minutes found that the Sunflower goal of 90% compliance was not met for PCPs (87.86%), but was met for specialists (96%). Sunflower will reassess these standards in 2016 and will provide communication to providers who did not meet the compliance of 90% to allow the opportunity to correct.

After-Hours Care

The 2015 CAHPS survey included question addressing After-Hours Care; Q#63 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#64 “In the last 6 months, when you phoned after regular office hours, how often did you get help or advice you needed?”; Q#87 on the Child Survey Supplemental Questions “In the last 6 months, did you phone your child’s personal doctor’s office after regular office hours to get help or advice for yourself?”, Q#88 “In the last 6 months, when you phoned after regular office hours, how often did you get help or advice you needed?”..

Results from the 2015 Child CAHPS After-Hours Care supplemental survey question #87 results indicated that for Title 19, only 16.1% called their providers office after hours in the last 6 months and to get help/advice for their child. For the Title 19 Child with Chronic Conditions there were 21.3%, Title 21 16.5% had called and Title 21 with Chronic Conditions 13.0% had called for help/advice after hours in the previous 6 months. Then for the After-Hours Care supplemental question #88 with regard to the last 6 months, when you phoned after regular offices hours how often did you get the help/advice you needed? The results for Title 19 were 81.7% reported always/usually and for Title 19 with Chronic Conditions 78.9% reported always/usually. Specific to the Title 21 population, the survey revealed 75.25 for always/usually and Title 21 with Chronic Conditions demonstrated 74.2% with responses always/usually.

The 2015 Adult CAHPS After-Hours Care supplemental survey question rate is 16.3% for phoning the members' personal doctor's office after regular office hours in the previous 6 months to get help or advice for themselves. The rate of getting the help or advice needed is 74.1%.

CAHPS Survey

Sunflower monitors practitioner appointment accessibility through analysis of relevant CAHPS® survey question results. Sunflower reviews results from CAHPS Question 4 "Obtaining needed care right away" and Question 6 "Obtaining care when needed, not when needed right away" in both the Adult and Child Medicaid surveys. Survey responses reported reflect the percent of members who report "Always" or "Usually" to the survey questions. In 2015, Sunflower utilized additional CAHPS questions to capture data for more providers to more globally assess primary care access information.

The table below demonstrates the Sunflower rates for CAHPS Adult member satisfaction survey results comparing 2015 to 2014. Also, the tables demonstrates the plans ranking per the 2014 Quality Compass ranking.

Composite & Question Ratings	2014 Rate	2015 Rate	2014 Quality Compass Plan Ranking
Getting Care Quickly	**87.0%**	**83.9%**	75th
• Obtaining needed care right away	89.3%	88.6%	95th
• Obtaining appointment for care as soon as needed	84.7%	79.2%	44th

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Below, is the table that represents Sunflowers Child CAHPS survey results for comparison of 2015 results with 2014 survey demonstrated by Title 19 and Title 21 member satisfaction survey results.

Child Composite & Question Ratings	2014 Rate Title 19	2015 Rate Title 19	Title 19 2014 Quality Compass All Plans Percentile	2014 Rate Title 21	2015 Rate Title 21	Title 21 2014 Quality Compass All Plans Percentile
Getting Care Quickly	**92.5%**	**90.9%**	**73rd**	**92.3%**	**90.0%**	43rd
• Obtaining needed care right away	.5%93	93.8%	73rd	92.6%	91.4%	47th
• Obtaining appointment for care as soon as needed	91.5%	90.7%	64th	92.0%	88.5	41st

*The 2014 Quality Compass benchmark is the mean summary rate from Medicaid Child samples submitted to NCQA 2014 approximately 132 samples.

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

Network Access

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

Cultural and Linguistic Capabilities

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

Practitioner Availability

Practitioner availability monitoring is completed for primary care practitioners (PCPs), high volume specialty care practitioners, and high volume behavioral health practitioners. As noted above, Cenpatico, the Plan's behavioral health vendor, monitors and analyzes behavioral health practitioner availability on behalf of Sunflower Health Plan.

The table below reflects the practitioner type, access standard, method of measurement and measurement frequency.

Results by Practitioner Type

Practitioner Type	Standard	Results	Goal Met?
PCPs: All Types	95% of urban members have at least 1 PCP within 20 miles	99.9%	Yes
	95% of rural members have at least 1 PCP within 30 miles	99.9%	Yes
	At least 1 PCP per 2000 members	1:51	Yes
PCPs: Family Practitioners / General Practitioners	95% of urban members have at least 1 FP or GP within 20 miles	99.9%	Yes
	95% of rural members have at least 1 FP or GP within 30 miles	99.9%	Yes
	At least 1 FP or GP per 2000 members	1:117	Yes
PCPs: Internal Medicine	95% of urban members ≥19 have at least 1 internist within 20 miles	99.5%	Yes
	95% of rural members ≥19 have at least 1internist within 30 miles	88.1%	No
	At least 1 IM per 2000 adult members	1:185	Yes
PCPs: Pediatrics	95% of urban members ≤18 years of age have at least 1 pediatrician within 20 miles	98.2%	Yes
	95% of rural members ≤18 years of age have at least 1 pediatrician within 30 miles	73.0%	No
	At least 1 pediatrician per 2000 child members	1:179	Yes
PCP Extenders: Nurse Practitioners	95% of members have at least 1 NP within 20 miles	98.9%	Yes
	95% of rural members have at least 1 NP within 30 miles	99.5%	Yes
	At least 1 NP per 2000 members	1:280	Yes
PCP Extenders: Physician Assistants	95% of members have at least 1 PA within 20 miles	98.0%	Yes
	95% of rural members have at least 1 PA within 30 miles	90.5%	No
	At least 1 PA per 2000 members	1:464	Yes

Results by Practitioner Type

Practitioner Type	Standard	Results	Goal Met?
Obstetrics and Gynecology	95% of urban female members have at least 1 OB/GYN within 15 miles	97.4%	Yes
	95% of rural female members have at least 1 OB/GYN within 60 miles	95.4%	Yes
	At least 1 OB/GYN per 2000 members	1:220	Yes
Cardiology	95% of urban members have at least 1 cardiologist within 25 miles	97.9%	Yes
	95% of rural members have at least 1 cardiologist within 100 miles	98.0%	Yes
	At least 1 cardiologist per 5000 members	1:400	Yes
Orthopedics	95% of urban members have at least 1 orthopedic specialist within 25 miles	99.8%	Yes
	95% of rural members have at least 1 orthopedic specialist within 100 miles	98.7%	Yes
	At least 1 orthopedic specialist per 5000 members	1:594	Yes
Hematology /Oncology	95% of urban members have at least 1 Hematology/Oncology provider within 25 miles	96.2%	Yes
	95% of rural members have at least 1 Hematology/Oncology provider within 100 miles	83.3%	No
	At least 1 Hematology/Oncology provider per 5000 members	1:1090	Yes

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

Availability for all PCP types combined and by specific type for family/general practitioners, internists, and pediatricians met Sunflower's standards for members residing in urban areas. Two standards were not met for Sunflower members residing in rural areas. The two that failed to meet the standard were internal medicine and pediatricians. Sunflower also measures availability for PCP-Extenders, i.e. nurse practitioners and physician assistants, which both met the standards for urban members in 2015. Availability of physician assistants for members residing in rural areas did not meet the standard of 95%, with results of 90.5%. All PCP types exceeded the numeric/ratio standards established by Sunflower: 1:2000 for all types of PCPs.

Sunflower's standards for OB/GYN practitioners are that 95% of female members have access to at least 1 OB/GYN within 15 miles for urban areas and within 60 miles for rural areas; both standards were met for OB/GYNs in 2015. In addition to OB/GYNs, high-volume specialty care practitioners are defined as any provider greater than 150 encounters per 1,000 members. The specialty care providers meeting this threshold were cardiologists, hematology/oncology practitioners, and

orthopedic specialists. The high-volume specialists met both the urban (95% of members have at least 1 specialists within 25 miles) and the rural (95% of members have at least 1 specialist within 100 miles) geographic standards, other than hematology/oncology, which fell below the 95% of rural members having at least 1 provider within 100 miles, at 83.3% for 2015.

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

In many rural areas in Kansas, hospitals are considered "critical access" and provide a variety of healthcare services, including primary care. Many rural hospitals have Rural Health Clinics (RHCs), Federally Qualified Healthcare Clinics (FQHCs) or health departments located in or near the acute care hospital that provide services to the entire county, and often to several surrounding counties as well. These arrangements, unique to rural and frontier/remote areas, may not accurately reflect the availability of services through Quest Analytics reporting. Sunflower believes that despite not meeting the geographic standards for internists, pediatricians, and physician assistants and Hematologists/Oncologists per Quest Analytics reporting, members in rural and frontier areas of the state do have adequate access to primary and specialty care when considering the overall availability of all PCPs, including PCP-Extenders and known primary care and specialty services available through hospitals, as Sunflower is contracted with all available hospitals in the rural and frontier areas.

Provider Satisfaction Survey

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

SPH Analytics followed a one-wave mail and internet with phone follow-up survey methodology to administer the provider satisfaction survey from September to October 2015. Sunflower's sample size was 1,500. SPH Analytics collected 359 surveys (97 mail, 25 internet, and 237 phone) from the eligible provider population. After adjusting for ineligible providers, the mail/internet survey response rate was 8.9%, and the phone survey response rate 36.5%. A response rate is only calculated for those providers who are eligible and able to respond. The methodology demonstrating the response rates for

mail, internet and phone survey responses is depicted below as well as shows how the ineligible provider responses are addressed.

Mail/Internet Component
97 (mail) + 25 (Internet) / 1,500 (sample) – 127 (ineligible) = 8.9%
Phone Component
237 (phone) / 919 (sample) – 269 (ineligible) = 36.5%

The 2015 survey results demonstrated the following: 64.8% of the responses were from primary care offices, 34.9% of the responses were from specialty practices, and 18.7% of the responses were from behavioral health offices. 10.9% were completed by the physician, 4.9% completed by a behavioral health clinician, 48.3% completed by the office manager, and 35.9% completed by a nurse or other staff.

Continuity and Coordination of Care between Medical and Behavioral Healthcare

Sunflower's Medical Management team works in collaboration with Cenpatico Behavioral Health, Sunflower's behavioral health delegate and sister organization. Sunflower annually assesses the following areas of collaboration between medical and behavioral healthcare:

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

The table below demonstrates how Sunflower specifically monitors these areas.

Specific Area Monitored	Description of Monitor
Exchange of Information	Rate of practitioner satisfaction with behavioral health practitioner communication as reported through the annual provider satisfaction survey.
Appropriate Diagnosis, Treatment and Referral of BH Disorders Commonly Seen in Primary Care & Appropriate Use of Psychotropic Medications	Antidepressant Medication Management (AMM) HEDIS Measure: Acute Phase & Continuation Phase.
Screening and Management of Coexisting Disorders	Number of members identified, screened and engaged in behavioral health services for perinatal depression.
Preventive Behavioral Program	Number of members identified and screened for perinatal depression.

Specific Area Monitored	Description of Monitor
Special Needs of Members with Serious and Persistent Mental Illness	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) HEDIS Measure.

Exchange of Information between Behavioral Health and Primary Care

Sunflower collects data and identifies opportunities to improve the exchange of information through the annual provider satisfaction survey, which includes evaluation of satisfaction with communication between behavioral health practitioners and primary care practitioners. Levels of primary care practitioner satisfaction with behavioral health practitioner communication are collected through the annual provider satisfaction survey, and shared with Cenpatico.

In the standardized survey tool administered by SPH Analytics for Sunflower's 2015 Provider Satisfaction Survey, two questions measure the timeliness and the frequency of communication from behavioral health practitioners to primary care practitioners. Responses for the specific questions are noted in the table below for 2015. The response for question 4E demonstrated an increase from 6.9% in 2014 to 10.4% for 2015. For question 4F, there was a minimal increase from 33.3% in 2014 to 33.7% in 2015.

Provider Satisfaction Questions	2015 Percent Satisfied*	2015 Responses Composite/Attribute
4E: Please rate the timeliness of exchange of information/feedback /reports from the behavioral health providers?	10.4%	Excellent – 3.1% Very Good – 7.4% Good – 54.6% Fair – 27.6% Poor – 7.4% (n=150)
4F: How often do you receive verbal and/or written communication from behavioral health providers regarding your patients?	33.7%	Always – 6.0% Usually – 27.7% Sometimes – 31.5% Rarely – 24.5% Never – 10.3% (n=125)

** Summary Rates represent the most favorable response percentage(s).*

Sunflower was unable to compare performance on the 2015 survey against a benchmark, as SPH Analytics does not provide Medicaid Book of Business benchmarks for the two relevant questions since these are custom questions. Similarly, the composite for the Network/Coordination of Care section of the survey does not include these custom questions so was not reviewed for this report. Significant opportunity for improvement is noted, in particular for the timeliness of the exchange of information between practitioners, based on the low rate (6.9%) of satisfaction noted on the 2014 provider survey. Sunflower's goal for the 2015 provider satisfaction survey is an increase of 5 percentage points on each survey question. Sunflower did not achieve the goal for either one of the questions.

Sunflower collaborates with Cenpatico Behavioral Health to promote the exchange of information through completion of an assessment for each member upon discharge for a

behavioral health inpatient admission. Cenpatico Behavioral Health identifies a member's PCP and faxes the discharge assessment, which includes information regarding discharge medications and behavioral health providers with whom the member has follow up care arranged. Discharge summaries containing protected health information related to HIV/AIDS or substance abuse treatment are not eligible for re-disclosure to the member's PCP unless the member provides specific written consent to release the information obtained by Cenpatico Behavioral Health. Efforts are made to obtain this consent to allow for the records to be provided to the PCP. Case managers and care coordinators also address this with members during initial or ongoing outreach, providing education to members regarding the importance of providing consent to allow the information to be shared with their PCP.

Sunflower and Cenpatico Behavioral staff also identified the following barriers related to the exchange of information between medical and behavioral healthcare providers:

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

Additionally, the following opportunities were identified to address the barriers with regard to making impact on improving communication between behavioral health providers and primary care:

- Member education to help establish relationship with a PCP.
- Staff education and ongoing auditing of inpatient cases.
- Member education regarding providing consent for information to be shared to allow for communication of treatment including HIV/AIDS and substance abuse treatment for improved coordination of care
- Education of medical providers regarding a member's behavioral health providers.
- Member education regarding importance of sharing information between providers.
- Education of behavioral health providers regarding a member's PCP.
- Member education regarding importance of sharing information between providers.
- Treatment record review for all high volume behavioral health providers to identify attempts to coordinate care and provide technical assistance to providers who do

not meet the standards.

- Work with members to understand that mental health also impacts all areas of their health and quality of life and encourage coordination of care with other providers.
- Minimize the number of people who are contacting the member to one case manager that will coordinate with other members of the care team.

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

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

The AMM HEDIS measure has two indicators:

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

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

AMM Indicator	HEDIS 2015	Goal*	HEDIS 2014	Goal**
Effective Acute Phase Treatment	49.09% (834/1699)	49.66%	57.14% (116/203)	51.47%
Effective Continuation Phase Treatment	33.78% (574/1699)	33.93%	37.44% (76/203)	35.26%

**Quality Compass 2014 Medicaid 50th percentile*
***Quality Compass 2013 Medicaid 50th percentile*

Sunflower's HEDIS 2015 (measurement year 2014) rate for the *Effective Acute Phase Treatment* measure did not meet the goal of reaching or exceeding the Quality Compass 50th percentile. The *Effective Acute Phase Treatment* indicator fell slightly below the performance goal of 49.66% with a rate of 49.09%. The *Effective Continuation Phase Treatment* rate for HEDIS 2015 also fell slightly below the performance target of 33.93%, with a rate of 33.78%. Sunflower will continue to work to increase performance in 2016.

Both AMM HEDIS 2015 rates demonstrate a decreased rate from HEDIS 2014, however due to Sunflower first beginning health plan operations in January 2013, the HEDIS 2014 final rates are not considered a valid indicator of Sunflower's performance and HEDIS 2015 rates were used as baseline.

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

Analysis of the data lead to the identification of the following barriers that were focused one:

- Member knowledge deficit regarding importance of adherence, ways to manage side effects, etc.
- The treating provider may not be aware the member is not consistently taking their prescribed medication.
- Treating providers not familiar with the depression clinical practice guideline.

The opportunities identified as interventions to address the barriers are noted below:

- Targeted outreach to members with a depression diagnosis and recently prescribed/fill of a new antidepressant prescription.
- Utilize pharmacy data to identify members who are non-adherent and distribute letter to prescribers to notify of member non-adherence.
- Article in the provider newsletter, educated providers about Sunflower's adopted clinical practice guidelines, including the depression guideline.

Management of Treatment Access and Follow-up for Members with Coexisting Medical and Behavioral Disorders & Primary or Secondary Preventive Behavioral Healthcare Program

Sunflower provides a preventive behavioral health program targeting early identification of pregnant members at risk for depression as a means to assure treatment access and follow-up for these members with coexisting conditions. The program, through collaboration with Cenpatico Behavioral Health, allows for early co-management of cases where a member may be experiencing depression along with their pregnancy. The collaborative efforts to identify members at risk for perinatal depression involve identifying all pregnant members and those who recently delivered Start Smart member mailings, and involves screening of members to identify those at risk or with depression, Depression education materials are provided to the mothers who are expecting and those who have delivered along with an Edinburgh Depression Scale and a self-addressed envelope. Education is provided to practitioners about the program to allow for referrals. Efforts also utilize case management and disease management as opportunities to identify members early with depression.

This program attempts to encourage the newly delivered woman to identify the signs and symptoms of depression and seek help for depression so that complications can be minimized and nurturing of the newborn can be optimal through the goals provided below.

- Educate members in the perinatal period about the risks of depression;
- Educate members regarding the signs and symptoms of depression;
- Educate the member about accessing services for treatment of depression;
- Educate the member's provider if the member demonstrates depression using the Edinburgh Scale; and,
- Identify members at moderate or high risk for depression and engage them in preventative care to avoid adverse outcomes.

Returned surveys are scored and assigned as high, moderate, or low risk. Then outreach is performed for each member regardless of their score. Response rates are low ranging from 1.6% to 4.0%. The majority of those who did respond indicated that their level was low on the survey. The trends with regard to low response rate to survey and low risk levels assessed are consistent with what was seen in 2014 as well. Of the surveys received in 2015, there was a minimal decrease in the number of those who scored as moderate or high in 2014 compared to 2015. The 2015 Survey results are noted below:

	Number Sent	Number Returned	Response Rate	Number Low	Rate Low	Number Moderate /High	Rate Moderate /High
Prenatal	3086	123	4.0%	87	70.7%	28	22.8%
Post-Partum	3871	63	1.6%	48	76.2%	6	9.5%
Total	6957	186	2.7%	135	72.6%	34	18.3%

The Cenpatico Behavioral Health clinical team is notified of all moderate or high risk members within two (2) business days of receipt of completed surveys. The clinical team set a target of 24 hours from receipt of notification to first outreach to the identified members. Clinical outreach demonstrated a successful increase in 2015 for 89% of the moderate and high risk prenatal members this reporting period compared to 2014 (72%), with a 24% change in rate. This is not a statistically significant increase (p>.0813). Cenpatico exceeded its performance goal to increase the successful outreach and engagement rate by 10%. Of the members who accepted Cenpatico's clinical outreach and engagement services, 100% accessed behavioral health services within 45 days of completion of their depression screen.

The following barriers and opportunities were identified regarding management of members with coexisting medical and behavioral health disorders and the Perinatal Depression Screening Program.

- Members at risk for perinatal depression cannot be identified due to low response rates to survey.
- Member knowledge deficit about the Start Smart program and benefits of the program (i.e. depression screening) and availability of behavioral health services.
- Provider knowledge deficit regarding services Sunflower can provide to members with perinatal depression.
- Provider perception that depression screening is time consuming and office lacks staff to do screening.
- Member and provider knowledge deficit about the Start Smart program and benefits of the program (i.e. depression screening) and availability of behavioral health services.

The opportunities identified were as follows:

- Sunflower CM staff complete depression screenings in real time with members during calls.
- Member and provider education related to Start Smart program and benefits as well as availability of behavioral health services
- Provider education related to Sunflower services available to members with Perinatal Depression
- Provider education related to importance of taking the time to complete the screening

Coordinating Special Needs of Members with Serious & Persistent Mental Illness

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

The SSD measure is a new measure for HEDIS 2015. Sunflower's HEDIS 2015 final rate serves as the baseline for this monitoring performance. For Sunflower's Health's baseline year (HEDIS 2015, Measurement Year 2014) the goal was to achieve the NCQA Quality Compass HMO Medicaid 50th percentile of 79.38%. Sunflower's final rate of 72.69% failed to meet that goal.

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

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

The collaborate efforts of Sunflower and Cenpatico Behavioral Health demonstrate efforts to overcome barriers that were initiated back into 2014 which were carried through for 2015 and new action as were added as well in 2015 based on analysis of data. Below are the actions taken with regard to overcoming and assisting members with improved health and quality of life.

- Member and provider newsletter articles about the availability of behavioral health services through Cenpatico
- Members with a depression diagnosis and recently prescribed/fill of a new antidepressant sent an informational brochure and personalized letter to encourage prescription compliance and provide general education regarding the prescription. Provide telephonic outreach to these members as well.
- Full integration of medical and behavioral health care management services – one primary lead case manager/care coordinator. Primary case manager addresses medical and behavioral health issues concurrently.
- Cenpatico staff re-trained regarding discharge assessment process and how to effectively identify the member's PCP. Monthly audits by Cenpatico QI staff continue, and include ongoing staff education regarding successful facilitation of the exchange of information.
- Enhance post-discharge outreach call script for medical inpatient admissions, to include addressing behavioral health treatment and encouraging members to share information between providers and provide consent if needed.
- Provider newsletter article regarding depression and availability of support from Sunflower
- Provider newsletter article regarding Sunflower's practice guidelines and how to access the guidelines, including the depression guideline.

UTILIZATION MANAGEMENT PROGRAM

Purpose

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

Scope

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

Goals

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

Implementation

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

Authority

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

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

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

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

Program Integration

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

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

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

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

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

- Services provided by local public health departments.

Complex Case/Care Management

Case management or coordination of care is a collaborative process of assessment, planning, coordinating, monitoring and evaluation of the services required to meet the members' individual needs. Case management serves as a means for achieving member wellness, recovery, and autonomy through advocacy, communication, education, identification of services resources and service facilitation. The goal of case management is provision of quality health care along a continuum, decreased fragmentation of care across settings, enhancement of the member's quality of life, and efficient utilization of patient care resources.

Members identified who will potentially benefit from care management are assigned a case manager who is registered nurses or social worker. The case manager will develop a care plan for the member and work with the member and the member's doctor to obtain the necessary care for the member. In order to optimize the outcome for all concerned, case management services are best offered in a climate that allows direct communication between the Case Manager, the member, and appropriate service personnel, while maintaining the member's privacy, confidentiality, health, and safety through advocacy and adherence to ethical, legal, accreditation, certification, and regulatory standards or guidelines.

Disease Management

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

- Asthma
- Diabetes
- Hypertension
- Heart disease

Sunflower determined the case management identification criterion being utilized was adequately identifying the population at risk. The data reviewed in this population assessment does not indicate a need for any fundamental changes in the case management program at this time, and Sunflower's protocol for complex case management will remain essentially the same in 2016 as no material changes in the membership relative to product line, age/gender, language, and race and ethnicity were identified. However, there have been many changes made to the overall case management services provided by Sunflower as the health plan moves into the third year of operations. Some of the improvements include:

- Development of an Emergency Department Diversion program to assure members are connected with a primary care provider to manage their care and to provide any needed education and resources.
- Two new post-discharge nurse positions to contact all members not in case management after they have been discharged from the hospital.
- Implementation of a dedicated Transplant Case Manager (2) to assist transplant members.

- Sickle Cell Case Management Program to assess and educate all sickle cell members, assists with resources, coordinates care between providers, and any other functions necessary.
- Refocused efforts on TANF and CHIP members; Sunflower has instituted efforts to assist new mothers to obtain four well-child visits within the first 6 months of life to ensure babies are receiving timely immunizations and meeting appropriate developmental milestones.
- Efforts to increase the percentage of Notice of Pregnancy forms completed on pregnant women to identify the high risk pregnancies and offer Start Smart Case Management, which includes identifying any mother at risk for pre-term deliver and working with the physician and the member to consider 17P injections to reduce the risk of a pre-term birth.
- Community baby showers to connect with members in their community and present information about pregnancy, newborn care, and breastfeeding.
- Partner closely with Utilization Management staff to arrange safe discharges for NICU babies.
- Initiated Integrated Case Management, a training program for staff conducted by the Case Management Society of America (CMSA). This program provides education and instruction for staff on how to work together to manage the member as a whole person. The program includes 40 hours of self-study, webinar sessions, 1.5 days of face-to-face training with CMSA instructors, and an exam with certificate upon successful completion of the course, earning case managers 59 CEUs. Sunflower case managers continue to complete the program.
- Continuation of the holistic care based on the ICM model which includes as its primary pillar a one case owner model. In doing so, behavioral health was integrated into the health plan operations as opposed to a contracted service from our sister company. This resolved the silo effect with working as one team across all populations to care for the entire population as opposed to segments. This member centric model allows for the primary case owner to remain if the member has an established relationship but allow them to bring in their SME for a particular health state.
- To improve coordination of care between departments, Sunflower began daily rounds on all inpatient members. Sunflower also began scheduling Complex Medical Rounds, Long Term Service and Supports (LTSS) rounds, and integrated rounds to discuss and coordinate care.
- Sunflower has a wide range of member materials, including a new diabetes handbook that is brightly colored and easy to read.
- Sunflower has also recently begun using the Krames Patient Education materials database which contains patient education materials for thousands of diagnoses, medications, and medical procedures.

Utilization Management Committee (UMC)

Daily oversight and operating authority of utilization management activities is delegated to the UMC, which reports to the Plan's QIC and ultimately to the Plan BOD. The UMC is responsible for the review and appropriate approval of medical necessity criteria and protocols and utilization management policies and procedures. The UMSC 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 for approval. The UMC monitors and analyzes relevant data to detect and correct patterns of potential or actual inappropriate under- or overutilization, which may impact health care services, coordination of care and appropriate use of services and resources as well as member and practitioner satisfaction with the UM process. Analysis of the above tracking and monitoring processes, as well as status of corrective action plans, as applicable, are reported to the Plan's QIC.

In addition to the above, the UMC also provides ongoing evaluation of the appropriateness and effectiveness of provider incentive programs based on utilization data. This includes evaluating the performance of the provider using pay for performance measures and the impact of the contracts on participating physicians to ensure the goal of providing sufficient incentives to ensure the provision of high quality, cost effective care.

UM Committee Scope

- Oversees the UM activities of Plan 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 satisfaction 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

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

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

- Chief Executive Officer

- Chief Medical Director / 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
- VP of Quality Improvement
- Other Plan operational staff as requested

Meeting Frequency and Documentation of Proceedings:
The UMC meets at least four (6) times per year and the VPMM maintains detailed records of all UMC meeting minutes, UM activities, case management program statistics and recommendations for UM improvement activities made by the UMC. The UMC submits to the QIC all meeting minutes and written reports regarding all UM studies and activities.

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

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, the Plan 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. The Plan will use 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. The Plan 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. For determination of medical necessity and appropriateness of substance use services, the Plan uses the ASAM as contained in KCPC. For determination of the community based services for behavioral health, the Plan uses InterQual and develops a medical necessity criteria based on the service description as needed; this criteria is submitted and approved to the Provider Advisory Council.

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 the plan 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 the Plan 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 the Plan of all inpatient admissions and long-term care facility admissions within one (1) business day following the admission. Post-stabilization services delivered in the emergency department do not require authorization. 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.

The Plan will make determinations for standard, non-urgent, pre-service prior authorization requests within 14 calendar days of receipt of the request. A determination for urgent pre-service care (expedited prior authorization) will be issued within 72 hours of receiving the request for service. The Plan will make determination for urgent concurrent, expedited continued stay and/or post stabilization review within 24 hours of receipt of the request for services. 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 the Plan. If the request does not meet the definition of urgent care, the request may be handled as a new request and decided within the time frame appropriate for the type of decision (i.e., pre-service and post-service). Medical necessity of post service decisions (retrospective review) will be limited to special circumstances and subsequent member/practitioner notification will occur no later than 30 calendar days from receipt of request.

New Technology Assessment

In instances of determining benefit coverage and medical necessity of new and emerging technologies and the new application of existing technologies or application of technologies for which no InterQual Criteria exists, the Medical Director shall first consult Centene's available Medical Policy Statements. The Centene Clinical Policy Committee, with representation from Sunflower and Centene Health Plans, develops these statements. The Corporate Clinical Policy Committee (CPC) is responsible for evaluating new technologies or new applications of existing technologies for inclusion in the benefit plan. The CPC shall develop, disseminate and annually update medical policies related to:

medical procedures, behavioral health procedures, pharmaceuticals and devices. The CPC or assigned designee shall review appropriate information to make the coverage decision including published scientific evidence, applicable government regulatory body information, CMS's National Coverage Decisions database/manual and input from relevant specialists and professionals who have expertise in the technology. Practitioners are notified in writing through the provider newsletters and the practitioner web portal of new technology determinations made by Sunflower. As with standard UM criteria, the treating practitioner may, at any time, request the medical policy criteria pertinent to a specific authorization by contacting the Medical Management Department or may discuss the UM decision with the Medical Director.

Inter-Rater Reliability

The purpose of inter-rater reliability is to evaluate the consistency with which utilization management (UM) staff involved in the UM process apply InterQual criteria in decision-making. Sunflower's goal is for 100% of Sunflower's UM and QI staff to pass all applicable IRR tests with a score of 90% or higher. At least annually, the Sunflower State Medical Management Department will conduct IRR tests as distributed by the Corporate Medical Management Department. There were no staff members that did not reach a final passing score, there are two allowed attempts. All staff that failed an IRR subset initially went through InterQual retraining for that subset before taking the re-take IRR for that subset.

The 2015 Annual IRR Testing was completed in October 2015, utilizing the 2014 InterQual criteria for test questions, allowing results to demonstrate knowledge of content end users have applied over the last year. There were twenty-seven staff members who took the annual IRR testing and passed with

Staff was assigned products for testing that are reflective of the end users role, to ensure accurate reporting data. Sunflower Medical Management/Training teams assign the product-specific tests in which each staff member conducts medical necessity review. InterQual product tests include: Acute Adult, Acute Pediatric, LTAH, Rehabilitation, Subacute/SNF, Home Care, Procedures, Imaging, and DME

Case Management Survey

Sunflower monitors member satisfaction with case management programs by obtaining feedback from members enrolled in case management and by qualitatively and quantitatively analyzing member complaints about case management. The goal is 90% satisfaction on all components of the Case Management program through direct member satisfaction survey.

The results are stratified by individual survey question in the table below for 2015.

Question	% of members responding as "very satisfied" or "somewhat satisfied"	Goal Met?
Q1. How satisfied are you with the help you received from your Case Manager?	91%	Yes
Q2. Were you able to understand the information from your Case Manager about your health condition(s)?	91%	Yes

Question	% of members responding as "very satisfied" or "somewhat satisfied"	Goal Met?
Q3. Have you been able to follow any of Case Manger's heath care suggestions to improve your health?	96%	Yes
Q4. Did you and your Case Manager come up with goals to work on?	87%	No
Q5. Was your Case Manager usually able to speak with you?	93%	Yes
Q6. Did your Case Manager help you get the health care services that you needed?	93%	Yes
Q7. How pleased are you with how well your Case Manager helped you with other resources?	91%	Yes
Q8. How satisfied are you with any learning materials you received from your Case Manager?	93%	Yes
Q9. If you had any cultural needs, how satisfied are you with how they were met by your Case Manager.	91%	Yes
Q10. How pleased are you with how your health and quality of life improved because you received help from your Case Manager?	92%	Yes
Q11. How satisfied overall are you with Case Management services you received?	92%	Yes

Barrier analysis conducted on the survey results revealed the following issues:

- The number of members surveyed was low. Initial attempts to obtain completed surveys by mail resulted in a very low return rate. Telephonic outreach was then attempted, but members were often difficult to reach by phone for survey completion.
- The number of low responses created a challenge for identifying areas of concerns across the membership in case management.
- The survey was for members who had completed case management, many were the same type of member so a larger sample might provider greater/broader representation.

The following opportunities for improvement were identified and implemented:

- To increase the survey completion rate, conduct surveys when member has already been contacted, i.e. when case managers are speaking with members, they can ask if the member is willing to conduct a short survey and transfer the member to another staff member, versus making outreach calls specifically for the purpose of conducting a survey. Members can be difficult to reach telephonically and the response rate to mailed surveys was very low.
- Educate staff to document reason why no response given to specific questions on surveys and attempt to gather specific information about why the member responded if a negative response given.
- Continue to educate staff regarding proper tracking and processing of complaints regarding the case management program.
- Regarding Q4: "Did you and your Case Manager come up with goals to work on?" - retrain staff on the importance of collaboration with the member regarding care

planning. As all active complex case management cases include development of a care plan in collaboration with the member or caregiver, this may be due more to the case manager not clearly requesting ongoing feedback and input into the plan with the member and communicating the care plan goals to the member.

- Educate Sunflower staff regarding results of the survey and specific questions where goals were not met, and brainstorm on ways to address areas of concern.
- Remind case management staff to clearly address the follow-up schedule with the member and ensure the member is in agreement, as well as addressing any barriers to reaching the member for follow-up (e.g. potential upcoming moves, alternative phone numbers to reach the member, etc.).
- Consider development of a survey tool that can be used for members remaining in Care Coordination in the MLTSS program to get a more broad view of services provided by Sunflower CM.

Grievances related to CM

Grievances received by the Sunflower were also reviewed as they relate to Case Management satisfaction. Review of 2015 member grievances/complaints regarding the case management program or case management process yielded 5 in total. All member grievances were investigated and resolved in a timely manner. Due to the low number of complaints received from Sunflower members, there were no overall opportunities regarding case management services that could be identified. Individual issues were addressed individually with the involved Case Management staff.

Member Satisfaction with UM

Sunflower annually monitors member satisfaction with UM through analysis of relevant CAHPS® survey question results. The 2015 scores for Sunflower are compared to the Quality Compass® All Plans means and percentiles for the applicable questions. As a new health plan, the goal is to reach the 50th percentile compared to Quality Compass.

The table below reflects the CAHPS Medicaid Adult and Child Survey Results for 2015:

Composite & Question Ratings	**Adult 2015 Rate**	**T19 Child 2015 Rate**	**T21 Child 2015 Rate**
Getting Needed Care	**84.1% (71st)**	**88.1% (76h)**	**90.9% (93rd)**
Q14: Ease of getting care, tests, or treatment needed	86.9% (92nd)	91.5% (64th)	93.3% (87th)
Q25: Obtaining appointment with specialist as soon as needed	81.3% (55th)	84.7% (78th)	88.6% (89th)
Getting Care Quickly	**83.9% (82nd)**	**92.3% (73rd)**	**90.0% (43rd)**
Q4: Obtaining needed care right away	88.6% (96th)	93.8% (73rd)	91.4% (47th)
Q6: Obtaining appointment for care as soon as needed	79.2% (48th)	90.7% (64h)	88.5% (41st)

*Percentile rankings are compared to 2014 Quality Compass all Plans as noted for general populations

An opportunity analysis was conducted to identify opportunities to improve performance and a barrier analysis to identify the root causes of member dissatisfaction with the UM

process. Along with the CAHPS survey results, Sunflower also looked at UM denials and appeals data to assess member satisfaction with the UM process, previously discussed.

Sunflower Quality Improvement, Medical Management, Customer Service, and Provider Relations staff completed an initial barrier analysis. Staff identified the following potential barriers and opportunities for improvement, with associated interventions.

As a result of the analysis of the results of the survey, the following were noted to be barriers that were in need of attention:

- Members are not aware of the assistance Sunflower can provide in locating a provider if they are experiencing difficulty.
- Online provider directory does not provide adequate search functionality to allow members to easily find available providers.
- Members do not understand the UM process or how authorization decisions are made.
- Limited specialists of some specialty types in some geographic areas.
- UM requests with insufficient information from providers can lead to denials or delay authorization.
- Member and provider knowledge deficit regarding the PDL, drugs that require prior authorization, and the process for obtaining prior authorization.
- Provider knowledge deficit regarding the appointment accessibility standards.
- Member lack of understanding of appointment standards.

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

- Member education regarding assistance Sunflower can provide in locating providers, including the availability of case management services for members with complex needs who access care with many different providers.
- Enhance the online provider directory.
- 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.
- Educate providers on the need for complete clinical information to make a timely decision to not delay care for members.
- Member and provider education regarding the PDL and medication prior authorization requirements.
- Provider education regarding standards for timeliness of appointments.
- Increase member knowledge of standard/expected timeframes to obtain an appointment.

Provider Satisfaction with UM

Sunflower monitors practitioner satisfaction with the UM process on an ongoing basis through internal quality monitoring, and annually through analysis of relevant questions on the practitioner satisfaction survey.

Sunflower saw improvement on the 2015 rate related to Utilization and Quality Management as well as the overall score for Pharmacy. Access to knowledgeable UM staff improved from 14.8% to 17.4%. Access to Case/Care Managers from the health plan also had an increase from 15.9% to 19.6%. Pharmacy areas noted with improvement include extent to which formulary reflects standard of care, branded drugs on formulary, ease of prescribing preferred drugs with formulary guidelines and availability of comparable drugs to substitute those not included in the formulary. The data is depicted in the table below from the Provider Satisfaction Survey Results specific to UM and Quality Management areas.

Composite & Key Questions	2015 Summary Rate	2014 SPHA Book of Business Medicaid	2014 Summary Rate
Utilization & Quality Management	**18.1%**	**33.9%**	**17.9%**
3A. Access to knowledgeable UM staff.	17.4%	31.8%	14.8%
3B. Procedures for obtaining pre-certification/ referral/ authorization information.	12.4%	33.3%	13.8%
3C. Timeliness of obtaining pre-certification/referral/authorization information.	12.7%	33.3%	16.1%
3D. The health plan's facilitation/support of appropriate clinical care for patients.	15.7%	32.4%	17.0%
3E. Access to Case/Care Managers from this health plan.	19.6%	30.6%	15.9%
3F. Degree to which the plan covers and encourages preventive care and wellness.	30.6%	41.9%	29.7%
3G. Extent to which UM staff share review criteria and reasons for adverse determinations.	12.2%	NA	15.2%
3H. Consistency of review decisions.	12.6%	NA	12.3%
Pharmacy	**12.7%**	**22.2%**	**10.2%**
5A. Consistency of the formulary over time.	8.8%	22.7%	8.9%
5B. Extent to which formulary reflects current standards of care.	13.7%	23.1%	9.3%
5C. Variety of branded drugs on the formulary.	13.3%	19.7%	11.4%
5D. Ease of prescribing your preferred medications within formulary guidelines.	15.6%	24.3%	11.7%
5E. Availability of comparable drugs to substitute those not included in the formulary.	12.3%	21.1%	9.6%

* Summary Rates represent the most favorable response percentage(s).
* SPH's 2014 Medicaid Book of Business consists of data from 23 plans representing 12,193 respondents.

To identify opportunities to improve performance, Sunflower conducted a barrier analysis to identify root causes of provider dissatisfaction with the UM process. Along with the provider satisfaction survey results, Sunflower also reviewed UM denials and appeals to assess provider satisfaction with the UM process. It should be noted that from the 2014 to the 2015 Provider Satisfaction gains were achieved overall for categories of Utilization & Quality Management and Pharmacy.

Sunflower Quality Improvement, Medical Management, Customer Service, and Provider Services staff completed an initial barrier analysis, along with support from the Centene

Corporation Quality Improvement Department. Staff identified the following potential barriers and opportunities for improvement.

Sunflower's data analysis led to the following barriers identified to work towards resolving to improve what the provider satisfaction survey demonstrated. Those barriers are noted below:

- Providers unaware of the availability of case management services through Sunflower.
- Providers unfamiliar with the UM process, authorization requirements, and how to contact the appropriate UM staff.
- Knowledge deficit of UM staff regarding processes.
- Providers not familiar with pharmacy processes and not aware that the PDL and authorization requirements are dictated by the State.
- Providers unaware of the availability of bulletins and other information available on the provider website.

Sunflower also identified the following interventions as opportunities that could help improving the provider satisfaction survey results:

- Educate and encourage providers to refer members to case management.
- Increase provider awareness of assigned case manager for members already in case management.
- Educate providers on the UM process, medical necessity criteria, and how to contact UM staff.
- Staff re-training and onboarding of qualified staff.
- Provider education regarding the pharmacy program, and limitations of Sunflower due to State control.
- Provider education regarding the array of resources available on the provider website.

Delegated Vendor Oversight

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

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

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

1. Cenpatico (CBH) - Sunflower's managed behavioral health care vendor. Cenpatico provides utilization management, network development and

maintenance, case management, credentialing of their network, and claims payment data.

2. OptiCare - Sunflower's vision care provider. OptiCare provides utilization management, network development and maintenance, credentialing of their network, and claims payment data.
3. US Script - Sunflower's pharmacy benefits manager. US Script provide information for prior authorizations, utilization management, verification of active licenses for all participating pharmacies, and claims payment data.
4. Nurtur - Sunflower's disease management provider. Nurtur provides disease management for the following programs: Asthma, Coronary Artery disease, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, Hypertension, Hyperlipidemia and Tobacco Smoking Cessation.
5. NurseWise - Sunflower's after-hours call center and nurse advice line. NurseWise is a bilingual care line of registered nurses which complete health screenings and after hours nurse advice.
6. National Imaging Associates (NIA) - Sunflower's high-tech radiological imaging provider. NIA provides prior authorizations, credentialing of their network, first level appeals, and claims information.
7. Logisticare - Sunflower's transportation vendor.
8. Alere - Assists Sunflower in obtaining risk assessment information on pregnant members and facilitating utilization of 17P.
9. Dental Health and Wellness (DHW) - They provide prior authorizations, utilization management, network development and maintenance and claim payment information.

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

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

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

The following table contains the results of vendor audits conducted in 2015 and scope of the review:

Vendor and Type	Date of Audit	Areas Audited	Scored Below 90%/QIP Implemented
NIA Radiology	**January 2015**	**UM:** P&Ps & UM Program Description; denial files; appeal files	No
		Credentialing: P&Ps & Credentialing Program Description, credentialing/recredentialing file review	No
		Compliance: P&Ps; Compliance Program Description; sample reports; staff interviews	No
		Member Rights & Responsibilities: applicable P&Ps	No
		Quality Improvement: P&Ps & QI Program Description	No
Opticare Vision	**October 2015**	**Claims:** P&Ps; claims file review	No
		Complaints: file review	No
		Compliance: P&Ps; Compliance Program Description; sample reports; staff interviews	No
		Credentialing: P&Ps & Credentialing Program Description, credentialing/recredentialing file review	No
		Member Rights & Responsibilities: applicable P&Ps	No
		Quality Improvement: P&Ps & QI Program Description	No
		UM: P&Ps & UM Program Description; denial files	No
Logisticare Transportation	**September 2015**	**Compliance:** P&Ps; Compliance Program Description; sample reports; staff interviews	Yes
		Driver Requirements and Training: P&Ps; sample provider agreement; provider materials	No
		Invoice Processing: P&Ps; sample reports; claims/billing manual	No
		Provider: P&Ps; sample provider agreement; provider materials	Yes

Vendor and Type	Date of Audit	Areas Audited	Scored Below 90%/QIP Implemented
		Safety & Security: sample provider agreement; provider materials; sample inspection form	No
		Vehicle Equipment Requirements & Maintenance: sample vehicle inspection form/report	No
US Script Pharmacy Benefits Manger	**March 2015**	**Claims:** P&Ps; claims file review	No
		Compliance: P&Ps; Compliance Program Description; sample reports; staff interviews	No
		Credentialing: P&Ps & Credentialing Program Description, credentialing/recredentialing file review	No
		Member Rights & Responsibilities: applicable P&Ps	No
		Performance Standards: P&P; reports	No
		Quality Improvement: P&Ps & QI Program Description	No
		UM: P&Ps & UM Program Description; denial file review	No
Cenpatico Behavioral Health	**April 2015**	**Case Management:** P&Ps; file review	Yes
		Claims: P&Ps; claims file review	No
		Complaints: file review	No
		Compliance: P&Ps; Compliance Program Description; sample reports; staff interviews	Yes
		Credentialing: P&Ps & Credentialing Program Description, credentialing/recredentialing file review	Yes
		Member Rights & Responsibilities: applicable P&Ps	No
		Quality Improvement: P&Ps & QI Program Description	Yes
		UM: P&Ps & UM Program Description; denial file review; appeal file review	No
Cenpatico STRS Therapies	**April 2015**	**Case Management:** P&Ps; file review	Yes
		Claims: P&Ps; claims file review	N/A

Vendor and Type	Date of Audit	Areas Audited	Scored Below 90%/QIP Implemented
		Complaints: file review	N/A
		Compliance: P&Ps; Compliance Program Description; sample reports; staff interviews	Yes
		Credentialing: P&Ps & Credentialing Program Description, credentialing/recredentialing file review	N/A
		Member Rights & Responsibilities: applicable P&Ps	No
Dental Health and Wellness Dental	**N/A**	**Claims**: P&Ps; claims file review	N/A
		Compliance: P&Ps; Compliance Program Description; sample reports; staff interviews	N/A
		Credentialing: P&Ps & Credentialing Program Description, credentialing/recredentialing file review	N/A
		Member Rights & Responsibilities: applicable P&Ps	N/A
		Quality Improvement: P&Ps & QI Program Description	N/A
		UM: P&Ps & UM Program Description; denial file review; appeal file review	N/A
Nutur Disease Management	**July2015**	**NCQA Disease Management standards:** Care Coordination, Clinical Quality, Evidence-based Programs, Patient Services, Practitioner Services & Program Operations - applicable P&Ps, sample reports, etc.	Yes
		Compliance: P&Ps; Compliance Program Description; training documents; sample reports	No
		Disease Management: DM case file review	Yes
NurseWise Nurse Hotline	**October 2015**	**Compliance:** P&Ps; Compliance Program Description; staff interviews; sample reports	No

Vendor and Type	Date of Audit	Areas Audited	Scored Below 90%/QIP Implemented
		URAC Core Standards: applicable P&Ps, program descriptions/work plans, meeting minutes	No
		Complaints/concerns: file review	Yes
		Triage calls: file review	Yes

Summary

Sunflower has identified strengths and opportunities for improvement which are outlined in more detail with action plans in the full annual evaluation report. Interventions included in the plan for continuation in 2015 were reviewed and continued as needed for measures requiring continued improvement.

Strengths:

- Member satisfaction results
- Steady improvement in HEDIS scores
- Access and Accessibility
- Re-design of Case Management
- Revised UM processes, strength of new executive leadership

Opportunities for Improvement:

- Provider satisfaction
- Practice Guideline adoption
- Physical and behavioral health provider integration

As a result of this analysis, it has been identified that processes and operational systems are starting to stabilize, producing early positive results, and in some cases negative findings as the plan matures and enforces guidelines. With two years of complete data, it is difficult to assert that trends have been identified for some processes, but statistically significant change has been found in some areas. The findings did not indicate the need for major revisions to Sunflower's QAPI, operations, or service delivery systems. Sunflower will continue to work to maintain and improve the gains achieved from 2015, and improve on the areas noted as priority opportunities for improvement for 2016.